

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE DID NOT PAY
SELECTED INPATIENT CLAIMS
FOR BONE MARROW AND
STEM CELL TRANSPLANT
PROCEDURES IN ACCORDANCE
WITH MEDICARE REQUIREMENTS**

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Office of Inspector General

<http://oig.hhs.gov>

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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

Medicare did not pay selected inpatient claims for bone marrow and stem cell transplant procedures in accordance with Medicare requirements, resulting in overpayments of \$6.3 million over more than 3½ years.

WHY WE DID THIS REVIEW

For calendar year 2012, Medicare paid hospitals \$185.9 million for inpatient claims related to bone marrow and stem cell transplant procedures (which we collectively refer to as “stem cell transplants”). Recent Office of Inspector General reviews identified Medicare overpayments to two hospitals that did not always comply with Medicare billing requirements for inpatient claims for stem cell transplants, resulting in overpayments of approximately \$4 million. The lengths of stay for the claims reviewed were 1 to 2 days, but generally the lengths of stay for claims with these procedures are from 10 to 21 days. Because claims with these disparities are at risk for billing errors, for this audit we reviewed \$7.3 million in Medicare payments nationwide for 143 selected inpatient claims for stem cell transplants from January 2010 through September 2013 (audit period).

Our objective was to determine whether Medicare paid selected inpatient claims for stem cell transplants in accordance with Medicare requirements.

BACKGROUND

Medicare Part A provides inpatient hospital insurance benefits, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which a beneficiary’s stay is assigned. The MS-DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary’s stay.

A CMS software program called the Medicare Severity Diagnosis Related Grouper (Grouper) determines the MS-DRG for each claim on the basis of the hospital’s reported billing data, which include diagnosis and procedure codes. To detect billing errors, the Grouper’s Medicare Code Editor (MCE) has coding, coverage, and clinical edits, such as consistency checks for correct use of diagnosis and procedure codes.

Patients with various kinds of blood-related cancers, such as leukemia and lymphoma, receive transplants of bone marrow and peripheral blood stem cells to restore stem cells that were destroyed by high doses of chemotherapy or radiation therapy or both. After being treated with anticancer drugs or radiation, the patient receives the harvested stem cells, which travel to the bone marrow and begin to produce new blood cells. Stem cell transplantation is not on CMS’s list of inpatient-only procedures, and according to an independent medical review contractor, stem cell transplantation is routinely performed as an outpatient procedure. However, with respect to stem cell transplants that are billed as inpatient services under Medicare Part A, the

procedure codes for these services primarily fall under one of four MS-DRGs and have geometric mean lengths of stay (GMLOS) from 10 to 21 days, as determined and published by CMS.

WHAT WE FOUND

Medicare paid 10 of the 143 selected inpatient claims for stem cell transplants in accordance with Medicare requirements. However, 133 claims did not comply with those requirements. The lengths of stay for these claims were 1 to 2 days. For 120 of these claims, the hospitals incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. These claims did not have clinical evidence supporting that an inpatient level of care was required before, during, or after the transplant procedures were performed. For the remaining 13 claims, the hospitals billed incorrect MS-DRGs. As a result of the 133 errors, Medicare overpaid the hospitals by \$6,341,441. This overpayment amount consisted of claims within the 3-year recovery period totaling \$4,574,228 and claims outside of the 3-year recovery period totaling \$1,767,213.

Medicare overpaid the hospitals because existing controls were not effective in preventing the overpayments. Specifically, the MCE edits for inpatient stem cell transplants did not check for disparities between the length of the inpatient stay and the GMLOS of the assigned MS-DRG for the stem cell transplant performed (which range from 10 to 21 days). As of the end of our fieldwork, the only CMS edits that specifically applied to inpatient stem cell transplants were MCE edits. For the period October 2013 through April 2015 (after our audit period), we identified an additional \$2,054,306 in payments nationwide for 58 inpatient claims for stem cell transplants with lengths of stay of 1 to 2 days that may have been incorrectly billed.

