

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF MASSACHUSETTS
GENERAL HOSPITAL
FOR CALENDAR YEARS
2010 AND 2011**

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April 2014
A-01-12-00520

Office of Inspector General

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EXECUTIVE SUMMARY

Massachusetts General Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of approximately \$1.2 million over more than 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Massachusetts General Hospital (Mass General) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Mass General is a 1,046-bed acute care hospital located in Boston, Massachusetts. Medicare paid Mass General approximately \$766 million for 33,702 inpatient and 752,283 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$4,449,487 in Medicare payments to Mass General for 590 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 238 inpatient and 352 outpatient claims. Of these 590 claims, 572 had dates of service in CYs 2010 or 2011, and 18 claims (involving outpatient drugs) had dates of service in CYs 2009 or 2012.

WHAT WE FOUND

Mass General complied with Medicare billing requirements for 137 of the 590 inpatient and outpatient claims we reviewed. However, Mass General did not fully comply with Medicare billing requirements for the remaining 453 claims, resulting in net overpayments of \$1,181,228 for CYs 2010 and 2011 (437 claims), CY 2009 (15 claims), and CY 2012 (1 claim). Specifically, 183 inpatient claims had billing errors, resulting in net overpayments of \$720,393,

and 270 outpatient claims had billing errors, resulting in overpayments of \$460,835. These errors occurred primarily because Mass General did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that Mass General:

- refund to the Medicare contractor \$1,181,228, consisting of \$720,393 in net overpayments for 183 incorrectly billed inpatient claims and \$460,835 in overpayments for 270 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

MASSACHUSETTS GENERAL HOSPITAL COMMENTS

In written comments on our draft report, Mass General stated that it was generally in agreement with our conclusions and recommendations. Mass General also stated that it has taken several steps to strengthen internal controls and has initiated processing the necessary adjustments with the Medicare contractor. We acknowledge Mass General's efforts to implement stronger controls.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether Massachusetts General Hospital (Mass General) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services

within each APC group.¹ All services and items within an APC group are comparable clinically and require comparable resources. In addition to the basic payments, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Claims at Risk for Incorrect Billing

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- inpatient short stays,
- inpatient and outpatient claims paid greater than charges,
- inpatient claims billed with high severity level DRG codes,
- inpatient transfers
- inpatient psychiatric facility (IPF) emergency department adjustments,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient same-day discharge and readmission,
- inpatient hospital-acquired conditions and present on admission indicator reporting,
- outpatient dental services,
- outpatient drugs,
- outpatient claims billed during inpatient stays,
- outpatient claims billed with observation services that resulted in outlier payments,
- outpatient claims billed with modifier -59, and
- outpatient claims billed with evaluation and management (E&M) services.

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.” We reviewed these risk areas as part of this review.

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

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Social Security Act (the Act), § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (section 1833(e)).

Federal regulations state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Massachusetts General Hospital

Mass General is a 1,046-bed acute care hospital located in Boston, Massachusetts. Medicare paid Mass General approximately \$766 million for 33,702 inpatient and 752,283 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS’s National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$4,449,487 in Medicare payments to Mass General for 590 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 238 inpatient and 352 outpatient claims. Of these 590 claims, 572 had dates of service in CYs 2010 or 2011 and 18 claims (involving outpatient drugs) had dates of service in CYs 2009 or 2012.² We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 94 claims to focused medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Mass General for Medicare reimbursement.

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 objectives.

Appendix A contains the details of our scope and methodology.

² We selected these 18 claims for review because they were brought to our attention through an OIG audit of high-risk outpatient drugs. We did not include these claims in the scope of the other audit.

FINDINGS

Mass General complied with Medicare billing requirements for 137 of the 590 inpatient and outpatient claims we reviewed. However, Mass General did not fully comply with Medicare billing requirements for the remaining 453 claims, resulting in net overpayments of \$1,181,228 for CYs 2010 and 2011 (437 claims), CY 2009 (15 claims), and CY 2012 (1 claim). Specifically, 183 inpatient claims had billing errors, resulting in net overpayments of \$720,393, and 270 outpatient claims had billing errors, resulting in overpayments of \$460,835. These errors occurred primarily because Mass General did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Mass General incorrectly billed Medicare for 183 of 238 selected inpatient claims, which resulted in net overpayments of \$720,393.

