DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

November 28, 2011

Report Number: A-09-11-02059

Ms. Denise Marroni
Chief Financial Officer
Providence Centralia Hospital
413 Lilly Road NE MS-02 W06
Olympia, WA 98506

Dear Ms. Marroni:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Outpatient Billing for Selected Drugs at Providence Centralia Hospital*. 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 Iman Zbinden, Senior Auditor, at (619) 557-6131, extension 109, or through email at Iman.Zbinden@oig.hhs.gov, or contact Alice Norwood, Audit Manager, at (415) 437-8360 or through email at Alice.Norwood@oig.hhs.gov. Please refer to report number A-09-11-02059 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
Regional Inspector General
for Audit Services

Enclosure

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 235
Kansas City, MO 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE OUTPATIENT BILLING FOR SELECTED DRUGS AT PROVIDENCE CENTRALIA HOSPITAL

Daniel R. Levinson
Inspector General

November 2011
A-09-11-02059

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 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.

Providence Centralia Hospital (Providence) is a not-for-profit hospital located in Centralia, Washington. Based on data analysis, we reviewed $371,396 in Medicare payments to Providence for 73 line items for injections of selected drugs that Providence billed to Medicare during our audit period (April 1, 2008, through February 28, 2011). These line items consisted of injections for infliximab, pemetrexed, alteplase, trastuzumab, rituximab, paclitaxel, bevacizumab, bortezomib, and adenosine.

OBJECTIVE

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

SUMMARY OF FINDINGS

For 20 of the 73 line items reviewed, Providence did not bill Medicare in accordance with Federal requirements:

- For 12 line items, Providence billed the incorrect number of units of service.
- For six line items, Providence used the incorrect HCPCS codes.
- For one line item, Providence billed for a drug that was not administered.
- For one line item, Providence used the combination of an incorrect HCPCS code and the incorrect number of units of service.

As a result, Providence received overpayments totaling $44,223. Providence attributed the overpayments to clerical errors.

RECOMMENDATIONS

We recommend that Providence:

- refund to the Medicare fiscal intermediary $44,223 in identified overpayments and
- ensure compliance with Medicare billing requirements.

PROVIDENCE CENTRALIA HOSPITAL COMMENTS

In written comments on our draft report, Providence provided information on actions that it had taken to address our recommendations. Providence'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 pemetrexed, trastuzumab, bevacizumab, rituximab, infliximab, paclitaxel, adenosine, bortezomib, and alteplase.

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]."

Trastuzumab

Trastuzumab is an injectable drug used to treat breast cancer that has progressed after treatment with other chemotherapy. 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]."

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]."

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

Rituximab

Rituximab is an injectable drug used to treat non-Hodgkin's lymphoma, chronic lymphocytic leukemia, and symptoms of adult rheumatoid arthritis. 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]."

Infliximab

Infliximab is an injectable drug used to treat rheumatoid and psoriatic arthritis, ulcerative colitis, Crohn's disease, and ankylosing spondylitis. Medicare requires providers to bill one service unit for each 10-milligram injection of infliximab. The HCPCS code for this drug is J1745 and is described as "Injection infliximab, 10 [milligrams]."

Paclitaxel

Paclitaxel is an injectable drug used to treat certain types of cancer (e.g., breast cancer, lung cancer, ovarian cancer, and AIDS-related Kaposi's sarcoma). Medicare requires providers to bill one service unit for each 30-milligram injection of paclitaxel. The HCPCS code for this drug is J9265 and is described as "Injection, paclitaxel, 30 [milligrams]."

Adenosine

Adenosine is an injectable drug used to treat supraventricular tachycardia. Medicare requires providers to bill one service unit for each 30-milligram injection of adenosine. The HCPCS code for this drug is J0152 and is described as "Injection, adenosine for diagnostic use, 30 [milligrams]."

Bortezomib

Bortezomib is an injectable drug used to treat multiple myeloma and mantle cell lymphoma. Medicare requires providers to bill one service unit for each 0.1-milligram injection of bortezomib. The HCPCS code for this drug is J9041 and is described as "Injection, bortezomib, 0.1 [milligrams]."

Alteplase

Alteplase is an injectable drug used to dissolve blood clots that have formed in the blood vessels and is used immediately after symptoms of a heart attack or stroke and to treat blood clots in the lungs. Medicare requires providers to bill one service unit for each 1-milligram injection of alteplase. The HCPCS code for this drug is J2997 and is described as "Injection, alteplase recombinant, 1 [milligram]."

Providence Centralia Hospital

Providence Centralia Hospital (Providence) is a not-for-profit hospital located in Centralia, Washington. Providence's claims are processed and paid by Noridian Administrative Services, LLC (Noridian), the Medicare Part A fiscal intermediary.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed $371,396 in Medicare payments to Providence for 73 line items that we judgmentally selected as potentially at risk for billing errors during our audit period (April 1, 2008, through February 28, 2011). These line items consisted of:

- 38 line items for infliximab totaling $221,567,[2]
- 8 line items for pemetrexed totaling $53,991,
- 15 line items for alteplase totaling $41,570,[3]
- 2 line items for trastuzumab totaling $13,831,
- 2 line items for rituximab totaling $12,986,
- 5 line items for paclitaxel totaling $12,332,[4]
- 1 line item for bevacizumab totaling $12,105,
- 1 line item for bortezomib totaling $2,182, and
- 1 line item for adenosine totaling $832.

We identified these payments through data analysis.

