



Office of Audit Services, Region III
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June 24, 2010

Report Number: A-03-10-10004

Ms. Deborah A. Morrison, R.N., M.G.A.
Vice President, Quality Improvement/Risk Management
Providence Hospital
1150 Varnum Street, NE
Washington, DC 20017

Dear Ms. Morrison:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Payments for Outpatient Infusion Therapy, Lithotripsy, and Blood Administration Services Provided at Providence Hospital, 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.

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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-03-10-10004 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

cc:

Michele A. Daley-Ryan
Manager
Monitoring & Inspections
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Direct Reply to HHS Action Official:

Nanette Foster Reilly
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Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



Daniel R. Levinson
Inspector General

June 2010
A-03-10-10004

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.

Providence Hospital (the hospital) is a 408-bed community hospital located in the District of Columbia. The hospital is a member of Ascension Health, a national Catholic health system of nonprofit corporations. 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, lithotripsy, and blood administration services billed by the hospital.

SUMMARY OF FINDING

Payments received by the hospital from its Medicare contractor for 1,448 claims were not appropriate. Each of these claims had errors relating to outpatient infusion therapy, lithotripsy, or blood administration services. As a result, the hospital received overpayments totaling \$127,391. The hospital received \$140,143 for 1,519 outpatient services, rather than the

allowable amount, \$12,752 for 40 outpatient services, resulting in overpayments totaling \$127,391 for 1,479 outpatient services. The hospital stated that it received these overpayments because it misinterpreted Medicare guidelines related to the billing for these services.

RECOMMENDATIONS

We recommend that the hospital:

- return the \$127,391 for the 1,479 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 stated that it reviewed the 1,519 services billed and agreed that the claims included payments for 1,479 services that Medicare did not cover. 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 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.

Extracorporeal Shock Wave Lithotripsy Services

Extracorporeal shock wave lithotripsy (lithotripsy) is a non-invasive method of treating kidney stones using a device called a lithotripter that uses acoustic shock waves generated outside the body to break up kidney stones in the upper urinary tract. Generally, providers bill for lithotripsy procedures using revenue code 0790 (extracorporeal shock wave therapy) and HCPCS code 50590 (lithotripsy). Some providers bill for lithotripsy procedures using revenue code 0360 (operating room services) and HCPCS code 50590 (lithotripsy).

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—

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.

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.

Providence Hospital

Providence Hospital (the hospital) is a 408-bed community hospital located in the District of Columbia. The hospital is a member of Ascension Health, a national Catholic health system of nonprofit corporations. 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, lithotripsy, and blood administration services billed by the hospital.

Scope

We reviewed payments totaling \$140,143 that the Medicare contractor paid the hospital for 1,519 outpatient infusion therapy, lithotripsy, and blood administration services billed on 1,448 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 January 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 and infusion therapy, lithotripsy and blood administration services with more than one unit per day;

- 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; 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 1,448 claims were not appropriate. Each of these claims had errors relating to outpatient infusion therapy, lithotripsy, or blood administration services. As a result, the hospital received overpayments totaling \$127,391. The hospital received \$140,143 for 1,519 outpatient services, rather than the allowable amount, \$12,752 for 40 outpatient services, resulting in overpayments totaling \$127,391 for 1,479 outpatient services. The hospital stated that it received these overpayments because it misinterpreted Medicare guidelines related to the billing for these services.

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 1,411 claims, the hospital billed and received payment for 1,419 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 \$117,098.

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

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

PAYMENT FOR OUTPATIENT SERVICES GREATER THAN ONE

For 37 claims, the hospital billed and received payment for excessive services because it billed Medicare for services greater than one: 27 claims for excessive infusion therapy services, 5 claims for excessive lithotripsy services, and 5 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 27 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 80 infusion therapy services of which 50 were in excess of one per visit. The hospital received \$8,087 for these infusion therapy services, rather than the allowable amount, \$3,056, resulting in overpayments totaling \$5,031.

Multiple Lithotripsy Services

CMS's *Manual*, chapter 4, section 20.4, defines service units as "the number of times the service or procedure being reported was performed."

For five claims, the hospital billed and received payment for excessive treatments because it billed Medicare twice for the same lithotripsy service. The hospital performed only one lithotripsy service for each date of service, but billed for two lithotripsy services using operating room revenue code 0360 with HCPCS code 50590. The hospital billed and received payment for 10 lithotripsy services of which 5 were not performed. The hospital received \$13,302 for these lithotripsy services, rather than the allowable amount, \$8,868, resulting in overpayments totaling \$4,434.

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 five 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 10 blood administration services of which 5 were in excess of one per day. The hospital received \$1,656 for these blood administration services, rather than the allowable amount, \$828, resulting in overpayments totaling \$828.

RECOMMENDATIONS

We recommend that the hospital:

- return the \$127,391 for the 1,479 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 stated that it reviewed the 1,519 services billed and agreed that the claims included payments for 1,479 services that Medicare did not cover. The hospital stated that it received these overpayments because it misinterpreted Medicare guidelines related to the billing for these services. The hospital's comments are included in the Appendix.

APPENDIX

APPENDIX: PROVIDENCE HOSPITAL COMMENTS



**PROVIDENCE
HOSPITAL**

1150 Varnum Street, NE
Washington, DC 20017
(202) 269-7000
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December 18, 2009

Bernard Siegel, Audit Manager
Department of Health and Human Services
Office Of Audit Services Region III
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Dear Mr. Siegel:

This letter is written in follow up to the original inquiry regarding claims paid under Medicare's Hospital Outpatient Prospective Payment System (HOPPS). The services and claims identified included infusion therapy (HCPCS codes Q0081 through Q0085 and C8950, CPT codes 90761 and 90780), blood administration (CPT code 36430) and lithotripsy procedures (CPT code 50590) paid during calendar years 2003 – 2007.

We have completed 100% review of the services and claims in question. At issue was the use of Modifier 59 and an interpretation of the use of this modifier for unbundled charges for services delivered during subsequent treatment within the same encounter. After review of the requested claims and CMS Transmittal 785, we have determined that the use of Modifier 59 and unbundling of these charges was an inadvertent error due to interpretation of the guidelines.

Please advise of the next steps necessary to bring these matters to resolution. Please do not hesitate to contact me at (202) 269-7474 or via email at dmorriso@provhosp.org.

Respectfully,

Deborah A. Morrison, RN, MGA
Vice President, QI/RM