



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



June 27, 2012

**TO:** Peter Budetti  
Deputy Administrator and Director  
Center for Program Integrity  
Centers for Medicare & Medicaid Services

Deborah Taylor  
Director and Chief Financial Officer  
Office of Financial Management  
Centers for Medicare & Medicaid Services

**FROM:** /Brian P. Ritchie/  
Assistant Inspector General for the  
Centers for Medicare & Medicaid Audits

**SUBJECT:** Medicare Compliance Review of Christiana Care Health System for  
Calendar Years 2008 Through 2010 (A-03-11-06101)

Attached, for your information, is an advance copy of our final report on our most recent hospital compliance review. We will issue this report to Christiana Care Health System within 5 business days.

This report is part of a series of the Office of Inspector General's hospital compliance initiative, designed to review multiple issues concurrently at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at [Brian.Ritchie@oig.hhs.gov](mailto:Brian.Ritchie@oig.hhs.gov), or your staff may contact Stephen Virbitsky, Regional Inspector General for Audit Services, at (215) 861-4470 or through email at [Stephen.Virbitsky@oig.hhs.gov](mailto:Stephen.Virbitsky@oig.hhs.gov).

Attachment

cc: Daniel Converse  
Office of Strategic Operations and Regulatory Affairs  
Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION III  
PUBLIC LEDGER BUILDING, SUITE 316  
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PHILADELPHIA, PA 19106

July 2, 2012

Report Number A-03-11-06101

Ronald Sherman, Esq.  
Chief Compliance Officer  
Christiana Care Health System  
MAP2, Suite 2210  
4735 Ogletown Stanton Road  
Newark, DE 19713

Dear Mr. Sherman:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Christiana Care Health System for Calendar Years 2008 Through 2010*. 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 call me at (215) 861-4470, or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through email at [Bernard.Siegel@oig.hhs.gov](mailto:Bernard.Siegel@oig.hhs.gov). Please refer to report number A-03-11-06101 in all correspondence.

Sincerely,

/Stephen Virbitsky/  
Regional Inspector General  
for Audit Services

Enclosure

Page 2 – Ronald Sherman, Esq.

cc: Ms. Michele A. Daley-Ryan, Manager  
Monitoring and Inspections, Novitas Solutions, Inc.

**Direct Reply to HHS Action Official:**

Ms. Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 East 12th Street, Room 355  
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Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
CHRISTIANA CARE  
HEALTH SYSTEM  
FOR CALENDAR YEARS  
2008 THROUGH 2010**



Daniel R. Levinson  
Inspector General

July 2012  
A-03-11-06101

# ***Office of Inspector General***

<http://oig.hhs.gov>

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## ***Office of Audit Services***

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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# *Notices*

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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.

## **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**

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Christiana Care Health System is a not-for-profit healthcare system that includes 2 acute care facilities (the Hospital): Christiana Hospital, a 913-bed hospital located in Newark, Delaware, and Wilmington Hospital, a 241-bed hospital located in Wilmington, Delaware. Medicare paid the Hospital approximately \$940 million for 71,504 inpatient and 532,253 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 through 2010 based on CMS's National Claims History data.

Our audit covered \$3,825,945 in Medicare payments to the Hospital for 156 inpatient and 125 outpatient claims that we identified as potentially at risk for billing errors. These 281 claims had dates of service in CYs 2008 through 2010.

### **OBJECTIVE**

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

## **SUMMARY OF FINDINGS**

The Hospital complied with Medicare billing requirements for 161 of the 281 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 120 claims, resulting in net overpayments totaling \$640,530 for CYs 2008 through 2010. Specifically, 66 inpatient claims had billing errors that resulted in net overpayments totaling \$310,448, and 54 outpatient claims had billing errors that resulted in net overpayments totaling \$330,082.

