Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE OUTPATIENT BILLING FOR SELECTED DRUGS AT SKY LAKES 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

December 2012
A-09-12-02061

Office of Inspector General

https://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:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

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.

Sky Lakes Medical Center (Center) is an acute-care hospital located in Klamath Falls, Oregon. Based on data analysis, we reviewed $66,840 in Medicare payments to the Center for four 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 rituximab and bevacizumab. Rituximab is a drug used to treat non-Hodgkin's lymphoma. Bevacizumab is a drug used to treat a certain type of brain tumor as well as cancers of the kidney, lung, colon, and rectum.

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 four line items reviewed, the Center did not bill Medicare in accordance with Federal requirements:

- For three line items, the Center billed the incorrect number of units of service.
- For one line item, the Center used the incorrect HCPCS code.

As a result, the Center received overpayments totaling $53,498. The Center attributed the overpayments to clerical errors.

RECOMMENDATIONS

We recommend that the Center:

- refund to the Medicare administrative contractor $53,498 in identified overpayments and
- ensure compliance with Medicare billing requirements.

SKY LAKES MEDICAL CENTER COMMENTS

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

TABLE OF CONTENTS

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 rituximab and bevacizumab.

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]."

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]."

Sky Lakes Medical Center

Sky Lakes Medical Center (Center) is an acute-care hospital located in Klamath Falls, Oregon. The Center's claims are processed and paid by Noridian Administrative Services, LLC (Noridian), 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 $66,840 in Medicare payments to the Center for four 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 rituximab totaling $56,075 and
- one line item for bevacizumab totaling $10,765.

We identified these payments through data analysis.

We did not review the Center's internal controls applicable to the four 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 Klamath Falls, Oregon.

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 rituximab and bevacizumab 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 four line items totaling $66,840 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 four line items reviewed, the Center did not bill Medicare in accordance with Federal requirements:

- For three line items, the Center billed the incorrect number of units of service.

- For one line item, the Center used the incorrect HCPCS code.

As a result, the Center received overpayments totaling $53,498. The Center attributed the overpayments to 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 three line items for rituximab, the Center billed the incorrect number of units of service. Rather than billing 7 or 8 service units, the Center billed from 14 to 75 service units. The incorrect billing resulted in overpayments totaling $45,664.

For the one line item for bevacizumab, the Center billed Medicare using the HCPCS code for the administration of bevacizumab rather than using the HCPCS code for the administration of bendamustine, the drug actually administered. The incorrect billing resulted in an overpayment of $7,834.

In total, the Center received overpayments of $53,498. The Center attributed the overpayments to clerical errors.

RECOMMENDATIONS

We recommend that the Center:

- refund to the Medicare administrative contractor $53,498 in identified overpayments and
- ensure compliance with Medicare billing requirements.

SKY LAKES MEDICAL CENTER COMMENTS

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

APPENDIX

APPENDIX: SKY LAKES MEDICAL CENTER COMMENTS

SKY LAKES
MEDICAL CENTER
LIFE : HEALING : PEACE™

2865 Daggett Avenue
Klamath Falls, OR 97601
Ph 541 882 6311

skylakes.org

Paul R. Stewart
President & CEO

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

Re: **Report Number:** A-09-1202061

Dear Ms. Ahlstrand:

Sky Lakes Medical Center ("Sky Lakes") is in receipt of your letter dated August 30, 2012, and the Draft Report entitled "Review of Medicare Outpatient Billing for Selected Drugs at Sky Lakes Medical Center". Sky Lakes has reviewed the Draft Report and concurs with its findings.

Upon receiving notice from the Office of Inspector General ("OIG") that a review of Medicare payments for outpatient services was being conducted to determine whether Sky Lakes billed Medicare for selected injectable drugs in accordance with applicable Federal requirements, Sky Lakes performed its own internal review. During the course of this review it was discovered that clerical issues had caused mathematical errors in the number of units being charged and that misapplication of Healthcare Common Procedure Coding System ("HCPCS") codes had occurred with the services in question.

Services that were discovered to be incorrectly billed during the review were recalculated based on the corrected number of units and correct HCPCS codes. Corrected claims were submitted to Noridian Administrative Services, LLC ("Noridian"), Sky Lakes' Medicare administrative contractor, for processing. The submission of the corrected claims resulted in a refund to Medicare of the full amount owing.

Sky Lakes has taken measures intended to ensure that the correct HCPCS codes are applied and that the correct number of units of service are billed in the future for injectable drugs. Using greater automation to reduce the opportunity for human error, the Sky Lakes Pharmacy Department has created processes intended to prevent further issues of this kind. The Sky Lakes Corporate Integrity Committee will conduct ongoing audits

of this process to assure future compliance with applicable Federal regulations. Any discrepancies identified in this process will be immediately corrected.

Sincerely,

Grant Kennon
Director of Risk, Quality and Resource Management