

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE
OUTPATIENT BILLING FOR
SELECTED DRUGS AT
METHODIST HEALTHCARE –
MEMPHIS HOSPITALS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Lori A. Ahlstrand
Regional Inspector General

August 2012
A-09-12-02022

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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.

Methodist Healthcare – Memphis Hospitals (Methodist Healthcare) is an acute-care hospital located in Memphis, Tennessee. Based on data analysis, we reviewed \$435,026 in Medicare payments to Methodist Healthcare for 82 line items for injections of selected drugs that Methodist Healthcare billed to Medicare during our audit period (January 1, 2008, through April 30, 2011). These line items consisted of injections for doxorubicin hydrochloride liposome, immune globulin, cetuximab, rituximab, epoetin alfa, bortezomib, and adenosine.

OBJECTIVE

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

SUMMARY OF FINDINGS

For 60 of the 82 line items reviewed, Methodist Healthcare did not bill Medicare in accordance with Federal requirements:

- For 58 line items, Methodist Healthcare billed the incorrect number of units of service.
- For two line items, Methodist Healthcare used the incorrect HCPCS code.

As a result, Methodist Healthcare received overpayments totaling \$177,834. Methodist Healthcare attributed the overpayments to billing system and clerical errors.

RECOMMENDATIONS

We recommend that Methodist Healthcare:

- refund to the Medicare fiscal intermediary \$177,834 in identified overpayments and
- ensure compliance with Medicare billing requirements.

METHODIST HEALTHCARE COMMENTS

In written comments on our draft report, Methodist Healthcare concurred with our recommendations and provided information on actions that it had taken to address the recommendations. Methodist Healthcare'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 doxorubicin hydrochloride (HCl) liposome, immune globulin, cetuximab, rituximab, epoetin alfa, bortezomib, and adenosine.

Doxorubicin Hydrochloride Liposome

Doxorubicin HCl liposome is an injectable drug used to treat metastatic ovarian cancer and AIDS-related Kaposi's sarcoma. Medicare requires providers to bill one service unit for each 10-milligram injection of doxorubicin HCl liposome. The HCPCS code for this drug is J9001 and is described as "Injection, doxorubicin hydrochloride, all lipid formulations, 10 [milligrams]."

Immune Globulin

Immune globulin is an injectable drug used to treat primary immune deficiency conditions (e.g., chronic inflammatory demyelinating polyneuropathy). Medicare requires providers to bill one service unit for each 500-milligram injection of immune globulin. The HCPCS code for this drug is J1566 and is described as "Injection, immune globulin, intravenous, lyophilized (e.g. powder), not otherwise specified, 500 [milligrams]."

Cetuximab

Cetuximab is an injectable drug used to treat cancers of the colon and rectum. Medicare requires providers to bill one service unit for each 10-milligram injection of cetuximab. The HCPCS code for this drug is J9055 and is described as "Injection, cetuximab, 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]."

Epoetin Alfa

Epoetin alfa is an injectable drug used to treat anemia. Medicare requires providers to bill one service unit for each 1,000 units of epoetin alfa. The HCPCS code for this drug is J0885 and is described as "Injection, epoetin alfa (for non-esrd [end-stage renal disease] use), 1000 units."

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]."

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]."

Methodist Healthcare – Memphis Hospitals

Methodist Healthcare – Memphis Hospitals (Methodist Healthcare) is an acute-care hospital located in Memphis, Tennessee. Methodist Healthcare's claims are processed and paid by Pinnacle Business Solutions, Inc. (Pinnacle), the Medicare Part A fiscal intermediary.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed \$435,026 in Medicare payments to Methodist Healthcare for 82 line items that we selected as potentially at risk for billing errors during our audit period (January 1, 2008, through April 30, 2011). These line items consisted of:

- 52 line items for doxorubicin HCl liposome totaling \$294,496,
- 17 line items for immune globulin totaling \$91,911,
- 4 line items for cetuximab totaling \$17,553,²
- 2 line items for rituximab totaling \$15,694,
- 2 line items for epoetin alfa totaling \$7,641,
- 3 line items for bortezomib totaling \$6,140, and
- 2 line items for adenosine totaling \$1,591.

We identified these payments through data analysis.

We did not review Methodist Healthcare's internal controls applicable to the 82 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 Methodist Healthcare, located in Memphis, Tennessee.

