

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF SOUTHCOAST
HOSPITALS GROUP FOR
CALENDAR YEARS 2010 AND
2011**

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Office of Inspector General

<https://oig.hhs.gov>

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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 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.

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 data 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.

Southcoast Hospitals Group (Southcoast) is a hospital system that includes three acute care hospitals: Charlton Memorial Hospital, located in Fall River, Massachusetts; St. Luke's Hospital, located in New Bedford, Massachusetts; and Tobey Hospital, located in Wareham, Massachusetts. Medicare paid Southcoast approximately \$403 million for 38,056 inpatient and 405,847 outpatient claims for services provided to beneficiaries during calendar years (CY) 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$2,801,148 in Medicare payments to Southcoast for 338 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2010 and 2011 and consisted of 217 inpatient and 121 outpatient claims.

OBJECTIVE

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

SUMMARY OF FINDINGS

Southcoast complied with Medicare billing requirements for 98 of the 338 inpatient and outpatient claims we reviewed. However, Southcoast did not fully comply with Medicare billing requirements for the remaining 240 claims, resulting in net overpayments of \$1,106,581 for CYs 2010 and 2011. Specifically, 165 inpatient claims had billing errors, resulting in net overpayments of \$953,566, and 75 outpatient claims had billing errors, resulting in overpayments of \$153,015. These errors occurred primarily because Southcoast 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 Southcoast:

- refund to the Medicare contractor \$1,106,581, consisting of \$953,566 in net overpayments for 165 incorrectly billed inpatient claims and \$153,015 in overpayments for 75 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

SOUTHCOAST HOSPITALS GROUP COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Southcoast concurred with our findings and recommendations with the exception of claims related to inpatient short stays. Southcoast stated that it disagrees that it billed 41 claims incorrectly and intends to appeal those claims. We maintain that these claims did not meet the medical necessity requirements for inpatient admissions. Southcoast stated that it would process the necessary adjustments through its Medicare contractor. Southcoast also stated it would continue to monitor and enhance its internal controls, educate staff, and implement software to minimize the risk of errors.

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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. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Claims at Risk for Incorrect Billing

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

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.

identified these types of hospital claims using computer matching, data mining, and data analysis techniques. Examples of the types of claims at risk for noncompliance included the following:

- inpatient short stays,
- inpatient and outpatient manufacturer credits for replaced cardiac medical devices,
- inpatient same-day discharges and readmissions,
- inpatient transfers,
- inpatient claims paid in excess of charges,
- inpatient claims billed with high severity level DRG codes,
- inpatient psychiatric facility (IPF) emergency department adjustments,
- inpatient manufacturer credits for replaced orthopedic medical devices,
- outpatient drugs,
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day),
- outpatient claims billed during skilled nursing facility (SNF) stays,
- outpatient dental services,
- outpatient claims billed with observation services that resulted in outlier payments,
- outpatient claims billed prior to and during inpatient stays, and
- outpatient claims billed with evaluation and management 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

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

The provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)). The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Southcoast Hospitals Group

Southcoast Hospitals Group (Southcoast) is a hospital system that includes three acute care hospitals: Charlton Memorial Hospital, located in Fall River, Massachusetts; St. Luke's Hospital, located in New Bedford, Massachusetts; and Tobey Hospital, located in Wareham, Massachusetts. Medicare paid Southcoast approximately \$403 million for 38,056 inpatient and 405,847 outpatient claims for services provided to beneficiaries during calendar years (CY) 2010 and 2011 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit covered \$2,801,148 in Medicare payments to Southcoast for 338 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2010 and 2011 and consisted of 217 inpatient and 121 outpatient claims.

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

We limited our review of Southcoast'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 Southcoast for Medicare reimbursement.

We conducted our fieldwork at Southcoast during September and October 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Southcoast'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 338 claims (217 inpatient and 121 outpatient claims) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;
- requested that Southcoast conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the itemized bills and medical record documentation provided by Southcoast to support the selected claims;
- used an independent medical review contractor to determine whether 100 selected claims met medical necessity requirements;
- reviewed Southcoast's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with Southcoast 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 Southcoast 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.

FINDINGS AND RECOMMENDATIONS

Southcoast complied with Medicare billing requirements for 98 of the 338 inpatient and outpatient claims we reviewed. However, Southcoast did not fully comply with Medicare billing requirements for the remaining 240 claims, resulting in net overpayments of \$1,106,581 for CYs 2010 and 2011. Specifically, 165 inpatient claims had billing errors, resulting in net overpayments of \$953,566, and 75 outpatient claims had billing errors, resulting in overpayments of \$153,015. These errors occurred primarily because Southcoast did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

Appendix A summarizes (by the risk areas we reviewed) the net overpayments identified in this report.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Southcoast incorrectly billed Medicare for 165 of 217 selected inpatient claims, which resulted in net overpayments of \$953,566.

