

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF ST. ELIZABETH'S
MEDICAL CENTER FOR
CALENDAR YEARS
2010 AND 2011**

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

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

St. Elizabeth's Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of approximately \$1.2 million over 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether St. Elizabeth's Medical Center (St. Elizabeth's) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

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

St. Elizabeth's, which is part of the Steward Health Care System, is a 252-bed acute care hospital located in Brighton, Massachusetts. Medicare paid St. Elizabeth's approximately \$167 million for 10,247 inpatient and 84,175 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$3,160,718 in Medicare payments to St. Elizabeth's for 282 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 206 inpatient and 76 outpatient claims.

WHAT WE FOUND

St. Elizabeth's complied with Medicare billing requirements for 57 of the 282 inpatient and outpatient claims we reviewed. However, St. Elizabeth's did not fully comply with Medicare billing requirements for the remaining 225 claims, resulting in net overpayments of \$1,209,936 for CYs 2010 and 2011. Specifically, 168 inpatient claims had billing errors, resulting in net overpayments of \$1,153,960, and 57 outpatient claims had billing errors, resulting in net overpayments of \$55,976. These errors occurred primarily because St. Elizabeth's did not have

adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that St. Elizabeth's:

- refund to the Medicare contractor \$1,209,936, consisting of \$1,153,960 in net overpayments for 168 incorrectly billed inpatient claims and \$55,976 in net overpayments for 57 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

ST. ELIZABETH'S MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, St. Elizabeth's concurred with most of our findings and recommendations. However, St. Elizabeth's disagreed that it incorrectly billed eight claims as inpatient and stated that it intends to appeal the claims at issue. We maintain these claims did not comply with Medicare billing requirements.

St. Elizabeth's also stated that it has developed corrective action plans to address the identified errors. We acknowledge St. Elizabeth's efforts to implement stronger controls.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether St. Elizabeth's Medical Center (St. Elizabeth's) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Medicare Program

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

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

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

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

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

Hospital Claims at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient same-day discharges and readmissions,
- inpatient claims paid greater than charges,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient psychiatric facility (IPF) emergency department adjustments,
- outpatient claims with payments greater than \$25,000,
- outpatient claims billed during inpatient stays,
- outpatient claims billed with modifier -59, and
- outpatient claims billed with evaluation and management (E&M) services.

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

Medicare Requirements for Hospital Claims and Payments

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

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

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

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).

St. Elizabeth's Medical Center

St. Elizabeth's, which is part of the Steward Health Care System, is a 252-bed acute care hospital located in Brighton, Massachusetts. Medicare paid St. Elizabeth's approximately \$167 million for 10,247 inpatient and 84,175 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$3,160,718 in Medicare payments to St. Elizabeth's for 282 claims that we judgmentally selected as potentially at risk for billing errors. These 282 claims consisted of 206 inpatient and 76 outpatient claims with dates of service in CYs 2010 or 2011. We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 14 claims to focused medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by St. Elizabeth's for Medicare reimbursement.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our scope and methodology.

FINDINGS

St. Elizabeth's complied with Medicare billing requirements for 57 of the 282 inpatient and outpatient claims we reviewed. However, St. Elizabeth's did not fully comply with Medicare billing requirements for the remaining 225 claims, resulting in net overpayments of \$1,209,936 for CYs 2010 and 2011. Specifically, 168 inpatient claims had billing errors, resulting in net overpayments of \$1,153,960, and 57 outpatient claims had billing errors, resulting in net overpayments of \$55,976. These errors occurred primarily because St. Elizabeth's did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

St. Elizabeth's incorrectly billed Medicare for 168 of 206 selected inpatient claims, which resulted in net overpayments of \$1,153,960.

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 107 of the 206 selected claims, St. Elizabeth's incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. St. Elizabeth's officials stated that the majority of these errors occurred because St. Elizabeth's did not have enough staff to review all patients' stays on a consistent and timely basis and staff had inadequate education on level of care documentation. As a result of these errors, St. Elizabeth's received overpayments of \$970,673.²

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states:

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

For 22 of the 206 selected claims, St. Elizabeth's billed Medicare separately for related discharges and readmissions within the same day. St. Elizabeth's officials stated that these errors occurred primarily because there was no report to identify all inpatients readmitted within 24 hours; therefore, St. Elizabeth's did not review these cases. As a result of these errors, St. Elizabeth's received net overpayments of \$114,601.

