



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

July 10, 2012

Report Number: A-09-12-02034

Mr. John Heider
Chief Financial Officer
Augusta Health Care, Inc.
78 Medical Center Drive
Fishersville, VA 22939

Dear Mr. Heider:

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 Augusta Health Care, Inc.* 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-09-12-02034 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 355
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE
OUTPATIENT BILLING FOR
SELECTED DRUGS AT
AUGUSTA HEALTH CARE, INC.**



Daniel R. Levinson
Inspector General

July 2012
A-09-12-02034

Office of Inspector General

<http://oig.hhs.gov>

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.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

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

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.

Augusta Health Care, Inc. (Augusta), is an acute-care hospital located in Fishersville, Virginia. Based on data analysis, we reviewed \$539,726 in Medicare payments to Augusta for 63 line items for injections of selected drugs that Augusta billed to Medicare during our audit period (January 1, 2008, through April 30, 2011). These line items consisted of injections for bevacizumab, alpha 1–proteinase inhibitor, bortezomib, immune globulin, trastuzumab, and adenosine.

OBJECTIVE

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

SUMMARY OF FINDINGS

For 14 of the 63 line items reviewed, Augusta did not bill Medicare in accordance with Federal requirements:

- For 10 line items, Augusta billed the incorrect number of units of service.
- For two line items, Augusta billed for drugs that were not administered.
- For two line items, Augusta used the incorrect HCPCS code.

As a result, Augusta received overpayments totaling \$24,772. Augusta attributed the overpayments to clerical errors.

RECOMMENDATIONS

We recommend that Augusta:

- refund to the Medicare administrative contractor \$24,772 in identified overpayments and
- ensure compliance with Medicare billing requirements.

AUGUSTA HEALTH CARE, INC., COMMENTS

In written comments on our draft report, Augusta concurred with our findings and recommendations. In addition, Augusta provided information on actions that it had taken to address the recommendations. Augusta'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
Augusta Health Care, Inc.....	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology.....	3
FINDINGS AND RECOMMENDATIONS	4
FEDERAL REQUIREMENTS	4
INCORRECT BILLING	5
RECOMMENDATIONS	5
AUGUSTA HEALTH CARE, INC., COMMENTS	6
APPENDIX	
AUGUSTA HEALTH CARE, INC., 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 bevacizumab, alpha 1–proteinase inhibitor, bortezomib, immune globulin, trastuzumab, and adenosine.

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].”

Alpha 1–Proteinase Inhibitor

Alpha 1–proteinase inhibitor is an injectable drug used to treat alpha 1–antitrypsin deficiency in people who have symptoms of emphysema. Medicare requires providers to bill one service unit for each 10-milligram injection of alpha 1–proteinase inhibitor. The HCPCS code for this drug is J0256 and is described as “Injection, alpha 1–proteinase inhibitor – human, 10 [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].”

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

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].”

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].”

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].”

Augusta Health Care, Inc.

Augusta Health Care, Inc. (Augusta), is an acute-care hospital located in Fishersville, Virginia. Augusta’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 Augusta billed Medicare for injections of selected drugs in accordance with Federal requirements.

Scope

We reviewed \$539,726 in Medicare payments to Augusta for 63 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:

- 28 line items for bevacizumab totaling \$288,301,²
- 24 line items for alpha 1–proteinase inhibitor totaling \$221,116,

² For bevacizumab, Augusta billed Medicare in accordance with Federal requirements.

- 7 line items for bortezomib totaling \$13,836,
- 2 line items for immune globulin totaling \$9,908,
- 1 line item for trastuzumab totaling \$5,815, and
- 1 line item for adenosine totaling \$750.

We identified these payments through data analysis.

We did not review Augusta's internal controls applicable to the 63 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 Augusta, located in Fishersville, Virginia.

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, alpha 1-proteinase inhibitor, bortezomib, immune globulin, trastuzumab, 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 63 line items totaling \$539,726 that Medicare paid to Augusta;
- contacted Augusta to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that Augusta 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 Augusta.

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 14 of the 63 line items reviewed, Augusta did not bill Medicare in accordance with Federal requirements:

- For 10 line items, Augusta billed the incorrect number of units of service.
- For two line items, Augusta billed for drugs that were not administered.
- For two line items, Augusta used the incorrect HCPCS code.