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 110 of 217 selected inpatient claims, Southcoast incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Southcoast attributed the patient admission errors primarily to inadequate internal controls over case management for monitoring short stays. As a result of these errors, Southcoast received overpayments of \$801,482.³

Incorrectly Billed Diagnosis-Related Group Codes

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, § 1862(a)(1)(A)). In addition, “[N]o such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider ... for the period with respect to which the amounts are being paid ...” (the Act, § 1815(a)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

³ Southcoast 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 or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

For 5 of 217 selected inpatient claims, Southcoast billed Medicare for incorrect DRG codes. For these claims, Southcoast used a diagnosis code that was incorrect or unsupported by the medical record to determine the DRG. Southcoast stated that these errors occurred because of inadequate controls to identify claims for further review. As a result of these errors, Southcoast received overpayments of \$52,739.

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 13 of 217 selected inpatient claims, Southcoast billed Medicare separately for related discharges and readmissions within the same day. Southcoast stated that this occurred because of inadequate procedures to review readmissions. As a result of this error, Southcoast received net overpayments of \$48,394.

Incorrect Discharge Status

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 (42 CFR § 412.4(b)). 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 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 4 of 217 selected inpatient claims, Southcoast incorrectly billed Medicare for patient discharges that should have been billed as transfers. For these claims, Southcoast should have coded the discharge status either as a transfer to an acute care hospital or to home under a written plan of care for the provision of home health services. However, Southcoast incorrectly coded the discharge status to "home" or "left against medical advice." Therefore, Southcoast should have received the per diem payment instead of the full DRG payment. Southcoast stated that these errors occurred because of inadequate procedures to correctly identify patient discharge status. As a result of these errors, Southcoast received overpayments of \$43,253.

Manufacturer Credit for a Replaced Medical Device Not Reported

Federal regulations require a reduction in the IPPS payment 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 the device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device (42 CFR § 412.89(a)). To correctly bill for a replacement device that was provided with a credit, hospitals must use the combination of condition code 49 or 50 (which identifies the replacement device) and value code “FD” (which identifies the amount of the credit, or cost reduction, received by Southcoast for the replaced device) (the Manual, chapter 3, § 100.8).

For 1 of 217 selected inpatient claims, Southcoast received a reportable medical device credit from the manufacturer for a replaced device, but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required. Southcoast stated that this error occurred because of inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result of this error, Southcoast received an overpayment of \$5,000.

Incorrectly Billed Source-of-Admission Code

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 (42 CFR § 412.424). CMS makes this additional payment regardless of whether the beneficiary used emergency department services (the Manual, chapter 3, § 190.6.4). However, the IPF should not receive the additional payment if the beneficiary was discharged from the acute-care section of the same hospital.

Source-of-admission “D” is reported by IPFs to identify IPF patients who have been transferred to the IPF from the same hospital (the Manual, chapter 3, § 190.6.4.1). The IPF’s proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 32 of 217 selected inpatient claims, Southcoast incorrectly coded the source-of-admission for beneficiaries who were admitted to the IPF upon discharge from Southcoast’s acute-care section. Southcoast stated that the source-of-admission was miscoded because of human error in selecting the admission source code. As a result of these errors, Southcoast received overpayments of \$2,698.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Southcoast incorrectly billed Medicare for 75 of 121 selected outpatient claims, which resulted in overpayments of \$153,015.

Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

Federal regulations require a reduction in the OPSS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45).

For services furnished on or after January 1, 2007, CMS requires a provider reporting no-cost or reduced-cost devices under the OPDS 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 (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3). 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.

Prudent Buyer Principle

“All payments to providers of services must be based on the reasonable cost of services ...” (42 CFR § 413.9). The CMS *Provider Reimbursement Manual* (the PRM), part 1, § 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.

Medicare providers are expected to pursue free replacements or reduced charges under warranties for medical devices (the PRM, § 2103.A). Section 2103.C.4 provides the following example:

Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment supplied.

For 9 of 121 selected outpatient claims, Southcoast received full credit for replaced devices but did not report the “FB” modifier and reduced charges on its claims (4 claims), or Southcoast did not obtain credits for replaced devices that were available under the terms of the manufacturers’ warranties (5 claims). Southcoast stated that these errors occurred because of inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result of these errors, Southcoast received overpayments of \$98,803.

Services Not Billable to Medicare Part B

SNFs are responsible for billing Medicare for most services, including outpatient hospital services, provided to a SNF resident during a covered Part A stay (the Act, §§ 1862(a)(18) and 1842(b)(6)(E)). The interim final rule implementing the SNF consolidated billing requirement states that 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.

