



Office of Audit Services, Region III
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July 9, 2010

Report Number: A-03-10-10002

Mr. Frank G. Gomes
Compliance Officer
Washington Hospital Center
100 Irving Street NW
Washington, DC 20010

Dear Mr. Gomes:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Payments for Outpatient Infusion Therapy and Blood Administration Services Provided at Washington Hospital Center, Washington, DC*. 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-03-10-10002 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

Page 2 – Mr. Frank G. Gomes

cc:

Michele A. Daley-Ryan
Manager
Monitoring & Inspections
Highmark Medicare Services Inc.

Direct Reply to HHS Action Official:

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Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PAYMENTS FOR OUTPATIENT
INFUSION THERAPY AND
BLOOD ADMINISTRATION SERVICES
PROVIDED AT
WASHINGTON HOSPITAL CENTER,
WASHINGTON, DC**



Daniel R. Levinson
Inspector General

July 2010
A-03-10-10002

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.

Washington Hospital Center (the hospital) is a 926-bed acute-care teaching and research hospital located in the District of Columbia. The hospital is a member of MedStar Health, a not-for-profit regional healthcare system. Before October 1, 2005, CareFirst of Maryland was the fiscal intermediary for the hospital. On October 1, 2005, Highmark Medicare Services (Highmark) became the hospital’s fiscal intermediary and, subsequently, on October 24, 2007, the Medicare administrative contractor. As the current Medicare contractor for the hospital, Highmark 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 and blood administration services billed by the hospital.

SUMMARY OF FINDING

Payments received by the hospital from its Medicare contractor for 260 claims were not appropriate. Each of these claims had errors relating to outpatient infusion therapy or blood administration services. As a result, the hospital received overpayments totaling \$34,059. The hospital received \$56,468 for 477 outpatient services, rather than the allowable amount, \$22,409

for 162 outpatient services, resulting in overpayments totaling \$34,059 for 315 outpatient services.

RECOMMENDATIONS

We recommend that the hospital:

- return the \$34,059 for the 315 outpatient procedure overpayments and
- review claims with these outpatient services paid by the Medicare contractor after December 31, 2007, and return any overpayments identified.

HOSPITAL COMMENTS

In written comments, the hospital described the actions it had taken and said that it would voluntarily refund the identified overpayments. The hospital stated that it received these overpayments because the billing and coding for these services in its “CDM” (charge description master) were not accurate. The hospital’s comments are included in 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 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.

Outpatient Services

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 0331 or 0335 (radiology—therapeutic: chemotherapy administration by injection or intravenous) 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.

Blood Administration Services

Blood administration includes the transfusion of blood and any blood product. Generally, providers bill for blood administration using revenue code 0391 (blood storage and processing – blood administration) and HCPCS code 36430 (transfusion—blood or blood components). Medicare pays providers for only one blood administration service per day, regardless of the number or volume of different blood products transfused. Providers bill and Medicare pays for the transfused blood and blood products separately.

Washington Hospital Center

Washington Hospital Center (the hospital) is a 926-bed acute-care teaching and research hospital located in the District of Columbia. The hospital is a member of MedStar Health, a not-for-profit

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.

regional healthcare system. Before October 1, 2005, CareFirst of Maryland was the fiscal intermediary for the hospital. On October 1, 2005, Highmark Medicare Services (Highmark) became the hospital's fiscal intermediary and, subsequently, on October 24, 2007, the Medicare administrative contractor. As the current Medicare contractor for the hospital, Highmark is responsible for collecting overpayments for the hospital's claims.

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 and blood administration services billed by the hospital.

Scope

We reviewed payments totaling \$56,468 that the Medicare contractor paid the hospital for 477 outpatient infusion therapy and blood administration services on 260 claims from January 1, 2003, through December 31, 2007. 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 November 2009 through May 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 and blood administration services with more than one unit per day and 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 sample of 111 of the 315 questioned services we identified; 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.

