

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW
OF BAYLOR ALL SAINTS MEDICAL
CENTER AT FORT WORTH FOR
CALENDAR YEARS 2010 AND 2011**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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**Patricia Wheeler
Regional Inspector General**

January 2014
A-06-12-00030

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Baylor All Saints Medical Center at Fort Worth did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of approximately \$372,000 over 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) 2011, Medicare paid hospitals \$151 billion, which represents 45 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 Baylor All Saints Medical Center at Fort Worth (the Hospital) 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.

The Hospital, located in Fort Worth, Texas, is a 525-bed full-service hospital affiliate of the Baylor Healthcare System. Medicare paid the Hospital approximately \$154 million for 12,334 inpatient and 42,163 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$2,870,949 in Medicare payments to the Hospital for 244 claims that we judgmentally selected as potentially at risk for billing errors. These 244 claims consisted of 182 inpatient and 62 outpatient claims with dates of service in CYs 2010 or 2011.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 121 of the 244 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 123 claims, resulting in net overpayments of \$371,952 for CYs 2010 and 2011. Specifically, 105 inpatient claims had billing errors, resulting in net overpayments of \$369,080, and 18 outpatient claims had billing errors, resulting in net overpayments of \$2,872. These errors occurred primarily because the Hospital 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 the Hospital:

- refund to the Medicare contractor \$371,952, consisting of \$369,080 in net overpayments for 105 incorrectly billed inpatient claims and \$2,872 in net overpayments for 18 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

BAYLOR ALL SAINTS MEDICAL CENTER AT FORT WORTH COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital partially agreed with our first recommendation. Specifically, the Hospital disagreed with our finding on 34 of the 182 selected inpatient claims incorrectly billed as inpatient, stating: “BASMC [The Hospital] provided inpatient level of care services based on the physician order and the patients’ presenting condition.” The Hospital added that it intends to dispute the claims at issue through the Medicare appeals process. The Hospital concurred with our recommendation to refund the remainder of the overpayments that we identified.

Regarding our second recommendation, the Hospital discussed steps that it had taken to strengthen its internal controls to ensure compliance with Medicare billing requirements.

After reviewing the Hospital’s comments, we maintain that our findings and recommendations are valid. We used CMS’s Medicare contractor medical review staff and an independent medical review contractor to determine whether the claims met medical necessity requirements. The contractors examined all of the medical records and documentation originally submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractors’ conclusions, we maintain that the 34 claims should have been billed as outpatient or outpatient with observation services.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
The Medicare Program	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System	1
Hospital Claims at Risk for Incorrect Billing	2
Medicare Requirements for Hospital Claims and Payments	2
Baylor All Saints Medical Center at Fort Worth	3
How We Conducted This Review	3
FINDINGS	3
Billing Errors Associated With Inpatient Claims	3
Incorrectly Billed as Inpatient	4
Incorrectly Billed as Separate Inpatient Stays	4
Incorrectly Billed Provider Number	4
Billing Errors Associated With Outpatient Claims	5
Incorrectly Billed Healthcare Common Procedure Coding System Codes	5
Insufficiently Documented Services	5
Incorrectly Billed Evaluation and Management Services	5
RECOMMENDATIONS	5
BAYLOR ALL SAINTS MEDICAL CENTER AT FORT WORTH COMMENTS	6
OFFICE OF INSPECTOR GENERAL RESPONSE	6
APPENDIXES	
A: Audit Scope and Methodology	7
B: Results of Review by Risk Area	9
C: Baylor All Saints Medical Center At Fort Worth Comments	10

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) 2011, Medicare paid hospitals \$151 billion, which represents 45 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 Baylor All Saints Medical Center at Fort Worth (the Hospital) 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. 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.

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 same-day discharges and readmissions,
- inpatient claims billed with high severity level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed with modifier -59,
- outpatient claims billed with evaluation and management (E&M) services, and
- outpatient services billed during home health episodes.

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.

Medicare Requirements for Hospital Claims and Payments

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 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 (§ 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) states: “In order to be processed correctly and promptly, a bill must be completed accurately” (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).

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

Baylor All Saints Medical Center at Fort Worth

The Hospital, located in Fort Worth, Texas, is a 525-bed full-service hospital affiliate of the Baylor Healthcare System. Medicare paid the Hospital approximately \$154 million for 12,334 inpatient and 42,163 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 \$2,870,949 in Medicare payments to the Hospital for 244 claims that we judgmentally selected as potentially at risk for billing errors. These 244 claims consisted of 182 inpatient and 62 outpatient claims with dates of service in CYs 2010 or 2011. 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 50 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 the Hospital 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.

