



Office of Audit Services, Region III
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Philadelphia, PA 19106-3499

July 28, 2010

Report Number: A-03-10-10005

Ms. Rosa Moody
Compliance Officer
Princeton Community Hospital
P.O. Box 1369
Princeton, WV 24740

Dear Ms. Moody:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Payments for Outpatient Infusion Therapy Services Provided at Princeton Community Hospital, Princeton, West Virginia*. 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 me at (215) 861-4470 or through email at Stephen.Virbitsky@oig.hhs.gov, or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through email at Bernard.Siegel@oig.hhs.gov. Please refer to report number A-03-10-10005 in all correspondence.

Sincerely,

/Bernard Siegel/ for
Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Page 2 – Ms. Rosa Moody

cc:

Ms. Sandra Miller
Senior Vice President &
President Federal Government Solutions
National Government Services
8115-8125 Knue Road
Indianapolis, IN 46250

Direct Reply to HHS Action Official:

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, Missouri 64106

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PAYMENTS FOR OUTPATIENT
INFUSION THERAPY SERVICES
PROVIDED AT
PRINCETON COMMUNITY HOSPITAL,
PRINCETON, WEST VIRGINIA**



Daniel R. Levinson
Inspector General

July 2010
A-03-10-10005

Office of Inspector General

<http://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 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.

Prior to October 1, 2005, section 1816(a) of the Act authorized CMS to contract with fiscal intermediaries. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or Medicare administrative contractor, whichever is applicable. Medicare contractors use CMS's outpatient prospective payment system to process and pay Medicare Part B claims for outpatient hospital services submitted by hospitals (providers) on a rate-per-service basis using the ambulatory payment classification group assigned to each service.

CMS requires providers to bill accurately using the appropriate revenue codes and Healthcare Common Procedure Coding System (HCPCS) codes and to report the correct units of service performed. Revenue codes identify the cost center used on the hospital's annual cost report. HCPCS codes are used to identify and group services into an ambulatory payment classification group. When providers performed multiple procedures for the same beneficiary on the same date of service, the system pays the maximum allowable payment for the first procedure and, generally, half the maximum allowable payment for each additional procedure. For other services, Medicare only pays for one service per day, regardless of the number of procedures performed. Payment for some specific outpatient services is included in the payment for the primary surgical procedure. Medicare refers to these types of services as "packaged" or "bundled" services. Medicare does not allow payment of bundled or packaged services on a rate-per-service basis.

Princeton Community Hospital (the hospital) is a 188-bed acute-care hospital located in Princeton, West Virginia. National Government Services is the fiscal intermediary for the hospital and is responsible for collecting overpayments for the hospital's claims.

OBJECTIVE

Our objective was to determine whether payments received by the hospital from its Medicare contractor were appropriate for outpatient infusion therapy services billed by the hospital.

SUMMARY OF FINDING

Payments received by the hospital from its Medicare contractor for 762 claims were not appropriate because they were for outpatient infusion therapy services provided as part of a surgical procedure and therefore were not separately payable by Medicare. As a result, the hospital received overpayments totaling \$105,845 for 1,387 outpatient services.

RECOMMENDATION

We recommend that the hospital return the \$105,845 for the 1,387 outpatient procedure overpayments.

HOSPITAL COMMENTS

The hospital described the action it had taken, which included reviewing 250 of the claims identified in our audit, and concurred with our recommendation to refund the overpayments. The hospital also identified claims that it billed appropriately and we adjusted our finding and recommendation accordingly. The hospital did not identify why these overpayments occurred but said that in July 2006 it established controls that resolved the issue. The hospital's comments are included in Appendix A.

Subsequent to the review, the hospital contacted National Government Services and returned the overpayments totaling \$105,845. The hospital's notice showing the return of the overpayments is included in Appendix B.

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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 Contractors

Prior to October 1, 2005, section 1816(a) of the Act authorized CMS to contract with fiscal intermediaries.¹ Medicare contractors process and pay Medicare Part B claims submitted by hospital outpatient departments (providers). Medicare contractors also conduct reviews and audits, and safeguard against fraud and abuse. CMS's *Intermediary Manual*, Pub. 13, part 3, section 3700, provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process providers' claims for hospital outpatient services, Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

Hospital Outpatient Prospective Payment System

Pursuant to the Balanced Budget Act of 1997, P.L. No. 105-33, CMS established the *Prospective Payment System for Hospital Outpatient Services* (Final Rule), effective July 1, 2000.²

CMS's *Medicare Claims Processing Manual*, Pub. 100-04 (*Manual*), requires providers to bill accurately using the appropriate revenue codes and Healthcare Common Procedure Coding System (HCPCS) codes and to report the correct units of service performed.³ Revenue codes identify the cost center used on the hospital's annual cost report. The outpatient prospective payment system uses the HCPCS code to identify and group services into an ambulatory payment classification group.