These overpayments occurred primarily because the Hospital did not have adequate controls over some areas to prevent incorrect billing of Medicare claims. Some overpayments occurred because of human error.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$640,530, consisting of \$310,448 in overpayments for 66 incorrectly billed inpatient claims and \$330,082 in overpayments for 54 incorrectly billed outpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

## **CHRISTIANA CARE HEALTH SYSTEM COMMENTS**

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations and described the actions it had taken or planned to take to address them. The Hospital's comments are included in their entirety as the Appendix.

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## INTRODUCTION

### BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.<sup>1</sup>

#### **Hospital Inpatient Prospective Payment System**

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

#### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>2</sup> The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.<sup>3</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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<sup>1</sup> 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 (MAC). Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs 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 MAC, whichever is applicable.

<sup>2</sup> In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

<sup>3</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

## **Hospital Payments at Risk for Incorrect Billing**

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis of claims. Examples of the types of claims at risk for noncompliance include the following:

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient stays billed with high severity level DRG codes,
- inpatient and outpatient claims for replaced medical devices,
- outpatient claims paid in excess of charges,
- outpatient claims billed with modifier -59,
- outpatient claims billed for Lupron (leuprolide acetate for depot suspension) injections, and
- outpatient claims billed for doxorubicin hydrochloride.

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.”

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

### **Medicare Requirements for Hospital Claims and Payments**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and 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.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment.

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

## **Christiana Care Health System**

Christiana Care Health System is a not-for-profit healthcare system that includes two acute care facilities (the Hospital): Christiana Hospital, a 913-bed hospital located in Newark, Delaware, and Wilmington Hospital, a 241-bed hospital located in Wilmington, Delaware.<sup>4</sup> Medicare paid the Hospital approximately \$940 million for 71,504 inpatient and 532,253 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 through 2010 based on CMS's National Claims History data.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### **Scope**

Our audit covered \$3,825,945 in Medicare payments to the Hospital for 281 claims that we judgmentally selected as potentially at risk for billing errors. These 281 claims had dates of service in CYs 2008 through 2010 and consisted of 156 inpatient and 125 outpatient claims.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not use medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas for review because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review enabled 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.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital during September 2011.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2008 through 2010;

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<sup>4</sup> Christiana Care Health System also includes facilities and locations throughout Delaware that provide a variety of outpatient and other services.

- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2008 through 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 281 claims (156 inpatient and 125 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Hospital officials.

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**

The Hospital complied with Medicare billing requirements for 161 of the 281 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 120 claims, resulting in net overpayments totaling \$640,530 for CYs 2008 through 2010. Specifically, 66 inpatient claims had billing errors that resulted in net overpayments totaling \$310,448, and 54 outpatient claims had billing errors that resulted in net overpayments totaling \$330,082.

These overpayments occurred primarily because the Hospital did not have adequate controls over some areas to prevent incorrect billing of Medicare claims. Some overpayments occurred because of human error.

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 66 of the 156 selected inpatient claims that we reviewed. These errors resulted in net overpayments totaling \$310,448.

### **Inpatient Short Stays**

Section 1862(a)(1)(A) of the Act states that 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.”

For 31 of the 72 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Hospital officials attributed the errors to weaknesses in the patient admission and admission screening processes. As a result, the Hospital received overpayments totaling \$120,617.<sup>5</sup>

### **Inpatient Claims for Replaced Medical Devices**

Federal regulations (42 CFR § 412.89) require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

#### *Billing Requirements for Medical Device Credits*

The Manual, chapter 3, section 100.8, states that to bill correctly for a replacement device that was provided with a credit, hospitals must use the combination of condition code 49 or 50, along with value code FD.

#### *Prudent Buyer Principle*

Under 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services ....” CMS’s *Provider Reimbursement Manual*, part 1, section 2102.1, states:

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service .... If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

Section 2103 of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example:

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<sup>5</sup> The Hospital refunded the full amount of the 31 incorrect Medicare Part A short-stay claims. The Hospital billed for a limited range of Part B services for 3 of the 31 claims, which were adjudicated by the MAC during our review.

Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits or payments available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment supplied.

### *Medical Device Credits Not Reflected in Claims*

For 11 of the 45 sampled claims, the Hospital either received a reportable credit for a replaced medical device from a manufacturer but did not adjust its inpatient claim with the proper condition and value codes to reduce payment (10 errors), or did not obtain a credit for a replaced medical device that was available under the terms of the manufacturer's warranty (1 error). For this one claim, the Hospital initiated the process to pursue the credit but failed to follow up to ensure that the credit was received. Hospital officials stated that these errors occurred because there were inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result, the Hospital received overpayments totaling \$63,404.

### **Inpatient Same-Day Discharges and Readmissions**

Section 1862(a)(1)(A) of the Act states that 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 Manual, chapter 3, section 40.2.5, states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay on a single claim.

For 17 of the 17 sampled claims, the Hospital either incorrectly billed Medicare separately for related discharges and readmissions within the same day (15 errors) or incorrectly billed Medicare Part A for inpatient stays that should have been billed as outpatient or outpatient with observation services (2 errors). Hospital officials stated that the incorrect billing occurred primarily because the Hospital's inpatient screening review process and its pre-payment billing edits failed to identify cases where a patient was discharged and subsequently readmitted for a related condition on the same day. As a result, the Hospital received overpayments totaling \$81,595 and was underpaid a total of \$16,225.

### **Inpatient Claims Billed With High Severity Level Diagnosis Related Groups**

Section 1862(a)(1)(A) of the Act states that 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.” In addition, the Manual, chapter 1, section 80.3.2.2, states, “In order to be processed correctly and promptly, a bill must be completed accurately.”

For 7 of the 22 sampled claims, the Hospital billed Medicare with incorrect diagnosis codes that resulted in higher DRG payments to the Hospital. Hospital officials stated that the incorrect diagnosis codes occurred because of human errors that were not identified and corrected by the routine internal reviews. As a result, the Hospital received overpayments totaling \$61,057.

## **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 54 of 125 selected outpatient claims that we reviewed. These errors resulted in net overpayments totaling \$330,082.

### **Outpatient Claims for Replaced Medical Devices**

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

Federal regulations (42 CFR § 419.45) require a reduction in the OPSS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device.

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual explain how a provider should report no-cost and reduced-cost devices under the OPSS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device.

The Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 35 of the 69 sampled claims, the Hospital incorrectly billed Medicare because it:

- received a full credit from a device manufacturer for a replaced device but did not report the “FB” modifier or reduced charges on its Medicare claim (26 errors);
- failed to follow up with the medical device manufacturer to ensure that credits, available under the terms of the manufacturer’s warranty, were obtained (6 errors);
- billed Medicare with the incorrect HCPCS code (2 errors); and
- billed Medicare with a HCPCS code for a separate procedure that was an integral component of another service and was included in the payment for that service billed on the same claim (1 error).

Hospital officials stated that the Hospital lacked adequate controls to identify, obtain, and report credits from device manufacturers and that it billed using incorrect HCPCS codes because of human error. As a result, the Hospital received overpayments totaling \$268,672 (34 errors) and was underpaid \$12,576 (1 error).

## **Outpatient Claims Paid in Excess of Charges**

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. In addition, chapter 4, section 20.4, of the Manual states that “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For the two sampled claims, the Hospital billed Medicare with the incorrect units of service for the injection of the drug docetaxel. Hospital officials stated that the errors occurred because of human error. As a result, the Hospital received overpayments totaling \$71,659.

## **Outpatient Claims Paid for Lupron Injections**

Section 1862(a)(1)(A) of the Act states that 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.” Local Coverage Determinations (LCD) for “luteinizing hormone releasing analogs,”<sup>6</sup> which include Lupron injections, state that HCPCS code J1950 (injection, leuprolide acetate for depot suspension, 3.75 mg) is indicated for the treatment of endometriosis, uterine leiomyomas, and malignant neoplasms of the breast. HCPCS code J9217 (leuprolide acetate for depot suspension, 7.5 mg) is indicated for the treatment of numerous types of cancers, including malignant neoplasms of the prostate.