FINDINGS AND RECOMMENDATIONS

Payments received by the hospital from its Medicare contractor for 260 claims were not appropriate. Each of these claims had errors relating to outpatient infusion therapy or blood administration services. As a result, the hospital received overpayments totaling \$34,059. The hospital received \$56,468 for 477 outpatient services, rather than the allowable amount, \$22,409 for 162 outpatient services, resulting in overpayments totaling \$34,059 for 315 outpatient services. The hospital stated that it received these overpayments because the billing and coding for these services in its “CDM” (charge description master) were not accurate.

PAYMENT FOR OUTPATIENT SERVICES GREATER THAN ONE

For 156 claims, the hospital billed and received payment for excessive services because it billed Medicare for services greater than one: 99 claims for excessive infusion therapy services and 57 claims for excessive blood administration services.

Multiple Infusion Therapy Services

CMS’s *Manual*, chapter 4, section 230.2.1, limits infusion therapy for nonchemotherapy and chemotherapy services to one service per visit, regardless of the number or volume of different fluids infused for services furnished.

For 99 claims, the hospital billed and received payment for excessive services because it billed Medicare for more than one infusion therapy service per visit. The hospital billed and received payment for 226 infusion therapy services of which 121 were in excess of one per visit. The hospital received \$25,334 for these infusion therapy services, rather than the allowable amount, \$12,405, resulting in overpayments totaling \$12,929.

Multiple Blood Administration Services

CMS’s *Manual*, chapter 4, section 231.8, states that providers should bill for blood transfusion services (HCPCS code 36430) on a per service basis. Medicare will pay the provider for transfusing blood products once per day, regardless of the number or volume of different blood products transfused.

For 57 claims, the hospital billed and received payments for excess blood administration services because it billed Medicare for more than one blood administration service for each date of service. The hospital billed and received payment for 121 blood administration services of which 64 were in excess of one per day. The hospital received \$21,236 for these blood administration services, rather than the allowable amount, \$10,004, resulting in overpayments totaling \$11,232.

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.⁵ 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.⁶

For 104 claims, the hospital billed and received payment for 130 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 overpayment totaling \$9,898.

RECOMMENDATIONS

We recommend that the hospital:

- return the \$34,059 for the 315 outpatient procedure overpayments and
- review claims with these outpatient services paid by the Medicare contractor after December 31, 2007, and return any overpayments identified.

HOSPITAL COMMENTS

In written comments, the hospital described the actions it had taken and said that it would voluntarily refund the identified overpayments. The hospital stated that it received these overpayments because the billing and coding for these services in its "CDM" (charge description master) were not accurate. The hospital's comments are included in the Appendix.

⁵ See 65 Fed. Reg. 18433, 18450 (April 7, 2000).

⁶ See 65 Fed. Reg. 18433, 18484 (April 7, 2000).

APPENDIX

APPENDIX: WASHINGTON HOSPITAL CENTER COMMENTS



MedStar Health

*Office of Corporate
Business Integrity*

April 26, 2010

Bernard Siegel, Audit Manager
Department of Health & Human Services
Office of the Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316
Philadelphia, PA 19106-3499

RE: Report # A-03-10-10002

Dear Mr. Siegel:

The purpose of this letter is to provide a narrative response relating to the above Report, which relate to claims paid under Medicare's Hospital Outpatient Prospective Payment System (HOPPS) at Washington Hospital Center. We will outline herein our understanding of the cause of the errors as well as actions being taken by MedStar Health to correct these issues going forward.

As part of our process for reviewing the claims in question, MedStar Health contracted with an outside healthcare auditing company to perform a comprehensive, independent review of the services that were identified in your Report. We had the services reviewed in accordance with the methodology outlined by our office, and those results have already been provided to you.

Please note that the billing and coding for some of these services, based on the date of service, occurred during the tenure of staff that are no longer with MedStar Health.