Incorrectly Billed as Inpatient or Without a Valid Physician Order

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, § 1862(a)(1)(A)). The Act also states: payment for services furnished to an individual may be made only to providers of services that are eligible and only if, “with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual’s medical treatment ...” (section 1814(a)(3)). Additionally, Medicare Part A pays for inpatient hospital services “... only if a physician certifies and recertifies, among other things, the reasons for continued hospitalization” (42 CFR § 424.13(a)).

For 89 of the 238 selected claims, Mass General incorrectly billed Medicare Part A for beneficiary stays that either should have been billed as outpatient or outpatient with observation services (87 claims), or did not have a valid physician’s order to admit the beneficiary to inpatient care (2 claims). For the majority of these claims, Mass General stated that case management staff relied on external level-of-care screening criteria and followed all available Medicare guidance, which Mass General officials believe is unclear. Additionally, Mass General attributed some errors to incomplete documentation by admitting physicians. For a limited number of claims, Mass General did not provide a cause because it did not agree with these billing errors. As a result of these errors, Mass General received overpayments of \$675,922.³

³ Mass General may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor prior to the issuance of our report.

Incorrect Discharge Status Codes

Hospitals must bill inpatient discharges as transfers when the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge (42 CFR § 412.4(b)). A hospital that transfers an inpatient under the above circumstance is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 6 of the 238 selected claims, Mass General incorrectly billed Medicare for patient discharges that were transfers to other hospitals. For these claims, Mass General incorrectly:

- coded the discharge status as “left against medical advice” based on the highest level of care known at the time of discharge and its plan for the patient; however, our audit found that these patients were admitted to other acute care hospitals on the same day (3 claims);
- coded the discharge status to home (2 claims); or
- coded the discharge status as transferred to another institution not defined elsewhere (1 claim).

Therefore, Mass General should receive a per diem payment instead of the full DRG payment when the claims are billed correctly. Mass General officials stated that some of these errors occurred because the patients left against medical advice and staff did not know until our audit that the patients entered other facilities, and other errors occurred because of human error. As a result of these errors, Mass General received overpayments of \$29,580.

Incorrect Source-of-Admission Code

CMS adjusts the Federal per diem rate upward for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department (42 CFR § 412.424). The Manual states that CMS makes this additional payment regardless of whether the beneficiary used emergency department services; however, the IPF should not receive the additional payment if the beneficiary was discharged from the acute care section of the same hospital (chapter 3, § 190.6.4). The Manual also states that IPFs report source-of-admission code “D” to identify patients who have been transferred to the IPF from the same hospital (chapter 3, § 190.6.4.1). An IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 82 of the 238 selected claims, Mass General incorrectly coded the source-of-admission for beneficiaries who were admitted to its IPF upon discharge from its acute care section. Mass General officials stated that the errors occurred because source-of-admission code “D” was not an available option in Mass General's billing system. As a result of these errors, Mass General received overpayments of \$7,278.

Manufacturer Credit for a Replaced Medical Device Not Reported or Obtained

Federal regulations require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). Federal regulations state: “All payments to providers of services must be based on the reasonable cost of services ...” (42 CFR § 413.9). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code “FD” (chapter 3, § 100.8).

The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements in additional detail (Pub. No. 15-1).⁴

For 2 of the 238 selected claims, Mass General either received a reportable medical device credit from a manufacturer for a replaced device, but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required, or did not obtain a credit for a replaced medical device for which a credit was available under the terms of the manufacturer’s warranty. Mass General officials stated that the errors occurred due to human error. As a result of these errors, Mass General received overpayments of \$4,550.

Incorrectly Billed Diagnosis-Related Group Codes

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act § 1862(a)(1)(A)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 4 of the 238 selected claims, Mass General billed Medicare for incorrect DRG codes. Mass General officials stated that two of the errors occurred due to human error. Mass General did not provide a cause for the remaining two errors because it did not agree with these billing errors. As a result of these errors, Mass General received net overpayments of \$3,063.

⁴ The PRM states: “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program” (part I, § 2102.1). Section 2103 further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example: “Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.”

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Mass General incorrectly billed Medicare for 270 of 352 selected outpatient claims, which resulted in overpayments of \$460,835. One claim contained more than one type of error.