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

The Manual states: “Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary’s admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage” (chapter 3, § 40.3.B).

For 26 of 121 selected outpatient claims, Southcoast either billed Medicare for services that should have been paid by the SNF (22 claims), billed Medicare for the treatment or removal of teeth (3 claims), or separately billed Medicare for services that should have been included on a Part A claim (1 claim).

Southcoast stated these errors occurred because it did not always have enough information to identify the beneficiary’s point of origin, a limitation in its computer software prevented the identification of claims for dental services, and inadequate controls over the identification of claims that should be included on a Part A claim. As a result of these errors, Southcoast received overpayments of \$18,934.

Incorrectly Billed Number of Units

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

For 8 of 121 selected outpatient claims, Southcoast submitted claims to Medicare with an incorrect number of units. Southcoast stated that these errors occurred because of human error. As a result of these errors, Southcoast received overpayments of \$15,867.

Incorrectly Billed Outpatient Services With Modifier -59

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

For 10 of 121 selected outpatient claims, Southcoast incorrectly billed Medicare for HCPCS codes, appended with modifier -59, which were not distinct from other services or procedures billed on the same claim. Southcoast stated that these errors occurred because hospital staff did not have adequate training on the use of modifier -59. As a result of these errors, Southcoast received overpayments of \$14,285.

Incorrectly Billed Observation Services

The Manual states: “Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services” (chapter 4, § 290.1). In addition, the Manual states: “Observation time begins at the clock time documented in the patient’s medical record, which coincides with the time that observation care is initiated in accordance with a physician’s order. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4 to 6 hours), which should be billed as recovery room services” (chapter 4, § 290.2.2).

For 22 of 121 selected outpatient claims, Southcoast incorrectly billed Medicare for observation hours resulting in incorrect outlier payments. For 21 claims, Southcoast overstated the hours of observation because it did not allow for the normal recovery period expected postoperatively and/or the medical records did not contain an order for the observation services. Southcoast stated these errors occurred because of inadequate controls over the identification and billing of observation hours. As a result of these errors, Southcoast received overpayments of \$5,126.

RECOMMENDATIONS

We recommend that Southcoast:

- refund to the Medicare contractor \$1,106,581, consisting of \$953,566 in net overpayments for 165 incorrectly billed inpatient claims and \$153,015 in overpayments for 75 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

SOUTHCOAST HOSPITALS GROUP COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Southcoast concurred with our findings and recommendations with the exception of claims related to inpatient short stays. Southcoast stated that it disagrees that it billed 41 claims incorrectly and intends to appeal those claims. We maintain that the stays did not meet the medical necessity requirements for an inpatient admission. Southcoast stated that it would process the necessary adjustments through its Medicare contractor. Southcoast also stated it would continue to monitor and enhance its internal controls, educate staff, and implement software to minimize the risk of errors. Southcoast’s comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Under / Over-payments	Value of Net Over-payments
Inpatient				
Short Stays	121	\$756,523	104	\$631,584
Manufacturer Credits for Replaced Cardiac Medical Devices	10	292,589	7	174,898
Same-Day Discharges and Readmissions	19	174,137	13	48,394
Transfers	4	73,804	4	43,253
Claims Paid in Excess of Charges	8	285,748	2	29,817
Claims Billed With High Severity Level Diagnosis-Related Group Codes	10	153,905	3	22,922
Psychiatric Facility Emergency Department Adjustments	37	275,826	32	2,698
Manufacturer Credits for Replaced Orthopedic Medical Devices	8	162,266	0	0
Inpatient Totals	217	\$2,174,798	165	\$953,566
Outpatient				
Manufacturer Credits for Replaced Cardiac Medical Devices	12	\$198,655	9	\$98,803
Drugs	25	125,410	8	15,867
Claims Billed With Modifier -59	16	63,337	10	14,285
Claims Billed During Skilled Nursing Facility Stays	22	13,130	22	13,130
Dental Services	3	5,451	3	5,451
Claims Billed With Observation Services That Resulted in Outlier Payments	23	218,013	22	5,126
Claims Billed Prior to and During Inpatient Stays	6	1,558	1	353
Claims Billed With Evaluation and Management Services	14	796	0	0
Outpatient Totals	121	\$626,350	75	\$153,015
Inpatient and Outpatient Totals	338	\$2,801,148	240	\$1,106,581

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 Southcoast Hospitals Group. 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.



