

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF NORTH SHORE MEDICAL
CENTER FOR CALENDAR YEARS
2009 AND 2010**

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Michael J. Armstrong
Regional Inspector General

March, 2013
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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 inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, 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, intended to be 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. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

North Shore Medical Center (the Hospital), is a private, nonprofit organization, consisting of two acute care facilities: Salem Hospital, a 273-bed hospital located in Salem, Massachusetts, and Union Hospital, a 126-bed hospital located in Lynn, Massachusetts. Medicare paid the Hospital approximately \$224 million for 19,993 inpatient and 359,181 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$2,723,341 in Medicare payments to the Hospital for 316 claims that we judgmentally selected as potentially at risk for billing errors. These 316 claims had dates of service in CYs 2009 and 2010 and consisted of 244 inpatient and 72 outpatient claims.

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 complied with Medicare billing requirements for 75 of the 316 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 241 claims, resulting in overpayments totaling \$816,003 for CYs 2009 and 2010. Specifically, 197 inpatient claims had billing errors, resulting in overpayments totaling \$791,743, and 44 outpatient claims had billing errors, resulting in overpayments totaling \$24,260. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements within the selected risk areas that contained errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$816,003, consisting of \$791,743 in overpayments for 197 incorrectly billed inpatient claims and \$24,260 in overpayments for 44 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

NORTH SHORE MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations and stated that it has taken steps to strengthen controls to ensure full compliance with Medicare requirements.

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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 after hospital discharge. 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.

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, 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 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) 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. 106-113.¹ The OPPS is 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 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.² All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis techniques. Examples of these types of claims at risk for noncompliance included the following:

¹ In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient transfers,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient psychiatric facility (IPF) emergency department adjustments,
- inpatient claims billed with high severity level DRG codes,
- outpatient claims billed with modifiers,
- outpatient intensity modulated radiation therapy (IMRT) planning services,
- outpatient claims billed during inpatient stays, 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.”

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 1862(a)(1)(A) of the Act states that 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.” In addition, 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.

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

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

North Shore Medical Center

North Shore Medical Center (the Hospital), is a private, nonprofit organization, consisting of two acute care facilities: Salem Hospital, a 273-bed hospital located in Salem, Massachusetts, and

Union Hospital, a 126-bed hospital located in Lynn, Massachusetts. Medicare paid the Hospital approximately \$224 million for 19,993 inpatient and 359,181 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 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 \$2,723,341 in Medicare payments to the Hospital for 316 claims that we judgmentally selected as potentially at risk for billing errors. (See Appendix A.) These 316 claims consisted of 244 inpatient and 72 outpatient claims. Of these 316 claims, 315 had dates of service in CYs 2009 and 2010. One claim (involving a replaced medical device) had a date of service in CY 2011.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 117 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.

Our fieldwork included contacting the Hospital, located in Salem and Lynn, Massachusetts, from May through November 2012.

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 2009 and 2010;

- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2009 through 2011;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 316 claims (244 inpatient and 72 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 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;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- used CMS's Medicare contractor medical review staff and an independent contractor to determine whether 117 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 objective.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 75 of the 316 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 241 claims, resulting in overpayments totaling \$816,003 for CYs 2009 and 2010. Specifically, 197 inpatient claims had billing errors, resulting in overpayments totaling \$791,743, and 44 outpatient claims had billing errors, resulting in overpayments totaling \$24,260. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully

understand the Medicare billing requirements within the selected risk areas that contained errors. For a detailed list of the risk areas that we reviewed and associated billing errors, see Appendix A.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 197 of 244 selected inpatient claims that we reviewed. These errors resulted in overpayments totaling \$791,743. One claim contained more than one type of error.

Incorrectly Billed as Inpatient

Section 1862(a)(1)(A) of the Act states that 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.”

