

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE
OUTPATIENT BILLING FOR
SELECTED DRUGS AT
OROVILLE HOSPITAL**

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**Lori A. Ahlstrand
Regional Inspector General**

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Office of Inspector General

<https://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 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 administers the program.

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains detail regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered.

Oroville Hospital (Hospital) is an acute-care hospital located in Oroville, California. Based on data analysis, we reviewed \$228,476 in Medicare payments to the Hospital for 18 line items that the Hospital billed to Medicare during our audit period (May 1, 2008, through August 31, 2011). These line items consisted of injections for trastuzumab, a drug used to treat breast cancer; pemetrexed, a drug used to treat malignant mesothelioma and certain types of non-small cell lung cancer; and rituximab, a drug used to treat non-Hodgkin's lymphoma.

OBJECTIVE

Our objective was to determine whether the Hospital billed Medicare for injections of selected drugs in accordance with Federal requirements.

SUMMARY OF FINDINGS

For 15 of the 18 line items reviewed, the Hospital did not bill Medicare in accordance with Federal requirements. Specifically, the Hospital billed the incorrect number of units of service. As a result, the Hospital received overpayments totaling \$189,842. The Hospital attributed the overpayments to billing system errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare administrative contractor \$189,842 in identified overpayments and
- ensure compliance with Medicare billing requirements.

OROVILLE HOSPITAL COMMENTS

In written comments on our draft report, the Hospital provided information on actions that it had taken to address our recommendations. The Hospital's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Requirements for Outpatient Claims	1
Selected Drugs	1
Oroville Hospital.....	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology.....	2
FINDINGS AND RECOMMENDATIONS	3
FEDERAL REQUIREMENTS	3
INCORRECT BILLING	4
RECOMMENDATIONS	4
OROVILLE HOSPITAL COMMENTS	4
APPENDIX	
OROVILLE HOSPITAL COMMENTS	

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 Requirements for Outpatient Claims

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains detail regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered.¹

Selected Drugs

The drugs we reviewed in this audit were trastuzumab, pemetrexed, and rituximab.

Trastuzumab

Trastuzumab is an injectable drug used to treat breast cancer. Medicare requires providers to bill one service unit for each 10-milligram injection of trastuzumab. The HCPCS code for this drug is J9355 and is described as “Injection, trastuzumab, 10 [milligrams].”

Pemetrexed

Pemetrexed is an injectable drug used to treat malignant mesothelioma and certain types of non-small cell lung cancer. Medicare requires providers to bill one service unit for each 10-milligram injection of pemetrexed. The HCPCS code for this drug is J9305 and is described as “Injection, pemetrexed, 10 [milligrams].”

Rituximab

Rituximab is an injectable drug used to treat non-Hodgkin’s lymphoma. Medicare requires providers to bill one service unit for each 100-milligram injection of rituximab. The HCPCS code for this drug is J9310 and is described as “Injection, rituximab, 100 [milligrams].”

¹ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Oroville Hospital

Oroville Hospital (Hospital) is an acute-care hospital located in Oroville, California. The Hospital's claims are processed and paid by Palmetto GBA, LLC (Palmetto), the Medicare administrative contractor.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital billed Medicare for injections of selected drugs in accordance with Federal requirements.

Scope

We reviewed \$228,476 in Medicare payments to the Hospital for 18 line items that we selected as potentially at risk for billing errors during our audit period (May 1, 2008, through August 31, 2011). These line items consisted of:

- 14 line items for trastuzumab totaling \$203,785,
- 3 line items for pemetrexed totaling \$18,174, and
- 1 line item for rituximab totaling \$6,517.

We identified these payments through data analysis.

We did not review the Hospital's internal controls applicable to the 18 line items because our objective did not require an understanding of controls over the submission 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 for our audit period, but we did not assess the completeness of the file.

Our fieldwork included contacting the Hospital, located in Oroville, California.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify paid Medicare claims for trastuzumab, pemetrexed, and rituximab during our audit period;
- used computer matching, data mining, and analysis techniques to identify line items potentially at risk for noncompliance with Medicare billing requirements;

- identified 18 line items totaling \$228,476 that Medicare paid to the Hospital;
- contacted the Hospital to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that the Hospital furnished to verify whether each selected line item was billed correctly;
- calculated overpayments using corrected payment information processed by Palmetto; and
- discussed the results of our review with the Hospital.

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

For 15 of the 18 line items reviewed, the Hospital did not bill Medicare in accordance with Federal requirements.² Specifically, the Hospital billed the incorrect number of units of service. As a result, the Hospital received overpayments totaling \$189,842. The Hospital attributed the overpayments to billing system errors.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires the Hospitals to report claims for outpatient services using HCPCS codes.

Section 1833(e) of the Act states: “No payment shall be made to any provider of services ... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ... for the period with respect to which the amounts are being paid”

CMS’s *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 4, section 20.4, states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

The Manual, chapter 17, section 90.2.A, states: “It is ... of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug ... that was used in the care of the patient.” If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, “[w]here HCPCS is

² For the three line items for pemetrexed, the Hospital billed Medicare in accordance with Federal requirements.

required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4”

Chapter 1, section 80.3.2.2, of the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

INCORRECT BILLING

For 15 line items reviewed, the Hospital billed Medicare for the incorrect number of units of service:

- For the 14 line items for trastuzumab, the Hospital billed the incorrect number of units of service. Rather than billing 12 or 35 service units, the Hospital billed 120 or 350 service units. The incorrect billing resulted in overpayments totaling \$186,342.
- For the one line item for rituximab, the Hospital billed the incorrect number of units of service. Rather than billing 7 service units, the Hospital billed 14 service units. The incorrect billing resulted in an overpayment of \$3,500.

In total, the Hospital received overpayments of \$189,842. The Hospital attributed the overpayments to billing system errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare administrative contractor \$189,842 in identified overpayments and
- ensure compliance with Medicare billing requirements.

OROVILLE HOSPITAL COMMENTS

In written comments on our draft report, the Hospital provided information on actions that it had taken to address our recommendations. The Hospital’s comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: OROVILLE HOSPITAL COMMENTS



Oroville Hospital

September 5, 2012

Ms. Lori A. Ahlstrand
HHS/OIG/OAS
90 7th Street
Suite 3-650
San Francisco, CA 94103

Re: Oroville Hospital-Provider #050030

Dear Ms. Ahlstrand,

In earlier correspondence, we have submitted corrected billing to CMS for overpayment of chemotherapy drug charges. The overpayment occurred as a result of billing units that were not properly defined in our system. We have since corrected the units to accurately reflect the appropriate quantity of drugs utilized. We have also conducted a self audit to identify any other similar occurrences. We have not found any more overpayments and can ensure compliance with Medicare billing requirements. As of this date, Oroville Hospital has returned \$189,842, representing overpayments identified by the audit.

Sincerely,

Ashok Khanchandani
Chief Financial Officer

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