See Appendix A for the details of our scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 121 of the 244 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 123 claims, resulting in net overpayments of \$371,952 for CYs 2010 and 2011. Specifically, 105 inpatient claims had billing errors resulting in net overpayments of \$369,080, and 18 outpatient claims had billing errors, resulting in net overpayments of \$2,872. These errors occurred primarily because the Hospital 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

The Hospital incorrectly billed Medicare for 105 of 182 selected inpatient claims, which resulted in net overpayments of \$369,080.

Incorrectly Billed as Inpatient

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)).

For 34 of the 182 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital did not provide a reason for these errors because it did not agree that these claims were billed in error. As a result of these errors, the Hospital received overpayments of \$249,126.²

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 68 of the 182 selected claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. Hospital officials stated that these errors occurred after the responsibility to review same-day readmissions was transferred to a different individual. As a result of these errors, the Hospital received overpayments of \$135,218.

Incorrectly Billed Provider Number

The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 3 of the 182 selected claims, the Hospital incorrectly billed Medicare using its acute care provider number instead of its inpatient rehabilitation facility or psychiatric facility provider number. Hospital officials stated that the errors occurred because the Hospital did not select the appropriate facility code associated with the rehabilitation or psychiatric provider number when it billed the claims, which resulted in underpayments of \$15,264.

² The Hospital 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 draft report.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 18 of 62 selected outpatient claims, which resulted in net overpayments of \$2,872.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

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

For 3 of the 62 selected claims, the Hospital submitted the claims to Medicare with incorrect HCPCS codes. Hospital officials attributed this to human error. As a result of these errors, the Hospital received net overpayments of \$1,693.

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 (§ 1833(e)).

For 11 of the 62 selected claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical records. These errors occurred primarily because of human error. As a result of these errors, the Hospital received overpayments of \$945.

Incorrectly Billed Evaluation and Management Services

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 4 of the 62 selected claims, the Hospital 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. Hospital officials attributed this to human error. As a result of these errors, the Hospital received overpayments of \$234.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$371,952, consisting of \$369,080 in net overpayments for 105 incorrectly billed inpatient claims and \$2,872 in net overpayments for 18 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

BAYLOR ALL SAINTS MEDICAL CENTER AT FORT WORTH COMMENTS

In written comments on our draft report, the Hospital partially agreed with our first recommendation. Specifically, the Hospital disagreed with our finding on 34 of the 182 selected inpatient claims incorrectly billed as inpatient, stating: “BASMC [The Hospital] provided inpatient level of care services based on the physician order and the patients’ presenting condition.” The Hospital added that it intends to dispute the claims at issue through the Medicare appeals process. The Hospital concurred with our recommendation to refund the remainder of the overpayments that we identified.

Regarding our second recommendation, the Hospital discussed steps that it had taken to strengthen its internal controls to ensure compliance with Medicare billing requirements.

The Hospital’s comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital’s comments, we maintain that our findings and recommendations are valid. We used CMS’s Medicare contractor medical review staff and an independent medical review contractor to determine whether the claims met medical necessity requirements. The contractors examined all of the medical records and documentation originally submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractors’ conclusions, we maintain that the 34 claims should have been billed as outpatient or outpatient with observation services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$2,870,949 in Medicare payments to the Hospital for 244 claims that we judgmentally selected as potentially at risk for billing errors. These 244 claims consisted of 182 inpatient and 62 outpatient claims with dates of service in CYs 2010 or 2011.

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 50 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of the Hospital'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 the Hospital for Medicare reimbursement.

We conducted our fieldwork from June 2012 through September 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital'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 244 claims (182 inpatient and 62 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 medical record documentation provided by the Hospital to support the selected claims;

- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- used CMS's Medicare contractor medical review staff and an independent contractor to determine whether 50 selected claims met medical necessity requirements;
- discussed the incorrectly billed claims with Hospital 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 Hospital 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 Underpayments /Overpayments	Value of Net Overpayments
Inpatient				
Short Stays	76	\$758,754	34	\$249,126
Same-Day Discharges and Readmissions	76	1,311,678	71	119,954
Claims Billed With High Severity Level Diagnosis-Related Group Codes	26	464,850	0	0
Manufacturer Credits for Replaced Medical Devices	4	104,020	0	0
Inpatient Totals	182	\$2,639,302	105	\$369,080
Outpatient				
Claims Billed With Modifier -59	14	\$16,822	5	\$2,217
Claims Billed With Evaluation and Management Services	24	14,700	13	654
Manufacturer Credits for Replaced Medical Devices	12	186,778	0	0
Services Billed During Home Health Episodes	12	13,347	0	0
Outpatient Totals	62	\$231,647	18	\$2,872
Inpatient and Outpatient Totals	244	\$2,870,949	123	\$371,952

