Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE OUTPATIENT BILLING FOR A SELECTED DRUG AT BANNER BAYWOOD 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

November 2012
A-09-12-02062

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.

Banner Baywood Medical Center (Center) is an acute-care hospital located in Mesa, Arizona. Based on data analysis, we reviewed $67,412 in Medicare payments to the Center for three 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, a drug used to treat non-Hodgkin's lymphoma.

OBJECTIVE

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

SUMMARY OF FINDING

For the three 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 $53,918. The Center attributed the overpayments to clerical errors.

RECOMMENDATIONS

We recommend that the Center:

- refund to the fiscal intermediary $53,918 in identified overpayments and
- ensure compliance with Medicare billing requirements.

BANNER BAYWOOD 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]

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]."

Banner Baywood Medical Center

Banner Baywood Medical Center (Center) is an acute-care hospital located in Mesa, Arizona. The Center's claims are processed and paid by Wisconsin Physicians Service Insurance Corporation (Wisconsin Physician Services), the fiscal intermediary.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed $67,412 in Medicare payments to the Center for three line items for rituximab that we selected as potentially at risk for billing errors during our audit period (May 1, 2008, through August 31, 2011). We identified these payments through data analysis.

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

We did not review the Center's internal controls applicable to the three 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 Mesa, Arizona.

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 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 three line items totaling $67,412 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 Wisconsin Physician Services; 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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

For the three 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 $53,918. 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 Medicare for the incorrect number of units of service. Rather than billing 10 or 11 service units, the Center billed from 15 to 100 service units. The incorrect billing resulted in overpayments totaling $53,918. The Center attributed the overpayments to clerical errors.

RECOMMENDATIONS

We recommend that the Center:

- refund to the fiscal intermediary $53,918 in identified overpayments and

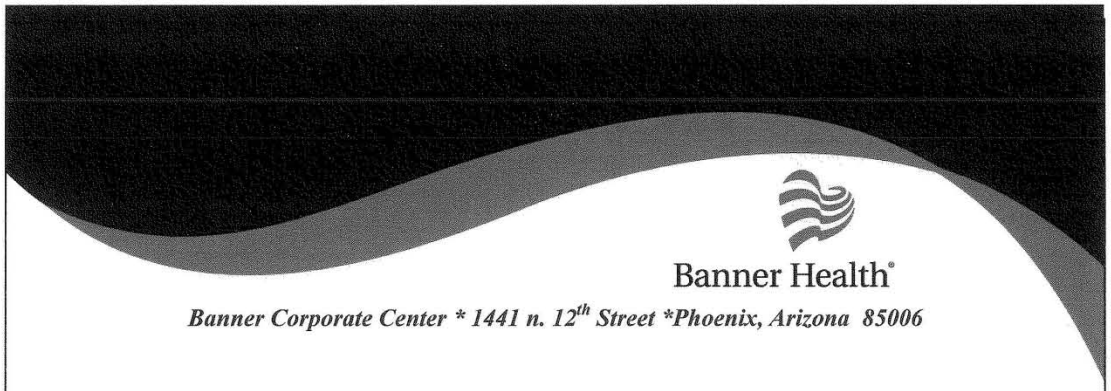
- ensure compliance with Medicare billing requirements.

BANNER BAYWOOD 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: BANNER BAYWOOD MEDICAL CENTER COMMENTS



Banner Health®

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September 7, 2012

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

Subject: (Draft Report) *Review of Medicare Outpatient Billing for a Selected Drug at Banner Baywood Medical Center* (Report Number A-09-12-02062)

Dear Ms. Ahlstrand,

Thank you for the opportunity to respond to the draft report for audit number A-09-12-02062, *Review of Medicare Outpatient Billing for a Selected Drug at Banner Baywood Medical Center*.

We concur with the recommendations made by the OIG. Three (3) accounts with dates of service spanning June, 2008 to February, 2010 were billed with incorrect units for the drug rituximab due to various clerical errors unique to each account.

OIG Recommendations:

- **Refund $53,918 in identified overpayments to the fiscal intermediary**
  - Banner Baywood Medical Center has already refunded these overpayments to our fiscal intermediary in December, 2011.
- **Ensure compliance with Medicare billing requirements**
  - We have provided education to pharmacy staff to address improper charging procedures caused by availability of appropriate vial sizes.
  - We have reviewed our CDM(charge description master) and system interface charging processes to ensure correct unit assignment of pharmacy charges.
  - We no longer permit manual batch charge posting for pharmacy services to further reduce opportunities for clerical errors.

Please contact Leslie Morgan at (602)747-4392 or by email at leslie.morgan@bannerhealth.com if you have any questions or if you need any additional information.

Sincerely,

David M. Ledbetter
V.P., Ethics & Compliance
Banner Health