

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE
OUTPATIENT BILLING FOR
SELECTED DRUGS AT
UNIVERSITY OF CALIFORNIA,
IRVINE, MEDICAL CENTER**

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**Lori A. Ahlstrand
Regional Inspector General**

**November 2012
A-09-12-02063**

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.

University of California, Irvine, Medical Center (Center) is an acute-care hospital located in Orange, California. Based on data analysis, we reviewed \$182,516 in Medicare payments to the Center for 18 line items that the Center billed to Medicare during our audit period (May 1, 2008, through August 31, 2011). These line items consisted of injections for:

- bevacizumab, a drug used to treat a certain type of brain tumor as well as cancers of the kidney, lung, colon, and rectum;
- rituximab, a drug used to treat non-Hodgkin's lymphoma; and
- pemetrexed, a drug used to treat malignant mesothelioma and certain types of non-small cell lung cancer.

OBJECTIVE

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

SUMMARY OF FINDINGS

For the 18 line items reviewed, the Center did not bill Medicare in accordance with Federal requirements. Specifically, the Center billed the incorrect number of units of service. As a result, the Center received overpayments totaling \$50,073. The Center attributed the overpayments to billing system errors.

RECOMMENDATIONS

We recommend that the Center:

- refund to the Medicare administrative contractor \$50,073 in identified overpayments and
- ensure compliance with Medicare billing requirements.

UNIVERSITY OF CALIFORNIA, IRVINE, MEDICAL CENTER COMMENTS

In written comments on our draft report, the Center concurred with our conclusion that the injections were billed incorrectly and provided information on actions that it had taken to address our recommendations. The Center's comments are included in their entirety as 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 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 bevacizumab, rituximab, and pemetrexed.

Bevacizumab

Bevacizumab is an injectable drug used to treat a certain type of brain tumor as well as cancers of the kidney, lung, colon, and rectum. Medicare requires providers to bill one service unit for each 10-milligram injection of bevacizumab. The HCPCS code for this drug is J9035 and is described as “Injection, bevacizumab, 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].”

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].”

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

University of California, Irvine, Medical Center

University of California, Irvine, Medical Center (Center) is an acute-care hospital located in Orange, California. The Center'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 Center billed Medicare for injections of selected drugs in accordance with Federal requirements.

Scope

We reviewed \$182,516 in Medicare payments to the Center 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:

- 12 line items for bevacizumab totaling \$133,375,
- 4 line items for rituximab totaling \$33,086, and
- 2 line items for pemetrexed totaling \$16,055.

We identified these payments through data analysis.

We did not review the Center'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 Center, located in Orange, 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 bevacizumab, rituximab, and pemetrexed 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 \$182,516 that Medicare paid to the Center;
- contacted the Center 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 Center 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 Center.

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 the 18 line items reviewed, the Center did not bill Medicare in accordance with Federal requirements. Specifically, the Center billed the incorrect number of units of service. As a result, the Center received overpayments totaling \$50,073. The Center 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 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 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 the 18 line items reviewed, the Center billed Medicare for the incorrect number of units of service:

- For the 12 line items for bevacizumab, the Center billed the incorrect number of units of service. Rather than billing from 150 to 165 service units, the Center billed 200 or 300 service units. The incorrect billing resulted in overpayments totaling \$31,646.
- For the four line items for rituximab, the Center billed the incorrect number of units of service. Rather than billing 12 service units, the Center billed 16 service units. The incorrect billing resulted in overpayments totaling \$9,323.
- For the two line items for pemetrexed, the Center billed the incorrect number of units of service. Rather than billing 75 and 85 service units, the Center billed 150 and 200 service units, respectively. The incorrect billing resulted in overpayments totaling \$9,104.

In total, the Center received overpayments of \$50,073. The Center attributed the overpayments to billing system errors.

RECOMMENDATIONS

We recommend that the Center:

- refund to the Medicare administrative contractor \$50,073 in identified overpayments and
- ensure compliance with Medicare billing requirements.

UNIVERSITY OF CALIFORNIA, IRVINE, MEDICAL CENTER COMMENTS

In written comments on our draft report, the Center concurred with our conclusion that the injections were billed incorrectly and provided information on actions that it had taken to address our recommendations. The Center’s comments are included in their entirety as the Appendix.

APPENDIX

**APPENDIX: UNIVERSITY OF CALIFORNIA,
IRVINE, MEDICAL CENTER COMMENTS**

UNIVERSITY OF CALIFORNIA, IRVINE

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UC IRVINE CORPORATE COMPLIANCE & PRIVACY OFFICE

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September 4, 2012

Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IX
90 – 7th Street Suite 3-650
San Francisco, CA 94103

Attn: Lori A. Ahlstrand
Regional Inspector General for Audit Services

Report Number: A-09-12-02063 University of California Irvine Medical Center

Dear Ms. Ahlstrand,

We are in receipt of your draft report regarding the review of Medicare Outpatient Billing for selected drugs at the University of California Irvine Medical Center focusing on eighteen (18) line items on claims submitted by the Medical Center for injections of bevacizumab, rituximab and pemetrexed medications.

The Medical Center concurs with the report's conclusion that the injections were billed incorrectly. As we previously have communicated, we traced the errors to our implementation of a component of our electronic health record ("EHR") system in October 2010. Specifically, the EHR was initially configured to automatically select the closest dose vial based on the dosage administered to the patient. When we learned of the errors, the EHR was reprogrammed to bill for actual dosages administered going forward. This corrective action measure addresses OIG's first recommendation.

In addition to remediating the EHR programming problem to avoid future billing errors, we also initiated a charge audit to analyze billing for all single use medications from the time the EHR was first implemented until the time it was reprogrammed. That charge audit resulted in a series of adjustments and repayments made to our Medicare Administrative Contractor, Palmetto GBA, between December 2011 and June 2012. These refunds address OIG's second and final recommendation.

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University of California Irvine Medical Center
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UC Irvine Medical Center is committed to ensuring the accuracy of our Medicare claims, and complying with all Medicare regulations and billing requirements. We greatly appreciate the professionalism and courtesy of your staff during this review.

Sincerely,

A handwritten signature in black ink, appearing to read 'Marion Mallory', with a long horizontal flourish extending to the right.

Marion Mallory,
Chief Compliance & Privacy Officer
Assistant Dean of Compliance
UC Irvine Healthcare