DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION IX
90 - 7TH STREET, SUITE 3-650
SAN FRANCISCO, CA 94103

April 13, 2012

Report Number: A-09-12-02010

Mr. James Dover, FACHE
President and Chief Executive Officer
O'Connor Hospital
2105 Forest Avenue
San Jose, CA 95128

Dear Mr. Dover:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Outpatient Billing for Selected Drugs at O'Connor Hospital*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to contact Iman Zbinden, Senior Auditor, at (619) 557-6131, extension 109, or through email at Iman.Zbinden@oig.hhs.gov, or contact Alice Norwood, Audit Manager, at (415) 437-8360 or through email at Alice.Norwood@oig.hhs.gov. Please refer to report number A-09-12-02010 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE OUTPATIENT BILLING FOR SELECTED DRUGS AT O'CONNOR HOSPITAL

Daniel R. Levinson
Inspector General

April 2012
A-09-12-02010

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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Notices

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services administers the program.

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains detail regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered.

O'Connor Hospital (the Hospital) is an acute-care hospital located in San Jose, California. Based on data analysis, we reviewed $63,405 in Medicare payments to the Hospital for 11 line items for injections of selected drugs that the Hospital billed to Medicare during our audit period (January 1, 2008, through April 30, 2011). These line items consisted of injections for doxorubicin hydrochloride liposome, rituximab, pemetrexed, cetuximab, and epoetin alfa.

OBJECTIVE

Our objective was to determine whether the Hospital billed Medicare for injections of selected drugs in accordance with Federal requirements.

SUMMARY OF FINDINGS

For 9 of the 11 line items reviewed, the Hospital did not bill Medicare in accordance with Federal requirements:

- For five line items, the Hospital used the incorrect HCPCS code.
- For four line items, the Hospital billed the incorrect number of units of service.

As a result, the Hospital received overpayments totaling $46,355. The Hospital attributed the overpayments to billing system and clerical errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare administrative contractor $46,355 in identified overpayments and
- ensure compliance with Medicare billing requirements.

O'CONNOR HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and provided information on actions that it had taken to address our recommendations. The Hospital's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Requirements for Outpatient Claims

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains detail regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered.[1]

Selected Drugs

The drugs we reviewed in this audit were doxorubicin hydrochloride (HCl) liposome, rituximab, pemetrexed, cetuximab, and epoetin alfa.

Doxorubicin Hydrochloride Liposome

Doxorubicin HCl liposome is an injectable drug used to treat metastatic ovarian cancer and AIDS-related Kaposi's sarcoma. Medicare requires providers to bill one service unit for each 10-milligram injection of doxorubicin HCl liposome. The HCPCS code for this drug is J9001 and is described as "Injection, doxorubicin hydrochloride, all lipid formulations, 10 [milligrams]."

Rituximab

Rituximab is an injectable drug used to treat non-Hodgkin's lymphoma, chronic lymphocytic leukemia, and symptoms of adult rheumatoid arthritis. Medicare requires providers to bill one service unit for each 100-milligram injection of rituximab. The HCPCS code for this drug is J9310 and is described as "Injection, rituximab, 100 [milligrams]."

Pemetrexed

Pemetrexed is an injectable drug used to treat malignant mesothelioma and certain types of non-small cell lung cancer. Medicare requires providers to bill one service unit for each 10-milligram injection of pemetrexed. The HCPCS code for this drug is J9305 and is described as "Injection, pemetrexed, 10 [milligrams]."

[1] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Cetuximab

Cetuximab is an injectable drug used to treat cancers of the colon and rectum. Medicare requires providers to bill one service unit for each 10-milligram injection of cetuximab. The HCPCS code for this drug is J9055 and is described as "Injection, cetuximab, 10 [milligrams]."

Epoetin Alfa

Epoetin alfa is an injectable drug used to treat anemia. Medicare requires providers to bill one service unit for each 1,000 units of epoetin alfa. The HCPCS code for this drug is J0885 and is described as "Injection, epoetin alfa, for non-esrd [end-stage renal disease] use), 1000 units."

O'Connor Hospital

O'Connor Hospital (the Hospital) is an acute-care hospital located in San Jose, California. The Hospital's claims are processed and paid by Palmetto GBA, LLC (Palmetto), the Medicare administrative contractor.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital billed Medicare for injections of selected drugs in accordance with Federal requirements.

Scope

We reviewed $63,405 in Medicare payments to the Hospital for 11 line items that we judgmentally selected as potentially at risk for billing errors during our audit period (January 1, 2008, through April 30, 2011). These line items consisted of:

- five line items for doxorubicin HCl liposome totaling $25,728,
- two line items for rituximab totaling $21,226,
- one line item for pemetrexed totaling $8,351,
- one line item for cetuximab totaling $6,309, and
- two line items for epoetin alfa totaling $1,791.[2]

We identified these payments through data analysis.

[2] For the two line items for epoetin alfa, the Hospital billed Medicare in accordance with Federal requirements.

We did not review the Hospital's internal controls applicable to the 11 line items because our objective did not require an understanding of controls over the submission of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file for our audit period, but we did not assess the completeness of the file.