We did not review Providence's internal controls applicable to the 73 line items because our objective did not require an understanding of controls over the submission of claims. Our review

[2] For 37 line items for infliximab, Providence billed Medicare in accordance with Federal requirements.

[3] For the 15 line items for alteplase, Providence billed Medicare in accordance with Federal requirements.

[4] For one line item for paclitaxel, Providence billed Medicare in accordance with Federal requirements.

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.

We conducted our audit from April to September 2011. Our fieldwork including contacting Providence, located in Centralia, Washington.

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 infliximab, pemetrexed, alteplase, trastuzumab, rituximab, paclitaxel, bevacizumab, bortezomib, and adenosine 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 73 line items totaling $371,396 that Medicare paid to Providence;
- contacted Providence to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that Providence furnished to verify whether each selected line item was billed correctly;
- calculated overpayments using corrected payment information processed by Noridian; and
- discussed the results of our review with Providence.

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 20 of the 73 line items reviewed, Providence did not bill Medicare in accordance with Federal requirements:

- For 12 line items, Providence billed the incorrect number of units of service.
- For six line items, Providence used the incorrect HCPCS codes.
- For one line item, Providence billed for a drug that was not administered.
- For one line item, Providence used the combination of an incorrect HCPCS code and the incorrect number of units of service.

As a result, Providence received overpayments totaling $44,223. Providence attributed the overpayments to clerical 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 12 line items reviewed, Providence billed Medicare for the incorrect number of units of service:

- For the eight line items for pemetrexed, Providence billed the incorrect number of units of service. Rather than billing from 90 to 120 service units, Providence billed from 150 to 200 service units. The incorrect billing resulted in overpayments totaling $15,628.

- For one line item for trastuzumab, Providence billed the incorrect number of units of service. Rather than billing 15 service units, Providence billed 115 service units. The incorrect billing resulted in an overpayment of $5,885.

- For the one line item for bevacizumab, Providence billed the incorrect number of units of service. Rather than billing 130 service units, Providence billed 230 service units. The incorrect billing resulted in an overpayment of $5,679.

- For one line item for rituximab, Providence billed the incorrect number of units of service. Rather than billing 8 service units, Providence billed 16 service units. The incorrect billing resulted in an overpayment of $3,961.

- For one line item for infliximab, Providence billed the incorrect number of units of service. Rather than billing 125 service units, Providence billed 130 service units. The incorrect billing resulted in an overpayment of $283.

For six line items reviewed, Providence billed Medicare using the incorrect HCPCS codes:

- For one line item for rituximab, Providence billed Medicare using the HCPCS code for the administration of rituximab rather than using the HCPCS code for the administration of etoposide, the drug actually administered. The incorrect billing resulted in an overpayment of $5,721.

- For four line items for paclitaxel, Providence billed Medicare using the HCPCS code for the administration of paclitaxel rather than using the HCPCS code for the administration of oxaliplatin, the drug actually administered. The incorrect billing resulted in overpayments totaling $5,512.

- For one line item for trastuzumab, Providence billed Medicare using the HCPCS code for the administration of trastuzumab rather than using the HCPCS code for the administration of bevacizumab, the drug actually administered. The incorrect billing resulted in an overpayment of $344.

For the one line item for adenosine, Providence billed Medicare for 15 units of adenosine that was not administered, resulting in an overpayment of $832.

For the one line item for bortezomib, Providence billed Medicare using the HCPCS code for the administration of bortezomib rather than using the HCPCS code for the administration of immune globulin, the procedure actually performed. In addition, rather than billing 70 service units for this line item, Providence billed 80 service units. The incorrect billing resulted in an overpayment of $378.

In total, Providence received overpayments of $44,223. Providence attributed the overpayments to clerical errors.

RECOMMENDATIONS

We recommend that Providence:

- refund to the Medicare fiscal intermediary $44,223 in identified overpayments and
- ensure compliance with Medicare billing requirements.

PROVIDENCE CENTRALIA HOSPITAL COMMENTS

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

APPENDIX

APPENDIX: PROVIDENCE CENTRALIA HOSPITAL COMMENTS

PROVIDENCE
Centralia
Hospital

October 25, 2011

Lori A. Ahlstrand
Office of Inspector General
Office of Audit Services, Region IX
90-7th Street, Suite 3-650
San Francisco, CA 94103

RE: Report Number A-09-11-02059

Dear Ms. Ahlstrand:

This letter is in response to the draft report entitled *Review of Medicare Outpatient Billing for Selected Drugs at Providence Centralia Hospital.* Your audit found 20 of 73 line items reviewed were not billed in accordance to federal requirements.

OIG Recommendation: The OIG recommends that Providence Centralia Hospital refund to the Medicare fiscal intermediary $44,223 in identified overpayments.

Providence Centralia Hospital Response: Providence Centralia Hospital has sent corrected claims to Noridian Administrative Services for all line items that were identified as overpayments. All 20 line items on the claims have been reprocessed and the correct payments have been posted.

OIG Recommendation: The OIG recommends that Providence Centralia Hospital ensure compliance with Medicare billing requirements.

Providence Centralia Hospital Response: Providence Centralia Hospital has made corrections regarding the use of the appropriate sized vial(s) related to the dose ordered. Providence Centralia Hospital has developed additional flagging mechanisms in the billing process to ensure the correct drug is charged. The charge entry staff has been made aware of the issues; a daily reconciliation of charges is now occurring and the name of the drug is being checked before the claim is sent.

We appreciate the opportunity to comment on this draft report. If you have further questions, please call Nancy Lawrence at 360-493-7145.

Sincerely,

Denise Marroni
Chief Financial Officer