WHAT WE RECOMMEND

We recommend that CMS:

- direct the Medicare contractors to recover the \$4,574,228 in identified overpayments for incorrectly billed claims that are within the 3-year recovery period;
- work with the Medicare contractors to notify providers of potential overpayments outside of the 3-year recovery period, which we estimate to be as much as \$1,767,213 for our audit period;
- review the 58 inpatient claims from October 2013 through April 2015 for stem cell transplants with lengths of stays of 1 to 2 days, which could save as much as \$2,054,306;
- strengthen controls related to MS-DRGs for stem cell transplants; and
- educate hospitals on the appropriate billing of stem cell transplants.

CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS partially concurred with our first recommendation and stated that the recovery amount is based on some of the claims receiving full denials when those claims may have been able to be billed as Medicare Part B. CMS stated that it would instruct the Medicare contractors to recover all overpayments consistent with the agency's policies and procedures. Regarding our second recommendation, CMS stated that it would work with the Medicare contractors to notify providers of potential overpayments outside of the recovery period if CMS determines through a cost-benefit analysis that this would be beneficial. CMS concurred with our remaining recommendations and provided information on actions that it planned to take or would consider taking to address our recommendations. Regarding our third recommendation, CMS requested that we furnish the necessary data to follow up on the 58 inpatient claims from October 2013 through April 2015 for stem cell transplants with lengths of stay of 1 to 2 days.

We provided to CMS the requested claim data for the 58 inpatient claims. We continue to recommend that CMS (1) direct the Medicare contractors to recover the identified overpayments that are within the recovery period and (2) work with the Medicare contractors to notify providers of potential overpayments outside of the recovery period. Notifying the providers of these potential overpayments would inform the providers that they may have liability under the 60-day rule and prompt them to perform a reasonable inquiry into the claims.

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INTRODUCTION

WHY WE DID THIS REVIEW

For calendar year 2012, Medicare paid hospitals \$185.9 million for inpatient claims related to bone marrow and stem cell transplant procedures (which we collectively refer to as “stem cell transplants”). Recent Office of Inspector General (OIG) reviews identified Medicare overpayments to two hospitals that did not always comply with Medicare billing requirements for inpatient claims for stem cell transplants, resulting in overpayments of approximately \$4 million.¹ The lengths of stay for the claims reviewed were 1 to 2 days, but generally the lengths of stay for claims with these procedures are from 10 to 21 days. Because claims with these disparities are at risk for billing errors, for this audit we reviewed \$7.3 million in Medicare payments nationwide for 143 selected inpatient claims for stem cell transplants from January 2010 through September 2013 (audit period).²

OBJECTIVE

Our objective was to determine whether Medicare paid selected inpatient claims for stem cell transplants in accordance with Medicare requirements.

BACKGROUND

The Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Social Security Act (the Act) § 1862(a)(1)(A)). In addition, payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act § 1815(a)). The provider must furnish to the

¹ *Medicare Compliance Review of University of Washington Medical Center* (A-09-13-02049), issued June 12, 2014, and *Medicare Compliance Review of Oregon Health & Science University* (A-09-13-02057), issued October 27, 2014.

² We did not include in our review the payments to the two hospitals we previously reviewed.

Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

The *Medicare Claims Processing Manual* requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2).

Medicare's Inpatient Prospective Payment System

The Act established the inpatient prospective payment system (IPPS) for inpatient hospital services provided to Medicare beneficiaries (§§ 1886(d) and (g)). Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which a beneficiary's stay is assigned. The MS-DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Determination of Medicare Severity Diagnosis-Related Groups and Detection of Billing Errors

A CMS software program called the Medicare Severity Diagnosis Related Grouper (Grouper) determines the MS-DRG for each claim on the basis of the hospital's reported billing data, including diagnosis and procedure codes. To detect billing errors, the Grouper's Medicare Code Editor (MCE) has coding, coverage, and clinical edits, such as consistency checks for correct use of diagnosis and procedure codes.