For the two sampled claims, the Hospital billed Medicare with the incorrect HCPCS code for the injection of Lupron provided to male beneficiaries with diagnoses of prostate cancer. Contrary to the coverage requirements of the LCDs, the Hospital used HCPCS code J1950 for its male patients with a diagnosis of prostate cancer rather than billing the correct HCPCS code J9217. Hospital officials stated that the ordering providers and pharmacy staff were not aware of the diagnoses restrictions for each of the doses. As a result, the Hospital received overpayments totaling \$3,857.

## **Outpatient Claims Billed With Modifier -59**

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

The Manual, chapter 4, section 20.4, states that “The definition of service units ... is the number of times the service or procedure being reported was performed.” In addition, chapter 23, section 20.9.1.1, of the Manual states: “The ‘-59’ modifier is used to indicate a distinct procedural service .... This may represent a different session or patient encounter, different

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<sup>6</sup> National Government Services Luteinizing Hormone-Releasing Hormone Analogs L26369 V6 (Rev. Eff. April 1, 2008), and Highmark Medicare Services Luteinizing Hormone-Releasing Hormone Analogs L27500 V25 (Rev. Eff. December 12, 2008).

procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).”

For 5 of the 23 sampled claims, the Hospital incorrectly billed Medicare for services not performed (2 errors), incorrect units of service (1 error), incorrect HCPCS code (1 error), and for a service that was included in the payment for another service billed on the same claim (1 error). Hospital officials stated that the errors occurred because of human error. As a result, the Hospital received net overpayments totaling \$528.

### **Outpatient Claims for Doxorubicin Hydrochloride**

The Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. In addition, chapter 4, section 20.4, of the Manual states that “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For 10 of the 29 sampled claims, the Hospital billed Medicare with incorrect units of service for injections of the drug doxorubicin hydrochloride. Hospital officials stated that the errors occurred because of human error. As a result, the Hospital received an overpayment of \$1,850 (one error) and was underpaid \$3,908 (nine errors).

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$640,530, consisting of \$310,448 in overpayments for 66 incorrectly billed inpatient claims and \$330,082 in overpayments for 54 incorrectly billed outpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

### **CHRISTIANA CARE HEALTH SYSTEM COMMENTS**

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations and described the actions it had taken or planned to take to address them. The Hospital’s comments are included in their entirety as the Appendix.

# **APPENDIX**

**APPENDIX: CHRISTIANA CARE HEALTH SYSTEM COMMENTS**

May 25, 2012

Report Number A-03-11-06101

Mr. Stephen Virbitsky  
Regional Inspector General for Audit Services  
Office of Inspector General  
Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, PA 19106

Dear Mr. Virbitsky:

On behalf of Christiana Care Health Services, Inc. ("CCHS"), please accept these comments in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG), draft report entitled "*Medicare Compliance Review of Christiana Care Health System for Calendar Years 2008 Through 2010.*" We appreciate the opportunity to respond to the draft report. The OIG draft report summarizes its findings related to targeted claims within identified "risk areas" of inpatient and outpatient services, identifies overpayments, and makes recommendations to assure future compliance. CCHS' specific responses to the draft report are as follows:

*Inpatient Short Stays*

CCHS has reviewed the 31 claims identified by the OIG as overpayments and, as noted in the draft report, CCHS has adjusted the claims as appropriate in accordance with the Medicare billing regulations.

During this time period, patients were screened for medical necessity for inpatient admission criteria utilizing industry accepted standards. Screening for medical necessity was performed by RN case managers. In cases where the medical record documentation did not support an inpatient admission, the attending physician was contacted for additional information. If, after obtaining the additional information from the attending physician, the documentation did not meet medical necessity for an inpatient admission, the case was referred to a physician member of the Utilization Review Committee for further review and follow-up.