We conducted our audit from May 2011 to February 2012. Our fieldwork included contacting the Hospital, located in San Jose, California.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify paid Medicare claims for doxorubicin HCl liposome, rituximab, pemetrexed, cetuximab, and epoetin alfa;
- used computer matching, data mining, and analysis techniques to identify line items potentially at risk for noncompliance with Medicare billing requirements;
- identified 11 line items totaling $63,405 that Medicare paid to the Hospital;
- contacted the Hospital to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that the Hospital furnished to verify whether each selected line item was billed correctly;
- calculated overpayments using corrected payment information processed by Palmetto; and
- discussed the results of our review with the Hospital.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

For 9 of the 11 line items reviewed, the Hospital did not bill Medicare in accordance with Federal requirements:

- For five line items, the Hospital used the incorrect HCPCS code.

- For four line items, the Hospital billed the incorrect number of units of service.

As a result, the Hospital received overpayments totaling $46,355. The Hospital attributed the overpayments to billing system and clerical errors.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires hospitals to report claims for outpatient services using HCPCS codes.

Section 1833(e) of the Act states: "No payment shall be made to any provider of services … unless there has been furnished such information as may be necessary in order to determine the amounts due such provider … for the period with respect to which the amounts are being paid …."

CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 4, section 20.4, states: "The definition of service units … is the number of times the service or procedure being reported was performed."

The Manual, chapter 17, section 90.2.A, states: "It is … of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug … that was used in the care of the patient." If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, "[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 …."

Chapter 1, section 80.3.2.2, of the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

INCORRECT BILLING

For the five line items for doxorubicin HCl liposome, the Hospital billed Medicare using the HCPCS code for the administration of doxorubicin HCl liposome rather than using the HCPCS code for the administration of doxorubicin HCl, the drug actually administered. The incorrect billing resulted in overpayments totaling $25,728.

For four line items reviewed, the Hospital billed Medicare for the incorrect number of units of service:

- For the two line items for rituximab, the Hospital billed the incorrect number of units of service. Rather than billing 10 service units, the Hospital billed 20 service units. The incorrect billing resulted in overpayments totaling $11,653.

- For the one line item for pemetrexed, the Hospital billed the incorrect number of units of service. Rather than billing 100 service units, the Hospital billed 200 service units. The incorrect billing resulted in an overpayment of $4,617.

- For the one line item for cetuximab, the Hospital billed the incorrect number of units of service. Rather than billing 50 service units, the Hospital billed 150 service units. The incorrect billing resulted in an overpayment of $4,357.

In total, the Hospital received overpayments of $46,355. The Hospital attributed the overpayments to billing system and clerical errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare administrative contractor $46,355 in identified overpayments and

- ensure compliance with Medicare billing requirements.

O'CONNOR HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and provided information on actions that it had taken to address our recommendations. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: O'CONNOR HOSPITAL COMMENTS

O'Connor Hospital

2105 Forest Avenue
San Jose, California 95128-1471
(408) 947-2500
www.oconnorhospital.org

March 6, 2012

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region IX
90 7th Street, Suite 3-650
San Francisco, CA 94103

Re: Report Number A-09-12-02010

Dear Ms. Ahlstrand,

This letter provides comments on behalf of O'Connor Hospital to the draft report entitled "*Review of Medicare Outpatient Billing for Selected Drugs at O'Connor Hospital*". O'Connor Hospital appreciates the opportunity to respond to the Draft Report.

As noted in the Draft Report, the Office of Inspector General (the "OIG") reviewed $63,405 in Medicare payments for 11 line items for the following drugs: Doxorubicin Hydrochloride Liposome; Rituximab; Pemetrexed; Cetuximab; & Epoetin Alfa. O'Connor Hospital concurs with the OIG's findings that of the 11 line items sampled, 9 had billing errors that resulted in overpayments totaling $46,355. The OIG's recommendations and the corrective action taken are set forth below:

1. *The OIG recommends that O'Connor Hospital refund to the Medicare contractor $46,355 in identified overpayments.*
   Over the period of July 2011 – September 2011, O'Connor Hospital refunded the $46,355 identified by the OIG to Palmetto GBA.

2. *The OIG recommends that O'Connor Hospital ensure compliance with Medicare billing requirements.*
   To address the issues raised by the OIG's findings, O'Connor Hospital has implemented several measures, including the following:

   - The Revenue Integrity Department conducted a comprehensive Pharmacy Chargemaster review to ensure that all drug charges and corresponding HCPC code and billing multiplier assignments were accurate.

- The Pharmacy Department implemented a revised process to identify and review all Pharmacy charges for the Outpatient Infusion Center. The Pharmacy Department is ensuring that there are no duplicated or erroneous Pharmacy charges.

- The Patient Financial Services Department activated the *Palmetto Maximum Allowable Unit* edits for many HCPCS drugs & biologicals. These billing edits are reviewed on every Medicare Outpatient claim to ensure proper billing to the Medicare Program.

O'Connor Hospital takes its compliance obligations very seriously and appreciates the assistance and guidance provided by OIG staff in the review process. We will continue to monitor and audit claims, and institute additional controls and procedures, in the above areas as necessary. Please contact myself or Pamela Brotherton-Sedano, MS, RN, Corporate Responsibility Officer if I can be of further assistance.

Very truly yours,

James Dover, FACHE
President and Chief Executive Officer

cc: **Adam Cramer, CPA, MSA**
Auditor
U.S. Department of Health and Human Services
Office of Inspector General | Office of Audit Services

Pamela Brotherton-Sedano, MS, RN
VP, Patient Safety/Corporate Responsibility Officer
O'Connor Hospital