Inpatient Bone Marrow and Stem Cell Transplant Procedures

Patients with various kinds of blood-related cancers, such as leukemia and lymphoma, receive transplants of bone marrow and peripheral blood stem cells to restore stem cells that were destroyed by high doses of chemotherapy or radiation therapy or both. After being treated with anticancer drugs or radiation, the patient receives the harvested stem cells, which travel to the bone marrow and begin to produce new blood cells. Stem cell transplantation is not on CMS's list of inpatient-only procedures,³ and according to an independent medical review contractor, stem cell transplantation is routinely performed as an outpatient procedure. However, with respect to cell transplants that are billed as inpatient services under Medicare Part A, the procedure codes for these services primarily fall under one of the four MS-DRGs shown in the table on the following page and have geometric mean lengths of stay (GMLOS)⁴ from 10 to 21 days.

³ The procedures on this list are payable under Medicare only when the procedures are performed in an inpatient setting in accordance with the IPPS. A procedure is designated as inpatient-only because of the nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged from the hospital. The inpatient-only list is published annually as Addendum E to the Hospital Outpatient Prospective System Final Rule.

⁴ The GMLOS is the national mean length of stay for each MS-DRG as determined and published by CMS. The geometric mean reduces the effect of very high or low values (i.e., outliers), which might bias the mean if a straight average (arithmetic mean) were used.

Table: Geometric Mean Lengths of Stay for Four Medicare Severity Diagnosis-Related Groups for Stem Cell Transplants

MS-DRG	Description⁵	GMLOS (in days)
009	Bone marrow transplant	17.7
014	Allogeneic bone marrow transplant	20.7
016	Autologous bone marrow transplant with a complication or comorbidity (CC)	18.1
017	Autologous bone marrow transplant without a CC or major CC	9.9

Previous Office of Inspector General Reviews

Previous OIG reviews identified Medicare overpayments to 2 hospitals that did not always comply with Medicare billing requirements for 43 inpatient claims related to stem cell transplants, resulting in overpayments of \$4 million:

- In our review of University of Washington Medical Center, 22 claims were for stem cell transplants and had an average length of stay of 1 day. We found that all 22 claims should have been billed as outpatient or outpatient with observation services. The 22 errors resulted in overpayments of \$2.1 million.
- In our review of Oregon Health & Science University, 25 claims were for stem cell transplants and had an average length of stay of 1 day. We found that 21 claims should have been billed as outpatient or outpatient with observation services, and 4 claims were billed correctly. The 21 errors resulted in overpayments of \$1.9 million.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$7,251,879 in Medicare payments to 45 hospitals nationwide for 143 inpatient claims for stem cell transplants that we judgmentally selected as at risk for billing errors from January 2010 through September 2013. We evaluated compliance with selected Medicare billing requirements for claims that had lengths of stay that were 1 to 2 days. We contracted with an independent medical review contractor to review 132 of the 143 claims to determine whether the services were medically necessary and met coding requirements.⁶

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

⁵ In allogeneic transplants, patients typically receive stem cells from a related donor; in autologous transplants, patients receive their own stem cells. In Federal fiscal year 2010, only MS-DRG 009 (bone marrow transplant) was available and did not distinguish between allogeneic and autologous transplants.

⁶ After we contacted the hospitals and requested supporting documentation, the hospitals canceled 11 of the 143 claims as a result of our review; therefore, we did not subject these claims to medical review. We treated the 11 claims as errors.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

Medicare paid 10 of the 143 selected inpatient claims for stem cell transplants in accordance with Medicare requirements. However, 133 claims did not comply with those requirements. The lengths of stay for these claims were 1 to 2 days. For 120 of these claims, the hospitals incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. For the remaining 13 claims, the hospitals billed incorrect MS-DRGs. As a result of the 133 errors, Medicare overpaid the hospitals by \$6,341,441. This overpayment amount consisted of claims within the 3-year recovery period totaling \$4,574,228 and claims outside of the 3-year recovery period totaling \$1,767,213.⁷ Medicare overpaid the hospitals because existing controls were not effective in preventing the overpayments.