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 the Hospital. 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: BAYLOR ALL SAINTS MEDICAL CENTER AT FORT WORTH COMMENTS



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January 4, 2014

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Regional Inspector General for Audit Services
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1100 Commerce Street, Room 632
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Report Number: A-06-12-00030, *Medicare Compliance Review of Baylor All Saints Medical Center at Fort Worth for Calendar Years 2010 and 2011*

Dear Ms. Wheeler:

Baylor All Saints Medical Center at Fort Worth ("BASMC") is in receipt of the November 21, 2013 draft report provided by the U. S. Department of Health and Human Services, Office of the Inspector General ("OIG") entitled Medicare Compliance Review of Baylor All Saints Medical Center at Fort Worth for Calendar Years 2010 and 2011. BASMC appreciates the opportunity to review the report and provide comments to the OIG regarding the report findings. BASMC is committed to complying with all regulations and standards governing Federal health care programs, improving internal controls, providing training and education, and proactively auditing and monitoring to minimize the risk of errors.

Responses to the findings referenced in the OIG draft report are detailed below. Corrective actions have been developed to address specific findings, including strengthening internal controls, providing additional education, work flow process improvement and focused auditing and monitoring.

SUMMARY OF OIG FINDINGS AND RECOMMENDATIONS

Findings

The Hospital complied with Medicare billing requirements for 121 of the 244 inpatient and outpatient claims reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 123 claims, resulting in net overpayments of \$371,952 for CYs 2010 and 2011. Specifically, 105 inpatient claims had billing errors resulting in net overpayments of \$369,080, and 18 outpatient claims had billing errors, resulting in net overpayments of \$2,872. These errors occurred

primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

Recommendations

We recommend that the Hospital:

- refund to the Medicare contractor \$371,952, consisting of \$369,080 in net overpayments for 105 incorrectly billed inpatient claims and \$2,872 in net overpayments for 18 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

REPORT FINDINGS AND COMMENTS

Incorrectly Billed as Inpatient

For 34 of the 182 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital did not provide a reason for these errors because it did not agree that these claims were billed in error. As a result of these errors, the Hospital received overpayments of \$249,126.

Response:

BASMC respectfully disagrees with the OIG report finding and medical review for the 34 claims determined not to meet medical necessity for a Medicare Part A inpatient stay. Based on the guidance provided in the Medicare Benefit Policy Manual, chapter 1, section 10, an inpatient is defined as;

*“An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an **inpatient** if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.*

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities

available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting."

One-day stays (short stays) are reviewed by the BASMC Care Coordination staff to determine the appropriateness of the stay based on the physician order and InterQual criteria. InterQual criteria are used as a basis to support the medical necessity of the inpatient status. Upon review, if it is determined that the patient status does not meet inpatient criteria, the Care Coordination staff will contact the admitting physician and the Medical Director of Care Coordination (MDCC) if appropriate, to verify the medical necessity of the admission status. In addition, BASMC provides ongoing InterQual training for the Care Coordination staff on an annual basis. Interrater Reliability ("IRR") testing is mandatory and is used to measure staff proficiency regarding the application of InterQual criteria.

BASMC provided inpatient level of care services based on the physician order and the patients' presenting condition. The 34 claims will be appealed through the Medicare appeals process.

Incorrectly Billed as Separate Inpatient Stays

For 68 of the 182 selected claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. Hospital officials stated that these errors occurred after the responsibility to review same-day readmissions was transferred to a different individual. As a result of these errors, the Hospital received overpayments of \$135,218.

Response:

BASMC concurs with the report finding. BASMC and Baylor Medical Center South West at Fort Worth ("BMCSW") were separate sites with physically different locations, licensed under the same provider number; and therefore considered one provider for claim submission purposes. The error occurred when patients were transferred from BMCSW to BASMC. The BMCSW location was closed on March 30, 2012; therefore, readmissions that occurred for this reason will no longer be a concern. The overpayments have been refunded through the claim adjustment process in the Medicare claim processing system.