CCHS identified weaknesses in the patient admission and admission screening processes. In an effort to improve its method of concurrent review and education, CCHS is working with experts to provide education to staff physicians and to assist staff with Medicare admission reviews. CCHS' utilization management and utilization review team also receives daily reports

from its consultants regarding the appropriate level of care. This information is communicated to our ordering physicians when a determination has been made that the documentation does not support an admission order. These reports strengthen our level-of-care determinations and ensure that ordering physicians receive feedback on the appropriate settings for patient care.

#### *Inpatient Claims for Replaced Medical Devices*

CCHS has reviewed the 11 claims identified by the OIG as overpayments and CCHS has adjusted the claims as appropriate in accordance with the Medicare billing regulations. Prior to notice of the OIG audit, CCHS had already initiated an information gathering process so that the hospital could appropriately track and follow-up with device manufacturers on credits due. A member of the medical audit staff reviews monthly reports of these cases to ensure that all devices/leads have been reviewed for possible credit.

#### *Inpatient Same-Day Discharges and Readmissions*

CCHS has reviewed the 17 claims identified by the OIG as overpayments and CCHS has adjusted the claims as appropriate in accordance with the Medicare billing regulations. CCHS has implemented additional controls to identify readmissions that are clinically related.

#### *Inpatient Claims Billed with High Severity Level Diagnosis Related Groups*

CCHS has reviewed the 7 claims identified by the OIG as overpayments and CCHS has adjusted the claims as appropriate in accordance with the Medicare billing regulations. Additional controls have been established regarding oversight and accuracy of coding.

#### *Outpatient Claims for Replaced Medical Devices*

CCHS has reviewed the 34 claims identified by the OIG as overpayments and CCHS has adjusted the claims as appropriate in accordance with the Medicare billing regulations. CCHS also corrected and re-submitted the claim identified by the OIG as an underpayment. Once again, prior to notice of the OIG audit, CCHS had already initiated an information gathering process so that the hospital could appropriately track and follow-up with device manufacturers on credits due.

#### *Outpatient Claims Paid in Excess of Charges*

CCHS has reviewed the 2 claims identified by the OIG as overpayments and CCHS has adjusted the claims as appropriate in accordance with the Medicare billing regulations. These two mistaken claims were submitted within months of the effective date of a change in billing code from J9170 (per 20 milligrams) to the newer code J9171 (per 1 milligram). One of the claims was initially submitted correctly, but by the time it was re-billed, the coding had changed and the coder failed to note the change. The staff member who made the error was individually educated. Moreover, CCHS performs periodic audits of the infusion departments to ensure compliance.

*Outpatient Claims Paid for Lupron Injections*

CCHS has reviewed the 2 claims identified by the OIG as overpayments and CCHS has adjusted the claims as appropriate in accordance with the Medicare billing regulations. These two errors are related to a rare Local Coverage Determination requiring the use of different codes to charge for Lupron, depending on the disease being treated. New entries have been added to medication order forms to alert ordering providers of the diagnoses restrictions for each of the Lupron doses. In addition, CCHS has provided education to credentialed providers regarding the diagnoses restrictions.

*Outpatient Claims Billed with Modifier 59*

CCHS has reviewed the 5 claims identified by the OIG resulting in a \$528 overpayments and CCHS has adjusted the claims as appropriate in accordance with the Medicare billing regulations.

*Outpatient Claims for Doxorubicin Hydrochloride*

Of the 10 claims identified by the OIG as billing errors, one resulted in an overpayment of \$1,850 and nine resulted in underpayments totaling \$3,908. CCHS and has adjusted the claims as appropriate in accordance with the Medicare billing regulations.

Again, CCHS appreciates the opportunity to comment on this report and note our continued commitment to compliance.

Sincerely,

A handwritten signature in cursive script that reads "Ronald Sherman".

Ronald Sherman, Esquire  
Chief Compliance Officer  
Christiana Care Health Services