Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE OUTPATIENT BILLING FOR SELECTED DRUGS AT DOCTORS MEDICAL CENTER

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Lori A. Ahlstrand
Regional Inspector General

October 2012
A-09-12-02041

Office of Inspector General

https://oig.hhs.gov

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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.

Doctors Medical Center (Center) is an acute-care hospital located in San Pablo, California. Based on data analysis, we reviewed $188,625 in Medicare payments to the Center for two line items that the Center billed to Medicare during our audit period (May 1, 2008, through August 31, 2011). These line items consisted of injections for bevacizumab and rituximab. Bevacizumab is a drug used to treat a certain type of brain tumor as well as cancers of the kidney, lung, colon, and rectum. Rituximab is a drug used to treat non-Hodgkin's lymphoma.

OBJECTIVE

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

SUMMARY OF FINDINGS

For the two line items reviewed, the Center did not bill Medicare in accordance with Federal requirements. Specifically, the Center billed the incorrect number of units of service. As a result, the Center received overpayments totaling $180,931. The Center attributed the overpayments to billing system errors.

RECOMMENDATIONS

We recommend that the Center:

- refund to the Medicare administrative contractor $180,931 in identified overpayments and

- ensure compliance with Medicare billing requirements.

DOCTORS MEDICAL CENTER COMMENTS

In written comments on our draft report, the Center provided information on actions that it had taken to address our recommendations. The Center'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 bevacizumab and rituximab.

Bevacizumab

Bevacizumab is an injectable drug used to treat a certain type of brain tumor as well as cancers of the kidney, lung, colon, and rectum. Medicare requires providers to bill one service unit for each 10-milligram injection of bevacizumab. The HCPCS code for this drug is J9035 and is described as "Injection, bevacizumab, 10 [milligrams]."

Rituximab

Rituximab is an injectable drug used to treat non-Hodgkin's lymphoma. 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]."

Doctors Medical Center

Doctors Medical Center (Center) is an acute-care hospital located in San Pablo, California. The Center's claims are processed and paid by Palmetto GBA, LLC (Palmetto), the Medicare administrative contractor.

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

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed $188,625 in Medicare payments to the Center for two line items that we selected as potentially at risk for billing errors during our audit period (May 1, 2008, through August 31, 2011). These line items consisted of:

- one line item for bevacizumab totaling $179,451 and
- one line item for rituximab totaling $9,174.

We identified these payments through data analysis.

We did not review the Center's internal controls applicable to the two 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.

Our fieldwork included contacting the Center, located in San Pablo, 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 bevacizumab and rituximab during our audit period;
- used computer matching, data mining, and analysis techniques to identify line items potentially at risk for noncompliance with Medicare billing requirements;
- identified two line items totaling $188,625 that Medicare paid to the Center;
- contacted the Center 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 Center 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 Center.

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 the two line items reviewed, the Center did not bill Medicare in accordance with Federal requirements. Specifically, the Center billed the incorrect number of units of service. As a result, the Center received overpayments totaling $180,931. The Center attributed the overpayments to billing system 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 two line items reviewed, the Center billed Medicare for the incorrect number of units of service:

- For the one line item for bevacizumab, the Center billed the incorrect number of units of service. Rather than billing 80 service units, the Center billed 3,200 service units. The incorrect billing resulted in overpayments totaling $175,843.

- For the one line item for rituximab, the Center billed the incorrect number of units of service. Rather than billing 9 service units, the Center billed 18 service units. The incorrect billing resulted in overpayments totaling $5,088.

In total, the Center received overpayments of $180,931. The Center attributed the overpayments to billing system errors.

RECOMMENDATIONS

We recommend that the Center:

- refund to the Medicare administrative contractor $180,931 in identified overpayments and

- ensure compliance with Medicare billing requirements.

DOCTORS MEDICAL CENTER COMMENTS

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

APPENDIX

APPENDIX: DOCTORS MEDICAL CENTER COMMENTS

DOCTORS MEDICAL CENTER

September 20, 2012
Lori A. Alhstrand
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Region IX, San Francisco Field Office
90 7th Street, Suite 3-650
San Francisco, CA 94103

Dear Lori:

In response to your request for information regarding Report Number A-09-12-02041. This is in regards to one line item for bevacizumab totaling $179,451 and one line item for rituximab totaling $9174.

1) All accounts were rebilled. We are now waiting for Medicare to reprocess the claim with a corrected payment.

2) What caused the incorrect billings?

- At the time we were under the impression that we were billing correctly for the Bevacizumab and Rituximab.
- Currently Patient Billing & Pharmacy use the Craneware software and vendor support will continue to update and monitor these charges. The Pharmacy Chargelink component of Craneware keeps the facility updated as to any changes in J-code increments.
- The facility also reviews the HCPCS quarterly reports for any changes to Medicare billing.

If you have any further questions regarding this case, you can call me directly at (510) 970-5310 or email at thelser@dmc-sp.org.

Sincerely,

Therese V. Helser, R.Ph.
Pharmacy Director
Medication Safety Officer