Infusion Therapy Packing Issue – During outpatient “surgery” procedures, the patient usually receives infusion therapy for hydration purposes and other injectable drugs, including anesthesia, are often administered through these intravenous “connections.” In this sense, infusion therapy is part of the surgery procedure and not a separate and distinct medical procedure.

We identified the infusion charge on the claim for one unit is billed with revenue code 260-Qoo81. On detail there are two charges that roll into the revenue code 260. These service codes are for IV infusion up to 1 hour and IV infusion 2-4 hours. Both carried a 260 revenue code at the time. The service codes for Infusion Therapy were inactivated 3/17/05.

Although the services were provided, and the documentation supports the services, the billing was incorrect. We reviewed the charge description master, to ensure it had been corrected regarding coding assignment for these services. Unfortunately, the billing errors occurred at the point of charge entry that reflects back through the mapping of our CDM, where charges were not bundled appropriately. We did not identify specific patterns of abuse, and this issue appears to have been corrected on 3/17/05 with the re-mapping of the CDM.

Action Plan: We propose the following actions:

- We will have our auditing company perform another round of random audits, for these services that occurred in 2008 and 2009. We will review a sample of 25 number of services;
- Update or create any policies and procedures that may be lacking in specific detail;
- Provide education to all affected staff and billing offices in the appropriate documentation and billing for these services; and
- We will voluntarily refund any overpayments identified.

Infusion Therapy Quantity Issue - For claims with infusion therapy charges that did not meet the criteria of a “packaged service” we determined whether the hospital billed for, and Medicare paid for, more than one unit of service per day. Medicare policy is to pay for one infusion therapy service per day, regardless of the number of infusion liquids that were administered. If infusion therapy is started at two distinct times during the day, then both would be covered.

This issue is was resolved on 3/17/05 by re-mapping the CDM to now bill based on units instead of time. We will, however, take the following steps to verify that appropriate controls and processes are in place.

Action Plan: We propose the following actions:

- We will have our auditing company conduct another round of random audits, for services occurring in 2008 and 2009. We will have 25 number of services reviewed;
- Update or create any policies and procedures that may be lacking in sufficiency, specifically, we will ensure that the policies and procedures require that the start and stop times for chemotherapy are documented.
- Provide education to all affected staff at both the hospital and billing office in the appropriate documentation and billing for these services; and
- We will make a voluntary refund any overpayments identified.

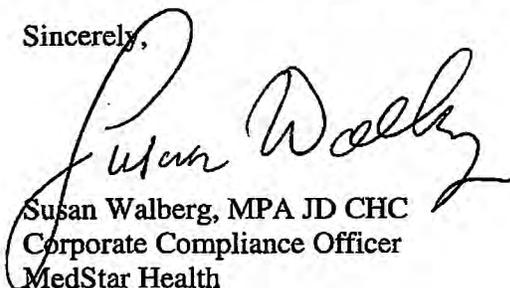
Blood transfusion (HCPCS Code 36430) - The error in this instance was that 2 -3 units were charged instead of one. The charges for blood administration and transfuse blood/blood comp. Both service codes have a CPT code of 36430. The UB-92 Editor recommends using revenue code 391 for CPT code 36430 which is attached to both service codes. This has been identified as an issue caused by our CDM mapping. This is not an issue in the billing to Medicare because the Medicare Administrative Contractor, Highmark Medicare Services, is using the CMS Medically Unnecessary Edits to stop this type of billing from going through, so there are no overpayments for these services going through at the present time. Because of the CMS edits, there have been no additional overpayments to repay.

Action Plan - We propose the following action steps:

- We will have our auditing company conduct another round of random audits, for services occurring in 2008 and 2009. We will have 25 number of services reviewed;
- Provide education to all affected staff at both the hospital and the billing office regarding the correct billing for these services
- We will make a voluntary refund if any overpayments are identified.

Please let us know if you have any questions or need any additional information. Thank you.

Sincerely,



Susan Walberg, MPA JD CHC
Corporate Compliance Officer
MedStar Health

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