Incorrect Billing for Dental Services

The Act states: “No payment may be made under Medicare Part A or Part B for any expenses incurred for items or services where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth ...” (section 1862(a)(12)).

For 105 of the 352 selected claims, Mass General incorrectly billed Medicare for the treatment or removal of teeth. Mass General stated these errors occurred because it relied on a third-party presubmission claim-editing tool that did not contain an edit to identify noncovered dental services. As a result of these errors, Mass General received overpayments of \$200,527.

Incorrectly Billed Number of Units and/or Healthcare Common Procedure Coding System Codes

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). In addition, the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed ...” (chapter 4, § 20.4).

For 30 of the 352 selected claims, Mass General submitted claims to Medicare with an incorrect number of units and/or incorrect HCPCS codes. Mass General officials stated the errors occurred due to human error. As a result of these errors, Mass General received overpayments of \$162,850.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45). For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.⁵

⁵ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

For 3 of the 352 selected claims, Mass General received full credit for replaced devices but did not properly report the “FB” modifier and reduced charges on its claims. Mass General officials stated that the errors occurred due to human error. As a result of these errors, Mass General received overpayments of \$42,150.

Incorrectly Billed Outpatient Services Provided During an Inpatient Stay

Certain items and nonphysician services furnished to inpatients are covered under Part A and consequently are covered by the inpatient prospective payment rate (the Manual, chapter 3, § 10.4).

For 115 of the 352 selected claims, Mass General incorrectly billed Medicare Part B for outpatient services provided during an inpatient stay. Mass General officials stated that the errors occurred primarily because Mass General’s outpatient registrar staff was not aware that the patients receiving these outpatient services were admitted to another inpatient facility at the time of the service. As a result of these errors, Mass General received overpayments of \$33,189.

Insufficiently Documented Services

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (section 1833(e)).

For 3 of the 352 selected claims, Mass General incorrectly billed Medicare for services that were not supported in the medical record. Mass General officials stated that these errors occurred due to human error. As a result of these errors, Mass General received overpayments of \$12,537.

Incorrectly Billed Observation Services

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act § 1862(a)(1)(A)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). The Manual (chapter 1, § 50.3.2) also states:

However, in accordance with the general Medicare requirements for services furnished to beneficiaries and billed to Medicare, even in Condition Code 44 situations, hospitals may not report observation services using HCPCS code G0378 (Hospital observation service, per hour) for observation services furnished during a hospital encounter prior to a physician's order for observation services. Medicare does not permit retroactive orders or the inference of physician orders.

The Manual states: “Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services” (chapter 4, § 290.1). “Observation time begins at the clock time documented in the patient’s medical record, which coincides with the time that observation care is initiated in accordance with a physician’s order Observation time ends when all medically necessary services related to observation care are completed

Reported observation time would not include the time patients remain in the hospital after treatment is finished ...” (chapter 4, § 290.2.2).

For 6 of the 352 selected claims, Mass General incorrectly billed Medicare for observation services that included incorrect units of billed observation services (4 claims) and lacked timely physician orders for observation services (2 claims). For the two claims that lacked timely physician orders, the physician signed one order after the observation care was no longer necessary and signed the other order when the observation services were nearly complete.

These errors resulted in a higher outlier payment than was warranted. Mass General officials stated the majority of the errors occurred because it did not have sufficient controls to accurately capture observation units in situations where there were either delays in moving a patient to a unit for observation services or delays in entering an observation order in the medical record. In some cases, the patient began to receive observation services in accordance with a verbal order. As a result of these errors, Mass General received overpayments of \$7,696.

Incorrectly Billed Outpatient Services With Modifier -59

The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). It also states: “The ‘59’ modifier is used to indicate a distinct procedural service This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)” (chapter 23, § 20.9.1.1).

For 1 of the 352 selected claims, Mass General incorrectly billed Medicare for a HCPCS code with modifier -59 for a service that was already included in the payment for another service billed on the same claim. Mass General officials stated that the error occurred due to human error. As a result of this error, Mass General received an overpayment of \$1,438.

Incorrectly Billed Evaluation and Management Services

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (section 1833(e)). The Manual states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure (chapter 12, § 30.6.6(B)).

