



Office of Audit Services, Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

March 2, 2011

Report Number: A-01-10-00521

Tessa L. Lucey
Director of Compliance/Privacy Officer
South Shore Hospital
55 Fogg Road
Weymouth, MA 02190-2455

Dear Ms. Lucey:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of South Shore Hospital for Calendar Years 2008 and 2009*. 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 call me, or contact Kimberly Rapoza, Audit Manager, at (617) 565-2695 or through email at Kimberly.Rapoza@oig.hhs.gov. Please refer to report number A-01-10-00521 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations (CFMFFSO)
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Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
SOUTH SHORE HOSPITAL
FOR CALENDAR YEARS
2008 AND 2009**



Daniel R. Levinson
Inspector General

March 2011
A-01-10-00521

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the prospective payment system (PPS) for inpatient hospital services. Under the PPS, CMS pays 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. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. The OPPS was effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. For purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas."

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

South Shore Hospital (the Hospital) is a 318-bed acute care hospital located in South Weymouth, Massachusetts. The Hospital was paid approximately \$163 million for 18,773 inpatient and 126,078 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2008 and 2009 based on CMS's National Claims History data.

Our audit covered \$1,891,118 in Medicare payments to the Hospital for 87 inpatient and 302 outpatient claims that we identified as potentially at risk for billing errors. These 389 claims had dates of service in CYs 2008 and 2009.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

SUMMARY OF FINDINGS

The Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, of 389 sampled claims, 249 claims had billing or coding errors, resulting in overpayments totaling \$341,033 for CYs 2008 and 2009. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing and coding of Medicare claims and did not fully understand the Medicare billing requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$341,033, consisting of \$167,894 in overpayments for the 35 incorrectly billed inpatient claims and \$173,139 in overpayments for the 214 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

SOUTH SHORE HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that it has implemented stronger internal controls and will continue to monitor the audited areas. Furthermore, the Hospital stated that it has begun the process of refunding the overpayments to the Medicare contractor.

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INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients who have been discharged from the hospital. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.¹

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the prospective payment system (PPS) for inpatient hospital services. Under the PPS, CMS pays 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. The DRG payment is, with certain exceptions, 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) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.² The OPPS was effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.³ All services and items within an APC group are comparable clinically and require comparable resources.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or Medicare administrative contractor, whichever is applicable.

² In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

³ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures.

Hospital Payments At Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. The types of payments to hospitals reviewed by this and related audits included payments for claims billed for:

- inpatient same-day discharges and readmissions,
- inpatient one-day stays,
- inpatient claims paid in excess of charges,
- outpatient surgeries billed with units greater than one,
- outpatient claims billed during diagnosis-related group payment windows,
- outpatient claims paid in excess of charges,
- outpatient services billed during skilled nursing facility stays, and
- outpatient manufacturer credits for medical devices.

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

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Medicare Requirements for Hospital Claims and Payments

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. In addition, pursuant to section 1862(a)(1)(A) of the Act, no Medicare payment may be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member.

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

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly. Chapter 3, section 10, of the Manual states that the hospital may bill only for services provided. In addition, chapter 23, section 20.3, of the Manual states: “Providers must use HCPCS codes ... for most outpatient services.”

South Shore Hospital

South Shore Hospital (the Hospital) is a 318-bed acute care hospital located in South Weymouth, Massachusetts. The Hospital was paid approximately \$163 million for 18,773 inpatient and 126,078 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2008 and 2009 based on CMS’s National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

Scope

Our audit covered \$1,891,118 in Medicare payments to the Hospital for 87 inpatient and 302 outpatient claims that we identified as potentially at risk for billing errors. These 389 claims had dates of service in CYs 2008 and 2009.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals.

Our review was based on selected billing requirements and did not include a 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. Our review allowed us to establish 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 at the Hospital during August and September 2010.

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 2008 and 2009;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 389 claims (87 inpatient and 302 outpatient) for detailed review;

- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed and/or coded 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 objective.

FINDINGS AND RECOMMENDATIONS

The Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, of 389 sampled claims, 249 claims had billing or coding errors, resulting in overpayments totaling \$341,033 for CYs 2008 and 2009. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing and coding of Medicare claims and did not fully understand the Medicare billing requirements.