For 120 of the 244 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 stated that it followed a clinical evaluation process by following Medicare guidance to the best of its ability and hired an outside consultant to review these claims. As a result of these errors, the Hospital received overpayments totaling \$635,716.³

Incorrectly Billed as Separate Inpatient Stays

The Manual, chapter 3, section 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 15 of the 244 selected claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that these errors occurred primarily because its patient registration software did not always identify claims for case management to determine whether the stays were related. As a result of these errors, the Hospital received overpayments totaling \$69,085.

³ The Hospital may be able to bill Medicare Part B for some services related to some of these incorrect Medicare Part A claims. 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 or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

Incorrect Discharge Status

Federal regulations (42 CFR § 412.4(b)) state that a discharge of a hospital inpatient is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge. A discharge of a hospital inpatient is also considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to an IPF or to home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstances 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 9 of the 244 selected claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers. For these claims, the Hospital should have coded the discharge status either as a transfer to an acute care hospital, to home under a written plan of care for the provision of home health services, or to an IPF. However, the Hospital incorrectly coded the discharge status to home, left against medical advice, or discharged to hospice; thus, the Hospital should have received the per diem payment instead of the full DRG. The Hospital stated that the errors occurred primarily because some of the patients left against medical advice and the hospital did not know that the patients entered another facility. As a result of these errors, the Hospital received overpayments totaling \$46,521.

Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

Federal regulations (42 CFR § 412.89) 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 cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device. The Manual, chapter 3, section 100.8, states that to correctly bill for a replacement device that was provided with a credit, hospitals must use the combination of condition code 49 or 50, along with value code "FD."

Prudent Buyer Principle

Federal regulations (42 CFR § 413.9) state that "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. 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.

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 4 of the 244 selected claims, the Hospital either received a reportable medical device credit from a manufacturer for a replaced device, but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required (3 errors), or did not obtain a credit for a replaced device that was available under the terms of the manufacturer's warranty (1 error). The Hospital stated that the errors occurred because it did not have procedures for coordinating functions among various departments (i.e., revenue cycle, patient accounts, and cardiac catheterization lab) to ensure that it submitted claims correctly. As a result of these errors, the Hospital received overpayments totaling \$33,375.

Incorrect Source-of-Admission Code

According to Federal regulations (42 CFR § 412.424), CMS increases the Federal per diem rate for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department. The Manual, chapter 3, section 190.6.4 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.

The Manual, chapter 3, section 190.6.4.1, states that source-of-admission "D" is reported by IPFs to identify IPF patients who have been transferred to the IPF from the same hospital. The IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 49 of the 244 selected claims, the Hospital incorrectly coded the source of admission for beneficiaries who were admitted to the IPF upon discharge from the Hospital's acute-care section. The Hospital stated that the errors occurred because the admission source code "D" was not an available option in the Hospital's billing system. As a result of these errors, the Hospital received overpayments totaling \$4,334.

Incorrectly Billed Diagnosis-Related Group Code

Section 1862(a)(1)(A) of the Act states that 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." In addition, the Manual, chapter 1,

section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately”

For 1 of the 244 selected claims, the Hospital billed Medicare for an incorrect DRG code. The Hospital attributed this to human error. As a result of this error, the Hospital received an overpayment of \$2,712.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 44 of 72 selected outpatient claims that we reviewed. These errors resulted in overpayments totaling \$24,260. One claim contained more than one type of error.

Incorrectly Billed Outpatient Services With Modifier -59

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 23, section 20.9.1.1, 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).”

For 6 of the 72 selected claims, the Hospital incorrectly billed Medicare for HCPCS codes, appended with modifier -59, for services that were already included in the payments for other services billed on the same claim. The Hospital stated that these errors occurred due to a misinterpretation of the billing requirements for modifier -59. As a result of these errors, the Hospital received overpayments totaling \$8,067.

Incorrectly Billed Intensity Modulated Radiation Therapy Planning Services

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 200.3.2, requires that certain services should not be billed when they are performed as part of developing an IMRT plan.