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 doxorubicin hydrochloride HCl liposome, immune globulin, cetuximab, rituximab, epoetin alfa, 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 82 line items totaling \$435,026 that Medicare paid to Methodist Healthcare;
- contacted Methodist Healthcare to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that Methodist Healthcare furnished to verify whether each selected line item was billed correctly;

² For cetuximab, Methodist Healthcare billed Medicare in accordance with Federal requirements.

- calculated overpayments using corrected payment information processed by Pinnacle; and
- discussed the results of our review with Methodist Healthcare.

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 60 of the 82 line items reviewed, Methodist Healthcare did not bill Medicare in accordance with Federal requirements:

- For 58 line items, Methodist Healthcare billed the incorrect number of units of service.
- For two line items, Methodist Healthcare used the incorrect HCPCS code.

As a result, Methodist Healthcare received overpayments totaling \$177,834. Methodist Healthcare attributed the overpayments to billing system and 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 58 line items reviewed, Methodist Healthcare billed Medicare for the incorrect number of units of service:

- For the 52 line items for doxorubicin HCl liposome, Methodist Healthcare billed the incorrect number of units of service. Rather than billing from 4 to 9 service units, Methodist Healthcare billed from 8 to 18 service units. The incorrect billing resulted in overpayments totaling \$156,347.
- For two line items for immune globulin, Methodist Healthcare billed the incorrect number of units of service. Rather than billing 80 and 96 service units, Methodist Healthcare billed 400 and 192 service units, respectively. The incorrect billing resulted in overpayments totaling \$10,946.
- For one line item for rituximab, Methodist Healthcare billed the incorrect number of units of service. Rather than billing 6 service units, Methodist Healthcare billed 12 service units. The incorrect billing resulted in an overpayment of \$3,206.
- For the two line items for adenosine, Methodist Healthcare billed the incorrect number of units of service. Rather than billing 3 and 6 service units, Methodist Healthcare billed 17 and 12 service units, respectively. The incorrect billing resulted in overpayments totaling \$1,093.
- For one line item for bortezomib, Methodist Healthcare billed the incorrect number of units of service. Rather than billing 35 service units, Methodist Healthcare billed 70 service units. The incorrect billing resulted in an overpayment of \$997.

For the two line items for epoetin alfa, Methodist Healthcare billed Medicare using the HCPCS code for the administration of epoetin alfa rather than using the HCPCS code for the administration of darbepoetin alfa, the drug actually administered. The incorrect billing resulted in overpayments totaling \$5,245.

In total, Methodist Healthcare received overpayments of \$177,834. Methodist Healthcare attributed the overpayments to billing system and clerical errors.

RECOMMENDATIONS

We recommend that Methodist Healthcare:

- refund to the Medicare fiscal intermediary \$177,834 in identified overpayments and
- ensure compliance with Medicare billing requirements.

METHODIST HEALTHCARE COMMENTS

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

APPENDIX

APPENDIX: METHODIST HEALTHCARE COMMENTS



June 7, 2012

Via Electronic Transmission - iman.zbinden@oig.hhs.gov

Ms. Lori A. Ahlstrand
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

Re: Report number A-09-12-02022

Dear Ms. Ahlstrand:

This letter is in response to your draft report dated May 24, 2012 entitled *Review of Medicare Outpatient Billing for Selected Drugs at Methodist Healthcare - Memphis Hospitals*.

The draft report recommends that Methodist Healthcare - Memphis Hospitals ("MHMH") refund identified overpayments, and that MHMH ensure compliance with Medicare billing requirements. MHMH concurs with the recommendations and has already refunded identified overpayments and has taken the appropriate measures to prevent similar errors from occurring in the future.

The Office of Inspector General's ("OIG") recommendations and the corrective action taken are as follows:

1. *The OIG recommends that MHMH refund to the Medicare fiscal intermediary \$177,834 in identified overpayments.*

MHMH has already refunded the \$177,834 identified by the OIG to Pinnacle Business Solutions, Inc.

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2. *The OIG recommends that MHMH ensure compliance with Medicare billing requirements.*

Corrections were made to the interface between the pharmacy electronic formulary database and the billing charge master to ensure that the conversion factor resulted in the appropriate quantity being calculated for proper billing.

Additionally, MHMH Pharmacy Department audited all J coded medications in the pharmacy database to ensure that this error was not duplicated and MHMH Patient Financial Services Department conducted further audits of claims to determine that the same error did not occur on the accounting side on any other claims than those identified by the OIG.

MHMH takes its compliance obligations very seriously and is committed to ensuring that it maintains an effective compliance program. We thank you for the assistance and courtesousness that was received from the OIG staff in the review process.

Sincerely,



Chris McLean
Chief Financial Officer