Of 87 sampled inpatient claims, 35 claims had billing or coding errors, resulting in overpayments totaling \$167,894.

- For inpatient claims with same-day discharges and readmissions, the Hospital incorrectly billed Medicare for same-day readmissions that should have been combined with the initial hospital stays in single claims for continuous stays rather than as separate claims for separate stays (22 errors totaling \$103,085 in overpayments).
- For claims with inpatient one-day stays, the Hospital incorrectly billed Medicare for patient stays whose medical records had missing or incomplete physician orders (11 errors totaling \$26,159 in overpayments).

- For inpatient claims paid in excess of charges, the Hospital billed Medicare with incorrectly coded DRGs (2 errors totaling \$38,649 in overpayments).

Of 302 sampled outpatient claims, 214 claims had billing or coding errors, resulting in overpayments totaling \$173,139 (six claims had two types of errors).

- For claims involving outpatient surgeries billed with units greater than one, the Hospital submitted claims to Medicare with incorrect numbers of surgical units of service performed (165 errors totaling \$129,115 in overpayments).
- For outpatient claims billed during DRG payment windows,⁴ the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays, services that should have been included on the Hospital's inpatient (Part A) bills to Medicare (29 errors totaling \$8,061 in overpayments).
- For outpatient claims paid in excess of charges, the Hospital submitted claims to Medicare with incorrect HCPCS codes (6 errors), incorrect HCPCS codes and units of service (6 errors), and missing medical record documentation (1 error), (13 errors totaling \$7,803 in overpayments).
- For outpatient services billed during skilled nursing facility (SNF) stays, the Hospital incorrectly billed Medicare Part B rather than the appropriate SNFs for services that were subject to the consolidated billing provisions of the Act and that had been included in the Medicare Part A prospective payments to the SNFs (5 errors totaling \$800 in overpayments).
- For claims involving outpatient manufacturer credits for medical devices, the Hospital incorrectly billed Medicare for medical devices when credits should have been obtained from the manufacturer (2 errors totaling \$27,360 in overpayments).

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 35 of 87 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$167,894.

Inpatient Same-Day Discharges and Readmissions

The Manual, chapter 3, section 40.2.5, states:

When a patient is discharged 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

⁴ The DRG payment window includes the date of a beneficiary's inpatient admission and the three calendar days immediately preceding that inpatient admission.

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 22 out of 30 sampled claims, the Hospital incorrectly billed Medicare for same-day readmissions that should have been combined with the initial hospital stays in single claims for continuous stays rather than as separate claims for separate stays. In each of these instances, the original claim and the claim(s) involving subsequent readmission were related to the same medical condition(s) and thus should have been billed as continuous stays. However, in each of these cases, the Hospital did not adjust the original claim by combining the original and subsequent stays onto a single claim. The Hospital stated that it relied on the beneficiaries' admitting physicians to determine the relationship between the original stay and the subsequent readmission and did not have an additional level of review in place to determine whether the stays were related. As a result of these errors, the Hospital received overpayments totaling \$103,085.

Inpatient One-Day Stays

Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services which 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."

For 11 out of 28 sampled claims, the medical records did not contain a valid physician order to admit the beneficiary to a hospital for inpatient care. The Hospital stated that these errors occurred because it did not have a process in place to review medical records to determine whether the physician completed an order to admit the beneficiary to inpatient care. As a result of these errors, the Hospital received overpayments totaling \$26,159.

Inpatient Claims Paid in Excess of Charges

Section 1862(a)(1)(A) of the Act states that no Medicare payment may be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member. In addition, the Manual, chapter 3, section 10, states that the hospital may bill only for services provided, and chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

For 2 out of 29 sampled claims, the Hospital billed Medicare with incorrectly coded DRGs. The Hospital stated that the errors occurred due to a combination of clerical errors and communication errors between members of the Hospital's coding team. As a result of these errors, the Hospital received overpayments totaling \$38,649.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 214 of 302 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$173,139 (six claims had two types of errors).