HOSPITALS INCORRECTLY BILLED MEDICARE FOR INPATIENT STAYS

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act § 1862(a)(1)(A)).

According to CMS’s *Medicare Benefit Policy Manual*, factors that determine whether an inpatient admission is medically necessary include the following: the severity of the signs and symptoms exhibited by the patient; the medical predictability of something adverse happening to the patient; the need for diagnostic studies that appropriately are outpatient services⁸ to assist in assessing whether the patient should be admitted; and the availability of diagnostic procedures at the time when and at the location where the patient presents (Pub. No. 100-02, chapter 1, § 10).

For 120 of 143 selected claims, the hospitals incorrectly billed Medicare Part A for beneficiary stays for stem cell transplants that should have been billed as outpatient or outpatient with observation services. According to the independent medical review contractor, the claims it reviewed did not have clinical evidence supporting that an inpatient level of care was required before, during, or after the stem cell transplant procedures were performed. For example, in one case, the hospital incorrectly submitted a Medicare Part A claim for a patient who was admitted

⁷ Section 1870(b) of the Act governs the recovery of excess payments. This section provides that excess payments identified are barred from recovery 3 years after the year in which the original payment was made. In addition, the hospitals are responsible for reporting and returning overpayments they identified to their Medicare administrative contractors. The 2010 Patient Protection and Affordable Care Act requires the reporting and return of Medicare overpayments along with written notice of the reason for the overpayment within 60 days after the overpayment was identified (60-day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

⁸ The *Medicare Benefit Policy Manual* defines outpatient services as those services whose performance does not ordinarily require the patient to remain at the hospital for 24 hours or more.

for elective high-dose chemotherapy followed by peripheral stem cell transplantation. The independent medical review contractor determined that this case did not have clinical evidence supporting that an inpatient level of care was required.

In contrast, another hospital correctly submitted a Medicare Part A claim for a patient who was admitted for peripheral stem cell transplantation. The patient developed hypoxia during the transfusion along with persistent thrombocytopenia.⁹ The independent medical review contractor determined that, at the time of admission, inpatient treatment was anticipated as a result of these complications, and the evaluation, preparation, treatment, and close monitoring that the patient received were appropriate for the patient's condition.

Hospitals primarily attributed the billing errors to human error. For example, the staff at one hospital believed these procedures were on Medicare's "inpatient-only" list. As a result of the 120 errors, the hospitals received overpayments of \$6,028,693.¹⁰

HOSPITALS BILLED INCORRECT MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act § 1862(a)(1)(A)). The *Medicare Claims Processing Manual* states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 13 of 143 selected claims, the hospitals billed Medicare with incorrect MS-DRGs. In each case, the incorrect MS-DRG was assigned because an incorrect diagnosis or procedure code was billed. For example, in one case, the length of stay was 2 days, and a procedure code for allogeneic hematopoietic stem cell transplant (41.05) was incorrectly billed instead of a procedure code for spinal fusion (81.08). This resulted in the incorrect assignment of MS-DRG 009 (bone marrow transplant), which has a GMLOS of 17.7 days, instead of MS-DRG 460 (spinal fusion except cervical without a CC or major CC), which has a GMLOS of 3 days.

Hospitals primarily attributed the billing errors to human error. As a result of the 13 errors, the hospitals received overpayments of \$312,748.¹¹

⁹ Hypoxia is a condition in which the body or a region of the body is deprived of adequate oxygen supply. Thrombocytopenia is a disorder in which there is a relative decrease of thrombocytes, commonly known as platelets, in the blood.

¹⁰ The hospitals may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount.

¹¹ The overpayment amount represents the difference between what was paid for the incorrectly billed MS-DRGs and what would have been paid if the MS-DRGs had been billed correctly.