July 23, 2013

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

RE: Audit Report Number A-01-12-00523, Medicare Compliance Review of Southcoast Hospitals Group for Calendar Years 2010 and 2011

Dear Mr. Lamir:

Southcoast Hospitals Group (the "Hospitals") is in receipt of the June 25, 2013 draft report provided by the Department of Health and Human Services, Office of the Inspector General (OIG) entitled "Medicare Compliance Review of Southcoast Hospitals Group for Calendar Years 2010 and 2011." We appreciate the opportunity to comment on the report.

The Hospitals are committed to compliance with all regulations governing Federal healthcare programs. Through our Compliance Program and other day-to-day operations, we strive to monitor and enhance our internal controls, educate staff, and implement software to minimize the risk of errors. However, and as the OIG has acknowledged in its Compliance Guidance to Hospitals, the existence of internal controls and other procedures cannot totally eliminate all errors in such a complex system.

Unless otherwise stated, the Hospitals generally agree with the OIG's findings and will process the necessary adjustments through its Medicare Administrative Contractor, NHIC. Responses to the recommendations are set forth below.

Inpatient Incorrectly Billed as Inpatient (Short Stays): Of the 110 claims found to be in error by the OIG, the Hospitals agreed that 69 were in error. The Hospitals have increased the case management staffing levels, provided additional education, and hired a consultant to assist with the concurrent determination of inpatient versus outpatient status.

To the extent applicable, and as noted by the OIG in the Report, the Hospitals intend to bill Medicare Part B for all services that would have been reasonable and necessary had the beneficiary been originally designated as an outpatient rather than admitted as an inpatient.

The Hospitals respectfully disagree with the assertion of inappropriateness for the remaining 41 claims, and intend to fully appeal these claims. The prevailing reason for the disagreement is that the Hospitals believe that denials based on a retrospectively determined duration of hospitalization are inconsistent with CMS' intent and written guidance in the Medicare Benefit Policy Manual, Chapter 1, Section 10:

“Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital.” Section 10 goes on to say that *“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.”*

Inpatient Incorrectly Billed Diagnosis-Related Group Codes: In addition to continuing education of the coding staff, the Hospitals have implemented a software tool to review all Medicare claims. The tool identifies accounts with certain criteria that may lead to incorrect coding prior to billing. Included in the criteria are high severity DRGs as well as accounts with DRG payment in excess of charges.

Inpatient Incorrectly Billed as Separate Inpatient Stays (Same Day Readmissions): The Hospitals have implemented a process change wherein Case Management makes the clinical decision as to whether the first and second admissions are related and notifies the Billing Department.

Inpatient Incorrect Discharge Status: The Hospitals and case management have implemented enhanced controls to properly determine discharge status.

Inpatient Manufacturer Credit for a Replaced Medical Device Not Reported: The Hospitals have implemented a process among the materials management, clinical, and billing departments to capture claims related to medical devices and are requiring the manufacturers' representatives to provide reports on the identification and analysis of warranties as well as refund status on all explanted devices.

Inpatient Incorrectly Billed Source of Admission Code: Enhancements were made to the billing system to better define source of admission for psychiatric patients.

Outpatient Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained: The Hospitals have implemented a process among the materials management, clinical, and billing departments to capture claims related to medical devices and are requiring the manufacturers' representatives to provide reports on the identification and analysis of warranties as well as refund status on all explanted devices.

Outpatient Services Not Billable to Medicare Part B: There were 26 erroneous claims in three areas: skilled nursing consolidated billing (22); dental services (3); and one diagnostic claim billed within three days of an inpatient stay. The Admissions staff has been trained to confirm with nursing homes the patients' Medicare status upon admission. When there is doubt, the nursing home will be billed prior to Medicare. Claims with dental services will be stopped and reviewed prior to billing. The Hospitals believe that the one diagnostic claim that was billed within three days of the inpatient stay was an isolated incident.

Outpatient Incorrectly Billed Number of Units: An assessment of this issue determined that user error was to blame for duplicate orders and the resulting overbilling of pharmacy units. The Hospitals re-educated the applicable staff and are implementing on-going monitoring processes.

Outpatient Incorrectly Billed Services With Modifier-59: The Hospitals provided education on the topic of modifier usage, particularly modifier-59, not only to the coding department but to ancillary departments that typically utilize this modifier. Continuous auditing and monitoring processes are being implemented.

Outpatient Incorrectly Billed Observation Services: The Case Management Department reviews all scheduled procedures with clinical staff to ensure correct assignment of status:inpatient/outpatient/observation. Order sets were reviewed in procedural areas and language was revised relative to patient status.

Thank you for the opportunity to respond to this OIG report. We appreciate the coordination, guidance, and professionalism afforded to us by the OIG audit team during this process.

Sincerely,

/Laura Macaluso/

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