For 19 of the 72 selected claims, the Hospital incorrectly billed Medicare for services that were already included in the payment for IMRT planning services billed on the same claim. These services were performed as part of developing an IMRT plan and should not have been billed in addition to the HCPCS code for IMRT planning. The Hospital stated that these errors occurred because the clinicians were not always aware of the IMRT billing requirements. As a result of these errors, the Hospital received overpayments totaling \$6,307.

Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations (42 CFR § 419.45) 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.

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPSS. 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.

For 1 of the 72 selected claims, the Hospital received full credit for a replaced device but did not report the “FB” modifier and reduced charges on its claim. The Hospital stated that the error occurred because it did not have procedures for coordinating functions among various departments (i.e., revenue cycle, patient accounts, and cardiac catheterization lab) to ensure that it submitted claims correctly. As a result of this error, the Hospital received an overpayment of \$5,341.

Insufficiently Documented Services

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.

For 4 of the 72 selected claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record. The Hospital attributed this to human error. As a result of these errors, the Hospital received overpayments totaling \$2,946.

Incorrectly Billed as Outpatient

The Manual, chapter 3, section 10.4, states that Part A covers certain items and nonphysician services furnished to inpatients and consequently the inpatient prospective payment rate covers these services.

For 8 of the 72 selected claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during an inpatient stay that should have been included on the Hospital’s inpatient (Part A) bills to Medicare. The Hospital stated that these errors occurred because its billing software was not programmed to identify all outpatient services provided during inpatient stays. As a result of these errors, the Hospital received overpayments totaling \$1,303.

Incorrectly Billed Evaluation and Management Services or Healthcare Common Procedure Coding System Code

The Manual, chapter 12, section 30.6.6(B), states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual pre- and post-operative work of the procedure. The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately”

For 7 of the 72 selected claims, the Hospital incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual pre- and post-operative work of the procedure (6 errors), or with an incorrect HCPCS code (1 error). The E&M services were primarily associated with joint injections. The Hospital stated that the E&M errors occurred because its coding staff did not always understand the billing requirements for E&M services and the incorrect HCPCS code to human error. As a result of these errors, the Hospital received net overpayments totaling \$296.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$816,003, consisting of \$791,743 in overpayments for 197 incorrectly billed inpatient claims and \$24,260 in overpayments for 44 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

NORTH SHORE MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations and stated that it has taken steps to strengthen controls to ensure full compliance with Medicare requirements. The Hospital's comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A: RISK AREAS REVIEWED AND BILLING ERRORS

| Risk Area | Selected Claims | Value Of Selected Claims | Claims With Over-payments | Value Of Over-payments |
|---------------------------------------------------------------------------|------------------------|---------------------------------|----------------------------------|-------------------------------|
| Inpatient | | | | |
| Short Stays | 106 | \$509,188 | 104 | \$489,274 |
| Claims Billed with High-Severity-Level Diagnosis-Related Group Codes | 40 | 354,620 | 15 | 142,534 |
| Same-Day Discharges and Readmissions | 18 | 304,815 | 16 | 75,705 |
| Transfers | 9 | 79,014 | 9 | 46,521 |
| Manufacturer Credits for Replaced Medical Devices | 7 | 184,464 | 4 | 33,375 |
| Psychiatric Facility Emergency Department Adjustments | 49 | 742,736 | 49 | 4,334 |
| Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting | 15 | 336,824 | 0 | 0 |
| Inpatient Totals | 244 | \$2,511,661 | 197 | \$791,743 |
| | | | | |
| Outpatient | | | | |
| Claims Billed with Modifiers | 22 | \$43,858 | 9 | \$10,272 |
| Intensity Modulated Radiation Therapy Planning Services | 20 | 91,021 | 20 | 7,003 |
| Manufacturer Credits for Replaced Medical Devices | 3 | 52,256 | 1 | 5,341 |
| Claims Billed During Inpatient Stays | 12 | 1,971 | 8 | 1,303 |
| Claims Billed with Evaluation and Management Services | 10 | 2,084 | 6 | 341 |
| Claims Billed for Doxorubicin Hydrochloride | 5 | 20,490 | 0 | 0 |
| Outpatient Totals | 72 | \$211,680 | 44 | \$24,260 |
| | | | | |
| Inpatient and Outpatient Totals | 316 | \$2,723,341 | 241 | \$816,003 |

