Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE OUTPATIENT BILLING FOR SELECTED DRUGS AT ST. LUKE'S BOISE 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

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A-09-12-02043

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.

St. Luke's Boise Medical Center (Center) is an acute-care hospital located in Boise, Idaho. Based on data analysis, we reviewed $98,688 in Medicare payments to the Center for six 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, a drug used to treat a certain type of brain tumor as well as cancers of the kidney, lung, colon, and rectum;
- rituximab, a drug used to treat non-Hodgkin's lymphoma; and
- adenosine, a drug used to treat supraventricular tachycardia.

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 six 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 $82,645. The Center attributed the overpayments to billing system and clerical errors.

RECOMMENDATIONS

We recommend that the Center:

- refund to the Medicare administrative contractor $82,645 in identified overpayments and
- ensure compliance with Medicare billing requirements.

ST. LUKE'S BOISE MEDICAL CENTER COMMENTS

In written comments on our draft report, the Center concurred with our recommendations and 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, rituximab, and adenosine.

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]."

Adenosine

Adenosine is an injectable drug used to treat supraventricular tachycardia. Medicare requires providers to bill one service unit for each 30-milligram injection of adenosine. The HCPCS code for this drug is J0152 and is described as "Injection, adenosine for diagnostic use, 30 [milligrams]."

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

St. Luke's Boise Medical Center

St. Luke's Boise Medical Center (Center) is an acute-care hospital located in Boise, Idaho. The Center's claims are processed and paid by Noridian Administrative Services, LLC (Noridian), the Medicare administrative contractor.

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 $98,688 in Medicare payments to the Center for six 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:

- three line items for bevacizumab totaling $77,042,
- two line items for rituximab totaling $20,980, and
- one line item for adenosine totaling $666.

We identified these payments through data analysis.

We did not review the Center's internal controls applicable to the six 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 Boise, Idaho.

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, rituximab, and adenosine 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 six line items totaling $98,688 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 Noridian; 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 six 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 $82,645. The Center 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 six line items reviewed, the Center billed Medicare for the incorrect number of units of service:

- For the three line items for bevacizumab, the Center billed the incorrect number of units of service. Rather than billing from 36 to 70 service units, the Center billed from 360 to 700 service units. The incorrect billing resulted in overpayments totaling $70,636.

- For the two line items for rituximab, the Center billed the incorrect number of units of service. Rather than billing 10 service units, the Center billed 20 service units. The incorrect billing resulted in overpayments totaling $11,565.

- For the one line item for adenosine, the Center billed the incorrect number of units of service. Rather than billing 4 service units, the Center billed 12 service units. The incorrect billing resulted in overpayments totaling $444.

In total, the Center received overpayments of $82,645. The Center attributed the overpayments to billing system and clerical errors.

RECOMMENDATIONS

We recommend that the Center:

- refund to the Medicare administrative contractor $82,645 in identified overpayments and

- ensure compliance with Medicare billing requirements.

ST. LUKE'S BOISE MEDICAL CENTER COMMENTS

In written comments on our draft report, the Center concurred with our recommendations and 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: ST. LUKE'S BOISE MEDICAL CENTER COMMENTS

September 7, 2012

Via Electronic Transmission

Lori A Ahlstrand
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

RE: Report Number A-09-12-02043

Ms. Ahlstrand:

This letter is in response to your draft report dated August 2012 entitled *Review of Medicare Outpatient Billing for Selected Drugs at St. Luke's Boise Medical Center.*

The draft report recommends that St. Luke's Boise Medical Center (St. Luke's) refund to the Medicare administrative contractor the identified overpayment and to ensure compliance with Medicare billing requirements. St. Luke's concurs with the recommendations and has implemented plans to address the errors identified.

The plans implemented are as follows:

1. The Office of Inspector General (OIG) recommends that St. Luke's refund to the Medicare administrative contractor $82,645 in identified overpayments.

   St. Luke's has already refunded the $82,645 identified by the OIG to Noridian Administrative Services, LLC.

2. The OIG recommends that St. Luke's ensure compliance with Medicare billing requirements.

   In December of 2009, St. Luke's charge master team identified the calculation error for Bevacizumab. The claims containing incorrect units were re-billed with the appropriate number of units. Unfortunately, the claims identified in your letter for Bevacizumab were deleted rather than re-billed. St. Luke's implemented a control in the re-bill process to ensure a validation review is performed when claims require correction in similar circumstances. In addition, St. Luke's charge entry staff is reminded of the importance of accurate charge capture

St Luke's

as the other errors were due to duplicate or triplicate charges entered for the same date of service.

Additionally, the St. Luke's Compliance Department has identified pharmacy billing units as an area for review during the 2012 calendar year. The intent of the review is to ensure the controls implemented have been effective.

St. Luke's is committed to ensuring it accurately reflects the services provided on the claims submitted to Medicare for payment. St. Luke's appreciates the assistance from the OIG in helping to identify opportunities to enhance St. Luke's commitment.

Sincerely,

Chris Roth
Chief Executive Officer