Outpatient Surgeries Billed With Units Greater Than One

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, section 20.4, of the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For 165 out of 199 sampled claims, the Hospital submitted claims to Medicare with incorrect numbers of surgical units of service performed. Rather than billing based upon the appropriate number of times (generally one) that the procedure was performed, the Hospital billed Medicare based upon the time it took to perform the procedure. These procedures, primarily carpal tunnel and knee arthroscopy, should have been billed as one surgical unit rather than as multiple units. These errors occurred because the Hospital’s computer software was programmed incorrectly. Specifically, a billing software upgrade had removed an edit for surgical codes billed with multiple units of service. As a result of these errors, the Hospital received overpayments totaling \$129,115.

Outpatient Claims Billed During Diagnosis-Related Group Payment Windows

The Manual, chapter 3, section 10.4, states that certain items and nonphysician services furnished to inpatients are covered under Part A and consequently are covered by the inpatient prospective payment rate. These services include laboratory services and transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient.

For 29 out of 54 sampled claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays that should have been included on the Hospital’s inpatient (Part A) bills to Medicare. Most of the claims billed in error were for ambulance services. In each of these cases, the Medicare program paid twice for the same service: once as part of the DRG payment (under Part A) and again under Part B. The Hospital attributed these overpayments to inadequate review and followup procedures in its quality assurance system and to insufficient training of staff responsible for coding ambulance services. As a result of these errors, the Hospital received overpayments totaling \$8,061.

Outpatient Claims Paid in Excess of Charges

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, section 20.4, of the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For 13 out of 28 sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes (6 errors), incorrect HCPCS codes and incorrect units of service (6 errors), and

missing medical record documentation to support the procedure performed (1 error). The Hospital stated that these overpayments occurred because the Hospital's coding staff misunderstood the Medicare coding requirements. The Hospital added that a billing software upgrade had removed a computerized edit for surgical codes billed with multiple service units. As a result of these errors, the Hospital received overpayments totaling \$7,803.

Outpatient Services Billed During Skilled Nursing Facility Stays

Under the consolidated billing provisions of sections 1862(a)(18) and 1842(b)(6)(E) of the Act, SNFs are responsible for billing Medicare for most services, including outpatient hospital services, provided to a SNF resident during a Part A covered stay. Pursuant to the interim final rule implementing the SNF consolidated billing requirement,⁵ outside suppliers, including outpatient hospitals, must bill according to the consolidated billing provisions for services furnished to SNF residents and must be paid by the SNF rather than by Medicare Part B.

For 5 out of 15 sampled claims, the Hospital incorrectly billed Medicare Part B rather than the appropriate SNFs for services that were subject to the consolidated billing provisions of the Act and that had been included in the Medicare Part A prospective payments to the SNFs. In each of these cases, the Medicare program paid twice for the same service: once to the SNF through the Part A prospective payment and again to the Hospital through Part B. These overpayments occurred because the Hospital relied on the Common Working File edits to determine whether beneficiaries were in SNF stays covered under Part A and did not attempt to identify the beneficiaries' SNF resident status at the time of Hospital registration. As a result of these errors, the Hospital received overpayments totaling \$800.

Outpatient Manufacturer Credits for Medical Devices

Federal regulations (42 CFR § 413.9) state: "All payments to providers of services must be based on the reasonable cost of services...." The *CMS Provider Reimbursement Manual (PRM)*, part I, section 2102.1, 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." Section 2103 of the PRM 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) of the PRM 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.

For two out of six sampled claims, the Hospital incorrectly billed Medicare for medical devices when credits should have been obtained from the manufacturer. Specifically, the Hospital did not fully comply with Medicare requirements for obtaining credits available from manufacturers

⁵ 63 Fed. Reg. 26252, 26300 (May 12, 1998).

and for reporting the appropriate modifier and charges to reflect the credits received. For these claims, the replacements were due to battery depletion within three years of implantation; credits were available from the manufacturer and reportable. However, the Hospital did not obtain the credits that were available under the terms of the manufacturer's warranty. These overpayments occurred because the Hospital did not have controls to obtain credits available under the terms of the manufacturer's warranties or to report the appropriate modifiers and charges to reflect credits received from manufacturers. Additionally, the Hospital did not have procedures for coordinating functions among various departments (i.e., accounts payable, patient accounts, and Medicare billing) to ensure that it submitted claims correctly. As a result of these errors, the hospital received overpayments totaling \$27,360.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$341,033, consisting of \$167,894 in overpayments for the 35 incorrectly billed inpatient claims and \$173,139 in overpayments for the 214 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

SOUTH SHORE HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that it has implemented stronger internal controls and will continue to monitor the audited areas. Furthermore, the Hospital stated that it has begun the process of refunding the overpayments to the Medicare contractor.