Medicare contractors use CMS's outpatient prospective payment system to pay for outpatient hospital services on a rate-per-service basis using the ambulatory payment classification group assigned to each service. When providers performed multiple procedures for the same beneficiary on the same date of service, the system pays the maximum allowable payment for the first procedure and, generally, half the maximum allowable payment for each additional

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors between October 2005 and October 2011. Most, but not all, of the Medicare administrative contractors are fully operational; for jurisdictions where the Medicare administrative contractors are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or Medicare administrative contractor, whichever is applicable.

² See 65 Fed. Reg. 18433-18820 (April 7, 2000).

³ See chapter 1, section 80, and chapter 4, section 20.

procedure. For other services, Medicare only pays for one service per day, regardless of the number of procedures performed.

Payment for some specific outpatient services is included in the payment for the primary surgical procedure. Medicare refers to these types of services as “packaged” or “bundled” services. Medicare does not allow payment of bundled or packaged services on a rate-per-service basis.

Infusion Therapy Services

Infusion therapy is the administration of fluids and medication through an intravenous injection. For nonchemotherapy infusion, providers generally bill using revenue code 0260 (intravenous therapy) and HCPCS code Q0081 (infusion therapy—other than chemotherapy). For chemotherapy infusion, providers generally bill using revenue code 0335 (radiology—therapeutic and/or chemotherapy administration) and HCPCS codes Q0083 through Q0085 (chemotherapy). Beginning January 1, 2005, CMS changed the HCPCS codes for infusion therapy services annually.⁴

During outpatient surgical procedures, patients receive nonchemotherapy infusion therapy for hydration and the administration of other injectable drugs, including anesthesia. Generally, Medicare does not pay for these infusion therapy services separately because the payment for the surgical procedure includes payment for these packaged services.

When a provider administers nonchemotherapy infusion that is not part of a surgical procedure or administers a chemotherapy infusion, Medicare pays providers only for one infusion therapy service per visit, regardless of the number or volume of different fluids infused. Medicare pays for multiple infusion therapy services provided on the same day only when they are performed during separate visits.

Princeton Community Hospital

Princeton Community Hospital (the hospital) is a 188-bed acute care hospital located in Princeton, West Virginia. National Government Services is the fiscal intermediary for the hospital and is responsible for collecting overpayments for the hospital’s claims. At the time of our audit, Medicare had not selected the Medicare administrative contractor for jurisdiction 11, which includes West Virginia.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether payments received by the hospital from its Medicare contractor were appropriate for outpatient infusion therapy services billed by the hospital.

⁴ For calendar years 2005 through 2007, the HCPCS codes used, as appropriate for the first/subsequent units administered per visit, were 90780/90781, C8950/C8951, and 90760/90761, respectively. Before 2007, Medicare did not generally pay for quantities greater than one unit per visit. However, Medicare required providers to report the total number of hours of infusion therapy administered. Beginning 2007, and depending on the type of service provided, Medicare paid for subsequent units at a reduced rate.

Scope

We reviewed payments totaling \$105,845 that the Medicare contractor paid the hospital for 1,387 outpatient infusion therapy services on 762 claims from January 1, 2003, through December 31, 2007.⁵ We limited our review of the hospital's internal controls to those applicable to these outpatient service claims because our objective did not require an understanding of all internal controls over the submission and processing 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, but we did not assess the completeness of the file.

We conducted fieldwork from March through June 2010. Our fieldwork included contacting the hospital.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to identify claims paid for hospital outpatient infusion therapy services that were provided as part of outpatient surgical procedures;
- contacted the hospital and requested that it determine whether the claims were overpayments and, if not, why the claims were not overpayments;
- reviewed documentation provided by the hospital for its review of 250 claims, with service dates prior to August 2006 that we identified as part of our audit; and
- discussed the overpayments with hospital personnel to determine why the overpayments occurred.

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.

FINDING AND RECOMMENDATION

Payments received by the hospital from its Medicare contractor for 762 claims were not appropriate because they were for outpatient infusion therapy services provided as part of a surgical procedure and therefore were not separately payable by Medicare. As a result, the hospital received overpayments totaling \$105,845 for 1,387 outpatient services. The hospital did

⁵ We initially identified 795 claims with potential overpayment; however, the hospital identified 34 claims with 721 infusion therapy services provided outside of surgery or recovery. Consequently, we did not include these claims in the report. One of the 795 claims included infusion therapy services that were included in the review and infusion therapy services that were not included in the review.

not identify why these overpayments occurred but said that in July 2006 it established controls that resolved the issue.