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RE: Report Number A-01-12-00506

Dear Mr. Armstrong:

On behalf on North Shore Medical Center (the "Hospital"), this letter is in response to the U.S. Department of Health and Human Services, Office of the Inspector General (OIG), draft report entitled *Medicare Compliance Review of North Shore Medical Center for Calendar Years 2009 and 2010*. North Shore Medical Center (NSMC) appreciates the opportunity to respond to the Government's report.

The OIG reviewed selected claims in thirteen areas determined to be at risk for noncompliance with Medicare billing requirements based on prior OIG Compliance Reviews of payments to hospitals. The OIG audit covered \$2,723,341 in Medicare payments to the Hospital for 316 claims (244 inpatient and 72 outpatient claims). We understand that these claims were judgmentally selected by the OIG as potentially at risk for billing errors. As a result of the detailed review, the OIG identified 241 claims with billing errors, totaling \$816,003 in net overpayments for CY 2009 and 2010.

The Hospital's responses to the OIG's recommendations are set forth below. Unless otherwise stated, the Hospital generally agrees with the Government's findings and is processing the necessary adjustments through its Medicare Administrative Contractor, NHIC.

Inpatient Short Stays: The Hospital has strengthened its controls in this area by educating physicians and residents on level of care determination. The hospitalist service has hired an in-house physician advisor to review cases with case managers and treating physicians on selecting the appropriate level of care. The Hospital will continue to provide documentation and compliance education to coding and clinical documentation improvement staff, and attending physicians and residents on an on-going basis. Further, the Hospital will continue to monitor and audit short stay admissions and remediate identified errors.

Inpatient Claims Billed with High-Severity-Level Diagnosis-Related Group Codes: Of the 244 selected claims, the OIG found 1 incorrect DRG code. The Hospital Coding Department has adequate controls in place.

Inpatient Same-Day Discharges and Readmissions: The Hospital has improved processes with Patient Registration and Case Management to prevent these errors. Hospital software has been reprogrammed to ensure the reporting of same day readmissions.

Inpatient Transfers: The Hospital and Case Management have implemented controls to ensure the accurate discharge status code is selected prior to billing.

Inpatient and Outpatient Manufacturer Credits for Replaced Medical Devices: NSMC has implemented controls and established operational procedure in coordination with Revenue Operations, Patient Accounts, and the Cardiac Catheterization Laboratory. The Hospital will continue to monitor the process to track potential no-cost and reduced-cost replacement devices.

Inpatient Psychiatric Facility Emergency Department Adjustments: The Hospital established controls in the billing system for source code “D” prior to the OIG audit. In 2009 and 2010, the error occurred because admission source code “D” was not an available option in the Hospital’s billing system.

Outpatient Claims Billed with Modifiers: The Hospital coding staff launched an initiative prior to the OIG audit to ensure the appropriate use of modifiers. The Coding Department will continue to monitor and audit the use of modifiers.

Outpatient Intensity Modulated Radiation Therapy Planning (IMRT) Services: The Hospital no longer provides IMRT services.

Outpatient Claims Billed with Evaluation and Management Services: The Hospital has provided education to the department where these errors occurred. The Hospital continues to monitor clinical departments to ensure the appropriate use of E/M services with procedures.

Outpatient Services Billed During Inpatient Stays: The Hospital has enhanced its process to identify all outpatient services provided within 72 hours of an inpatient stay.

North Shore Medical Center is committed to compliance with applicable Federal and State laws and regulations and the requirements of payers. We appreciate the coordination, collaboration, and guidance of the OIG audit team throughout the process, and thank you for the opportunity to respond to the OIG’s draft report.

Sincerely,

/Marcia Widmer/

Marcia Widmer, MPP, CPC
Director of Compliance and Audit Services