As a result, Augusta received overpayments totaling \$24,772. Augusta 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 10 line items reviewed, Augusta billed Medicare for the incorrect number of units of service:

- For the seven line items for bortezomib, Augusta billed the incorrect number of units of service. Rather than billing 35 service units, Augusta billed 70 service units. The incorrect billing resulted in overpayments totaling \$6,958.
- For two line items for alpha 1–proteinase inhibitor, Augusta billed the incorrect number of units of service. Rather than billing 2,000 service units, Augusta billed 2,800 service units. The incorrect billing resulted in overpayments totaling \$5,840.
- For the one line item for trastuzumab, Augusta billed the incorrect number of units of service. Rather than billing 71 service units, Augusta billed 102 service units. The incorrect billing resulted in an overpayment of \$1,968.

For two line items reviewed, Augusta billed Medicare for drugs that were not administered:

- For one line item for alpha 1–proteinase inhibitor, Augusta billed for 2,800 units of alpha 1–proteinase inhibitor that was not administered, resulting in an overpayment of \$9,256.
- For the one line item for adenosine, Augusta billed for nine units of adenosine that was not administered, resulting in an overpayment of \$750.

For the two line items for immune globulin, Augusta billed Medicare using the HCPCS code for the administration of lyophilized immune globulin rather than using the HCPCS code for the administration of non-lyophilized immune globulin containing Gammagard Liquid, the drug actually administered. The incorrect billing did not have an impact on our calculation of overpayments.

In total, Augusta received overpayments of \$24,772. Augusta attributed the overpayments to clerical errors.

RECOMMENDATIONS

We recommend that Augusta:

- refund to the Medicare administrative contractor \$24,772 in identified overpayments and
- ensure compliance with Medicare billing requirements.

AUGUSTA HEALTH CARE, INC., COMMENTS

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

APPENDIX

APPENDIX: AUGUSTA HEALTH CARE, INC., COMMENTS



Augusta Health
P.O. Box 1000
Fishersville, VA 22939

Phone (540) 332-4000 **Staunton**
Phone (540) 932-4000 **Waynesboro**
Toll Free 1-800-932-0262
www.augustahealth.com

June 7, 2012

Via Email & Certified Mail

Lori A. Ahlstrand
Regional Inspector General for Audit Services
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

RE: Augusta Health Care, Inc.
Provider No. 490018
Report Number: A-09-12-02034

Dear Ms. Ahlstrand:

Augusta Health Care, Inc. ("Augusta Health") appreciates the opportunity to respond to the Department of Health and Human Services, Office of Inspector General draft report titled "Review of Medicare Outpatient Billing for Selected Drugs at Augusta Health Care, Inc." Augusta Health concurs with the findings and recommendations contained in the draft report and responds as follows:

Recommendation 1: "refund to the Medicare administrative contractor \$24,772 in identified overpayments."

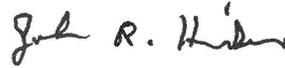
Augusta Health concurs with this recommendation and has submitted corrected claims to its Medicare administrative contractor for each of the identified errors resulting in a repayment of \$24,772. Documentation supporting each of the claim adjustments was previously provided to the Department of Health and Human Services, Office of Inspector General on June 27, 2011, August 3, 2011, and January 20, 2012.

Recommendation 2: "ensure compliance with Medicare billing requirements."

Augusta Health concurs with this recommendation. The incorrect claims were due to clerical data entry errors and a missing signature. Involved staff were counseled and routine auditing and monitoring has been instituted to reduce the potential for future errors. In addition, a review of electronic systems was conducted to assure that missing signatures are flagged for follow-up.

Augusta Health takes its commitment to compliance with Medicare billing seriously and appreciates the opportunity to identify and correct these billing errors. Augusta Health believes that it has made all necessary payment adjustments and has taken appropriate corrective action. We are pleased to have this matter closed and appreciate your assistance and your support of our compliance efforts.

Sincerely,

A handwritten signature in black ink that reads "John R. Heider". The signature is written in a cursive style with a large initial "J" and "H".

John R. Heider
V.P. of Finance/Chief Financial Officer

Cc: Adam Cramer, Auditor, Office of Inspector General, Office of Audit Services
Alex Brown, Interim Corporate Compliance and Privacy Officer