PAYMENT FOR SURGERY-RELATED INFUSION THERAPY SERVICES

The preamble to CMS's Final Rule described packaged services as those that are directly related and integral in the performance of certain outpatient procedures and services.⁶ CMS does not make separate payments for these directly related and integral services when performed as a packaged service. The Final Rule identified these packaged services by the revenue codes that hospitals usually use to bill Medicare for these services, not by the HCPCS codes. The Final Rule identified nonchemotherapy intravenous infusion therapy (revenue code 0260) as a packaged service when performed in conjunction with a related outpatient surgical procedure.⁷

For 762 claims, the hospital billed and received payment for 1,387 nonchemotherapy infusion therapy services provided during outpatient surgical procedures. These infusion therapy services were not separately billable by the provider or payable by Medicare. As a result, the hospital received overpayments of \$105,845.

RECOMMENDATION

We recommend that the hospital return the \$105,845 for the 1,387 outpatient procedure overpayments.

HOSPITAL COMMENTS

The hospital described the action it had taken, which included reviewing 250 of the claims identified in our audit, and concurred with our recommendation to refund the overpayments. The hospital also identified claims that it billed appropriately and we adjusted our finding and recommendation accordingly. The hospital did not identify why these overpayments occurred but said that in July 2006 it established controls that resolved the issue. The hospital's comments are included in Appendix A.

Subsequent to the review, the hospital contacted National Government Services and returned the overpayments totaling \$105,845. The hospital's notice showing the return of the overpayments is included in Appendix B.

⁶ See 65 Fed. Reg. 18433, 18450 (April 7, 2000).

⁷ See 65 Fed. Reg. 18433, 18484 (April 7, 2000).

APPENDIXES

APPENDIX A: PRINCETON COMMUNITY HOSPITAL COMMENTS



Mr. John Carlucci, CPA
Senior Auditor
HHS-OIG- Office of Audit Services
150 South Independence Mall West, Suite 316
Philadelphia, PA 19106

Provider: 510046- Princeton Community Hospital Association, Inc.
Report #: A-03-10-10005

Dear Mr. Carlucci:

Princeton Community Hospital Association reviewed two hundred fifty claims with service dates prior to August, 2006. Our findings support your internal review results; therefore, we did not review additional claims with service dates prior to that time line.

Princeton Community Hospital Association implemented charge master reviews and charge processes with HMI, incorporated in May 2006 and subsequently developed an internal Revenue Integrity position July 30, 2006. Our findings indicate post August, 2006 the rate of error is greatly reduced.

PCHA is requesting a reduction of \$13,291.78 representing forty three accounts where hydration services were performed outside of surgery or recovery. A separate tab has been added to the OIG provider spreadsheet labeled 'pch review chrgd from OBS or ER' identifying the accounts.

We request to make direct payment of \$105,845.46 to the appropriate source in lieu of processing adjusted claims through National Government Services. This will greatly reduce the administrative burden for both PCHA and NGS.

Additionally, PCHA ran calendar year 2008 and 2009 internal reports for hydration services performed in conjunction with a surgical procedure. The data indicates hydration services charged post surgery and recovery.

Please advise next steps.

Thank you,

A handwritten signature in black ink, appearing to read 'Greg Yost', is written over a horizontal line.

Greg Yost

APPENDIX B: PRINCETON COMMUNITY HOSPITAL NOTICE OF RETURN OF
OVERPAYMENTS TO NATIONAL GOVERNMENT SERVICES



June 24, 2010

Mr. Mike Scholz
Senior Auditor- Underpayments
National Government Services
P.O. Box 29622
New York, New York 10087-9622

Provider: 510046- Princeton Community Hospital Association, Inc.
Report #: A-03-10-10005- OIG Review

Dear Mr. Scholz:

Princeton Community Hospital encloses a check in the sum of One Hundred Five Thousand Eight Hundred Forty Five Dollars and Forty Six cents (\$105,845.46) refunding National Government Services as a result of an overpayment review conducted in coordination with the OIG.

As you and I discussed, refunding directly greatly reduces the administrative burden for both PCHA and NGS while reducing associated costs of submitting adjusted claims for services dating back to calendar year 2006.

Please also find enclosed correspondence which explains and supports the issue in detail. Should you have questions or require further explanation please contact me directly at 304-487-7266.

Thank you,

A handwritten signature in black ink, appearing to read 'G Yost', is written over a horizontal line.

Greg Yost
PFS Director

cc: Frank Sinicrope
Rosa Moody
John Carlucci