For 8 of the 352 selected claims, Mass General incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. Mass General officials stated that these errors occurred primarily due to a lack of physician education regarding Medicare requirements for billing E&M services. As a result of these errors, Mass General received overpayments of \$448.

RECOMMENDATIONS

We recommend that Mass General:

- refund to the Medicare contractor \$1,181,228, consisting of \$720,393 in net overpayments for 183 incorrectly billed inpatient claims and \$460,835 in overpayments for 270 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

MASSACHUSETTS GENERAL HOSPITAL COMMENTS

In written comments on our draft report, Mass General stated that it was generally in agreement with our conclusions and recommendations. Mass General also stated that it has taken several steps to strengthen internal controls and has initiated processing the necessary adjustments with the Medicare contractor. We acknowledge Mass General's efforts to implement stronger controls. Mass General's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$4,449,487 in Medicare payments to Mass General for 590 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 238 inpatient and 352 outpatient claims. Of these 590 claims, 572 had dates of service in CYs 2010 or 2011 and 18 claims (involving outpatient drugs) had dates of service in CYs 2009 or 2012.

We focused our review on the risk areas that we had identified as a result of prior Office of Inspector General reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 94 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of Mass General's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Mass General for Medicare reimbursement.

Our fieldwork included contacting Mass General in Boston, Massachusetts, from October 2012 through November 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Mass General's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2010 and 2011;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2010 and 2011;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 590 claims (238 inpatient and 352 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by Mass General to support the selected claims;
- requested that Mass General conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed Mass General's procedures for submitting Medicare claims;
- used an independent medical review contractor to determine whether 94 selected claims met medical necessity requirements;
- discussed the incorrectly billed claims with Mass General personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Mass General officials.

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 objectives.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Under / Over-payments	Value of Net Over-payments
Inpatient				
Short Stays	100	\$616,709	78	\$474,665
Claims Paid Greater Than Charges	10	281,025	6	152,847
Claims Billed With High Severity Level Diagnosis-Related Group Codes	20	366,445	9	51,473
Transfers	6	96,282	6	29,580
Psychiatric Facility Emergency Department Adjustments	82	1,257,773	82	7,278
Manufacturer Credits for Replaced Medical Devices	9	395,181	2	4,550
Same-Day Discharge and Readmission	1	32,713	0	0
Hospital-Acquired Conditions and Present on Admission Indicator Reporting	10	171,994	0	0
Inpatient Totals	238	\$3,218,122	183	\$720,393
Outpatient				
Dental Services	111	\$229,824	106	\$200,591
Drugs	54	441,242	28	139,974
Claims Paid Greater Than Charges	5	76,775	3	47,383
Claims Billed During Inpatient Stays	115	33,189	115	33,190
Manufacturer Credits for Replaced Medical Devices	10	285,849	2	28,463
Claims Billed With Observation Services That Resulted in Outlier Payments	10	26,461	6	7,696
Claims Billed With Modifier -59	27	118,980	3	2,704
Claims Billed With Evaluation and Management Services	20	19,045	7	834
Outpatient Totals	352	\$1,231,365	270	\$460,835
Inpatient and Outpatient Totals	590	\$4,449,487	453	\$1,181,228

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at Mass General. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX C: MASSACHUSETTS GENERAL HOSPITAL COMMENTS



MASSACHUSETTS
GENERAL HOSPITAL

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Sally Mason Boemer
Senior Vice President for Finance

March 5, 2014

Mr. David Lamir
Regional Inspector General for Audit Services
Office of Inspector General
JFK Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Dear Mr.Lamir:

We appreciate the opportunity to respond to the draft report of your Medicare Compliance Review of Massachusetts General Hospital (MGH) for calendar years 2010 and 2011. We are generally in agreement with the conclusions and recommendations detailed in the report.

As a result of this review, MGH has initiated processing the necessary adjustments with the Medicare Administrative Contractor, National Government Services.

MGH has also taken several steps to strengthen our controls in each of the areas noted in the review, as was detailed in our previously submitted Internal Controls Questionnaires.

We appreciate the professionalism with which your staff completed this review. Please let me know if you have any questions concerning our ongoing efforts to ensure appropriate documentation and billing for services provided to all patients.

Sincerely,

Sally Mason Boemer
Senior Vice President for Finance
Massachusetts General Hospital