Incorrectly Billed Provider Number

For 3 of the 182 selected claims, the Hospital incorrectly billed Medicare using its acute care provider number instead of its inpatient rehabilitation facility or psychiatric facility provider number. Hospital officials stated that the errors occurred because the Hospital did not select the appropriate facility code associated with the rehabilitation or psychiatric provider number when it billed the claims, which resulted in underpayments of \$15,264.

Response:

BASMC concurs with the report finding. For two (2) of the claims in this category, the patient was discharged from an inpatient rehabilitation provider to an acute care provider; however, the claims were submitted with the acute care provider number. The remaining error in this category resulted from a discharge from an inpatient psychiatric provider to an acute care provider; however, both claims were submitted with the acute care provider number. The errors resulted in acute care same day readmissions, when they should have been billed as an inpatient psychiatric or rehabilitation stay. During the registration process, the appropriate medical service code that was associated with the psychiatric or rehabilitation provider number was not selected, which resulted in the acute care provider number being associated with the claim.

Training and education was provided to the registration staff regarding the selection of the appropriate medical service code associated with the provider type and number. A compliance review was completed for readmissions that occurred between July 1, 2011 and June 30, 2012, to evaluate Medicare claims for patients that were readmitted to the same facility on the same day they were discharged, to determine if the claims were billed appropriately and complied with Medicare guidelines. Ongoing monitoring is performed with respect to readmissions to validate that the readmission is compliant with Medicare regulations and should be submitted as a separate encounter and not as a combined claim.

The BASMC inpatient psychiatric unit was closed on October 4, 2010; therefore, readmissions that had previously occurred when patients were discharged from the inpatient psychiatric provider to the acute care provider will no longer be a concern. The claims were adjusted in the Medicare claim processing system.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

For 3 of the 62 selected claims, the Hospital submitted the claims to Medicare with incorrect HCPCS codes. Hospital officials attributed this to human error. As a result of these errors, the Hospital received net overpayments of \$1,693.

Response:

BASMC concurs with the report finding. The errors in this category are related to the application of modifier 59, indicating a separate or distinct procedure performed on the same day. The modifier is used to identify services or procedures that are not normally performed together, but may be appropriate under certain circumstances. BASMC has provided additional coding education regarding the appropriate use of HCPCS codes and performs ongoing coding audits to validate coding quality and identify coding training opportunities. The overpayments have been refunded through the claim adjustment process in the Medicare claim processing system.

Insufficiently Documented Services

For 11 of the 62 selected claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical records. These errors occurred primarily because of human error. As a result of these errors, the Hospital received overpayments of \$945.

Response:

BASMC concurs with the report finding. The errors occurred due to insufficient documentation in the medical record to support the application of modifier 25 for Evaluation and Management (“E&M”) services and modifier 59 indicating a distinct and separate procedure performed on the same day. The modifier 59 is appended by certified coders, who adhere to standards and guidelines defined by the Current Procedural Terminology (“CPT”) code set. Additional coding education regarding the documentation requirements to support the application of modifier 59 has been provided to the coding staff. In addition, training and education has been provided to the charge entry staff on the appropriate application of modifier 25. The overpayments have been refunded through the claim adjustment process in the Medicare claim processing system.

Incorrectly Billed Evaluation and Management Services

For 4 of the 62 selected claims, the Hospital 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. Hospital officials attributed this to human error. As a result of these errors, the Hospital received overpayments of \$234.

Response:

BASMC concurs with the report finding. The claim errors occurred due to a misunderstanding by the clinical department on the appropriate use of modifier 25 to indicate a separate and distinct procedure performed in addition to an Evaluation and Management (“E&M”) service. Additional training has been provided to charge entry staff regarding the appropriate use of modifier 25 for E&M services. The overpayment has been refunded through a claim adjustment in the Medicare claim processing system.

BASMC remains committed to ongoing compliance with Medicare billing regulations through the continued training and education, ongoing auditing and monitoring, and enhancement of internal controls.

Nothing herein should be deemed an admission by BASMC of any regulatory violation. BASMC reserves the right to appeal any claims denied by the Medicare Administrative Contractor.

We appreciate the professionalism of the OIG audit staff through the review process. Please contact me directly if you have additional questions regarding this response.

Sincerely,



Robert Michalski, CHC
Chief Compliance Officer
Baylor Scott & White Health

cc: David Klein, M.D.
Lucy Catala
Lygia Dunswoth