EXISTING CONTROLS WERE NOT EFFECTIVE IN PREVENTING OVERPAYMENTS FOR INPATIENT STEM CELL TRANSPLANTS

Medicare overpaid the hospitals \$6,341,441 because existing controls were not effective in preventing the overpayments. (Of this amount, \$4,574,228 was within the 3-year recovery period and \$1,767,213 was outside of that period.) Specifically, the MCE edits for inpatient stem cell transplants did not check for disparities between the length of the inpatient stay and the GMLOS of the assigned MS-DRG for the stem cell transplant performed (which range from 10 to 21 days). As of the end of our fieldwork, the only CMS edits that specifically applied to inpatient stem cell transplants were MCE edits. For the period October 2013 through April 2015 (after our audit period), we identified an additional \$2,054,306 in payments nationwide for 58 inpatient claims for stem cell transplants with lengths of stay of 1 to 2 days that may have been incorrectly billed.

RECOMMENDATIONS

We recommend that CMS:

- direct the Medicare contractors to recover the \$4,574,228 in identified overpayments for incorrectly billed claims that are within the 3-year recovery period;
- work with the Medicare contractors to notify providers of potential overpayments outside of the 3-year recovery period, which we estimate to be as much as \$1,767,213 for our audit period;
- review the 58 inpatient claims from October 2013 through April 2015 for stem cell transplants with lengths of stays of 1 to 2 days, which could save as much as \$2,054,306;
- strengthen controls related to MS-DRGs for stem cell transplants; and
- educate hospitals on the appropriate billing of stem cell transplants.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS partially concurred with our first recommendation and provided information on actions that it planned to take with respect to our second recommendation. CMS concurred with our remaining recommendations and provided information on actions that it planned to take or would consider taking to address our recommendations. CMS's comments are included in their entirety as Appendix B.

CMS COMMENTS

CMS had the following comments on our recommendations:

- Regarding our first recommendation, CMS stated that the recovery amount is based on some of the claims receiving full denials when those claims may have been able to be

billed as Medicare Part B. CMS stated that it would instruct the Medicare contractors to deny the Medicare Part A claims and inform the providers that they can resubmit the claims to Medicare Part B. In addition, CMS stated that it would instruct the Medicare contractors to recover all overpayments consistent with the agency's policies and procedures.

- Regarding our second recommendation, CMS stated that it would work with the Medicare contractors to notify providers of potential overpayments outside of the recovery period if CMS determines through a cost-benefit analysis that this would be beneficial.
- Regarding our third recommendation, CMS requested that we furnish the necessary data to follow up on the 58 inpatient claims from October 2013 through April 2015 for stem cell transplants with lengths of stay of 1 to 2 days.
- Regarding our fourth recommendation, CMS stated that it would consider instructing the Medicare contractors "to make short stay inpatient admission for stem cell transplants a priority for the type of cases to be reviewed for compliance."
- Regarding our fifth recommendation, CMS provided information on how it educates providers on avoiding common billing errors and stated that it would continue to use those channels to educate providers.

OFFICE OF INSPECTOR GENERAL RESPONSE

We provided to CMS the requested claim data for the 58 inpatient claims. We continue to recommend that CMS (1) direct the Medicare contractors to recover the identified overpayments that are within the recovery period and (2) work with the Medicare contractors to notify providers of potential overpayments outside of the recovery period. Notifying the providers of these potential overpayments would inform the providers that they may have liability under the 60-day rule and prompt them to perform a reasonable inquiry into the claims.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$7,251,879 in Medicare payments to 45 hospitals nationwide for 143 inpatient claims for stem cell transplants that we judgmentally selected as at risk for billing errors from January 2010 through September 2013. We evaluated compliance with selected Medicare billing requirements for claims that had lengths of stay that were 1 to 2 days. We subjected 132 of the 143 claims to medical review to determine whether the services were medically necessary and met coding requirements.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History file, but we did not assess the completeness of the file.

We limited our review of CMS's internal controls to those applicable to inpatient claims for stem cell transplants because our objective did not require an understanding of all internal controls over the submission and processing of claims.