APPENDIX



**South Shore
Hospital**

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February 22, 2011

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Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General, Office of Audit Services, Region I
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Boston, MA 02203

Report # A-01-10-00521

Dear Mr. Armstrong:

South Shore Hospital (SSH) is in receipt of the draft report provided by the Department of Health & Human Services, Office of Inspector General entitled, "*Medicare Compliance review of South Shore Hospital For Calendar Years 2008 and 2009*". SSH has had an opportunity to review your report and we generally agree with the findings outlined therein.

As the report indicates, OIG originally selected for review certain inpatient and outpatient claims submitted by SSH for dates of service between January 1, 2008 through December 31, 2009, covering eight (8) audit areas. More particularly, it is our understanding that this type of audit, covering multiple areas at one time based on OIG's identification of issues in reviews at other hospitals, is the first of its kind. In all, 87 inpatient claims and 302 outpatient claims were reviewed and, as set forth in your findings, the audit identified 35 inpatient and 214 outpatient claims errors.

As you are aware, prior to this audit, SSH conducted regular audits on the DRG coding performed by both its internal staff and by SSH contracted experts. SSH continues to conduct such audits and expects to in the future. Additionally, SSH has provided, and continues to provide, quarterly coder training updates using a SSH contracted expert. All of our coders are credentialed annually in either CCS, RHIA or RHIT. All three designations require annual CEUs. SSH will continue to require this training and credentialing.

Notably, the vast majority of the outpatient claims errors you identified were attributed to a software upgrade error that dropped edits which should have prevented certain surgical codes from being billed with units greater than one. These errors were corrected in a subsequent software update and SSH has implemented additional internal controls to verify that edits are not lost as a result of future software or systems upgrades.

In addition, for five out of the 214 outpatient claims audited, the common working file edits did not identify outpatient services billed during patient SNF stays as being covered under consolidated billing. SSH no longer relies on common working file edits to assess whether or not outpatient services provided to SNF patients are eligible for separate reimbursement.

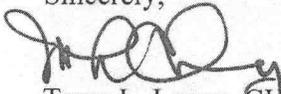
With respect to the outpatient manufacturer credits for medical devices, SSH historically relied on device vendors to determine appropriate warranty payments due to the hospital. With respect to the six claims reviewed, it was agreed that in two instances, there was a failure to identify devices that should have been covered under warranty. SSH did not receive nor has it since received credits from the manufacturer for those two devices. In response to this audit, SSH has established enhanced internal controls which includes a review by SSH staff to determine the availability of a warranty in cases where SSH performed the procedure for both the original device and the replacement device. SSH has met with vendor representatives and reviewed the internal controls. Among other things, vendors are required to notify SSH prior to the procedure that the device may be covered under warranty. In addition, for cases where SSH provides both the initial implant and the replacement, SSH is tracking dates of service and will be able to contact the vendor directly for any replacements that are within the manufacturer's warranty period.

OIG has recommended that SSH refund to the Medicare contractor \$341,033, consisting of \$167,894 in overpayments for the 35 incorrectly billed inpatient claims and \$173,139 in overpayments for the 214 incorrectly billed outpatient claims. Furthermore, OIG has recommended that SSH strengthen its controls to ensure full compliance with Medicare requirements.

SSH has processed the OIG's recommended refunds and, to the extent permitted by Medicare rules, has begun rebilling claims as appropriate. In addition, SSH has implemented stronger internal controls aimed at reducing the risk of these types of errors from occurring in the future. SSH will continue to monitor all of the audited areas and will update its controls as necessary.

SSH takes its compliance obligations very seriously. Please feel free to call me if you have any questions about the Hospital's efforts in this regard or if you require additional information. I can be reached directly at (781) 624-8828.

Sincerely,



Tessa L. Lucey, CHC

Director of Compliance/Privacy Officer