We conducted our fieldwork from December 2013 to April 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify inpatient claims related to stem cell transplants during our audit period;
- used computer matching, data mining, and data analysis techniques to identify and judgmentally select for review 143 claims for stem cell transplants at risk for noncompliance with selected Medicare billing requirements;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether they had been canceled or adjusted;
- requested that each hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the itemized bills and medical record documentation provided by each hospital to support the selected claims;
- used an independent medical review contractor to determine whether services for 132 selected claims were medically necessary and met coding requirements;

- calculated the correct payments and the overpayments for those claims requiring adjustments;
- calculated the overpayments that were both within and outside of the 3-year recovery period;
- interviewed CMS officials and reviewed documentation provided by them to determine the underlying causes for overpayments to providers that submitted stem cell transplant claims that did not comply with Medicare requirements;
- used computer matching, data mining, and data analysis techniques to identify additional claims at risk for noncompliance with selected Medicare billing requirements that were billed from October 2013 to April 2015; and
- discussed the results of our review with CMS officials and notified them that we would provide them with all the claims identified in this review.

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 objectives.

APPENDIX B: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

NOV 16 2015

200 Independence Avenue SW
Washington, DC 20201

To: Daniel R. Levinson
Inspector General
Office of the Inspector General

From: Andrew M. Slavitt 
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: Medicare Did Not Pay Selected Inpatient Claims for Bone Marrow and Stem Cell Transplant Procedures in Accordance with Medicare Requirements, (A-09-14-02037)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of the Inspector General's (OIG) draft report.

CMS is committed to providing Medicare and Medicaid beneficiaries with high quality health care and to being a good steward of taxpayer dollars by preventing improper billing. CMS has taken actions to prevent overpayments for Medicare Part A, by educating providers on proper billing, and implementing system checks to prevent improper billing. CMS uses a number of claim-review initiatives to identify and address incorrect billing caused by coverage or coding errors made by providers.

OIG Recommendation

OIG recommends that CMS direct Medicare contractors to recover the \$4,572,228 in identified overpayments for incorrectly billed claims that are within the 3-year recovery period.

CMS Response

CMS partially concurs with this recommendation. The \$4.57 million is based on some of the claims receiving full denials when those claims may have been able to be billed as Medicare Part B. CMS will instruct its contractors to deny the Medicare Part A claims and inform the providers that they can resubmit the claims to Medicare Part B. In addition, CMS will instruct its contractors to recover all overpayments consistent with agency's policies and procedures.

OIG Recommendation

OIG recommends that CMS work with the Medicare contractors to notify providers of potential overpayments outside of the 3-year recovery period, which we estimate to be as much as \$1,767,213 for our audit period.

CMS Response

CMS will work with the Medicare contractors to notify providers of potential overpayments outside of the 4-year recovery period, which we estimate to be as much as \$1,767,213 for our audit period, if CMS determines through a cost-benefit analysis that this would be beneficial.

OIG Recommendation

OIG recommends that CMS review the 58 inpatient claims from October 2013 through April 2015 for stem cell transplants with lengths of stays of 1 to 2 days, which could save as much as \$2,054,306.

CMS Response

CMS concurs with this recommendation. CMS requests that OIG furnish the necessary data to follow-up on the claims. Upon receipt of the files from OIG, CMS will conduct an analysis to determine the potential return on investment from a medical review of the claims provided. Based on the analysis and contractor resources, CMS will determine an appropriate number of claims to review.

OIG Recommendation

The OIG recommends that CMS strengthen controls related to MS-DRGs for stem cell transplants.

CMS Response

CMS concurs with this recommendation. CMS will consider instructing contractors to make short stay inpatient admission for stem cell transplants a priority for the type of cases to be reviewed for compliance.

OIG Recommendation

OIG recommends that CMS educate hospitals on the appropriate billing of stem cell transplants.

CMS Response

CMS concurs with this recommendation. CMS educates providers on avoiding common Medicare billing errors through various channels, including the Medicare Learning Network (MLN). CMS uses weekly electronic newsletters and quarterly compliance newsletters to educate providers on avoiding common Medicare billing errors, including billing for excessive units of service, as well as errors due to the use of incorrect Healthcare Common Procedure Coding System (HCPS) codes. CMS will continue to use these channels to educate providers.