Incorrectly Billed Diagnosis-Related Group Code

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

² St. Elizabeth's may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor prior to the issuance of our report.

body member” (the Act § 1862(a)(1)(A)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 7 of the 206 selected claims, St. Elizabeth’s billed Medicare for an incorrect DRG code. St. Elizabeth’s officials attributed this to human error. As a result of these errors, St. Elizabeth’s received overpayments of \$63,066.

Manufacturer Credit for a Replaced Medical Device Not Obtained

Federal regulations require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). Federal regulations state, “All payments to providers of services must be based on the reasonable cost of services . . .” (42 CFR § 413.9). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code “FD” (chapter 3, § 100.8). The *CMS Provider Reimbursement Manual (PRM)* reinforces these requirements in additional detail (Pub. No. 15-1).³

For 1 of the 206 selected claims, St. Elizabeth’s did not obtain a credit for a replaced medical device for which a credit was available under the terms of the manufacturer’s warranty. St. Elizabeth’s officials stated that the error occurred because St. Elizabeth’s did not have procedures for tracking devices and coordinating functions among various departments (i.e., accounting and the coding department) to ensure that it submitted claims correctly. As a result of this error, St. Elizabeth’s received an overpayment of \$5,007.

Incorrect Source-of-Admission Code

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

³ The PRM states: “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service” (part I, § 2102.1). Section 2103 further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example: “Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.”

For 30 of the 206 selected claims, St. Elizabeth's incorrectly coded the source-of-admission for beneficiaries who were admitted to its IPF upon discharge from its acute-care section. St. Elizabeth's officials stated that the errors occurred because billing staff was not fully educated to select and enter the proper source-of-admission code. As a result of these errors, St. Elizabeth's received overpayments of \$3,570.

Incorrect Provider Number Used

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

For 1 of the 206 selected claims, St. Elizabeth's incorrectly billed Medicare using its acute-care hospital number for services provided in the psychiatric unit of the same hospital. St. Elizabeth's officials attributed this to human error. As a result of this error, St. Elizabeth's was underpaid \$2,957.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

St. Elizabeth's incorrectly billed Medicare for 57 of 76 selected outpatient claims, which resulted in net overpayments of \$55,976.

Incorrectly Billed Charges

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 1 of the 76 selected claims, St. Elizabeth's submitted a claim to Medicare with incorrect charges, resulting in a higher outlier payment than was warranted. St. Elizabeth's officials attributed this to human error. As a result of this error, St. Elizabeth's received an overpayment of \$23,524.

Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

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

manufacturer, the provider must report a charge of no more than \$1 for the device.⁴ As described on page 5, footnote 3, of this report, the PRM, part I, chapter 21, reinforces these requirements in additional detail.

For 2 of the 76 selected claims, St. Elizabeth's either received full credit for a replaced device but did not properly report the "FB" modifier or reduced charges on its claim or did not obtain a credit for a replaced device that was available under the terms of the manufacturer's warranty. St. Elizabeth's officials stated that the errors occurred because it did not have procedures for tracking devices and coordinating functions among various departments (i.e., accounting and the coding department) to ensure that it submitted claims correctly. As a result of these errors, St. Elizabeth's received overpayments of \$14,565.

Incorrectly Billed Outpatient Services Provided During an Inpatient Stay

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

For 24 of the 76 selected claims, St. Elizabeth's incorrectly billed Medicare Part B for outpatient services provided during an inpatient stay that should have been included on its inpatient (Part A) bills to Medicare. St. Elizabeth's officials stated that the errors occurred because its billing software was not programmed to identify all outpatient services provided during inpatient stays. Additionally, St. Elizabeth's attributed the overpayments to inadequate review by hospital staff prior to billing and staff misunderstanding the billing requirements. As a result of these errors, St. Elizabeth's received overpayments of \$9,458.

Incorrectly Billed Outpatient Services with Modifier -59

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

For 13 of the 76 selected claims, St. Elizabeth's incorrectly billed Medicare for HCPCS codes with modifier -59 for the services that were already included in the payments for other services billed on the same claim. St. Elizabeth's officials attributed these errors primarily to an error in its charge description master and staff misinterpretation of the billing requirements for modifier -59. As a result of these errors, St. Elizabeth's received overpayments of \$7,582.

Insufficiently Documented Services

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

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

For 8 of the 76 selected claims, St. Elizabeth's incorrectly billed Medicare for E&M services that were not supported in the medical record. The incorrectly billed E&M services were primarily associated with injections of the anemia management drug, Epogen (i.e., epoetin alfa). St. Elizabeth's officials stated that these errors occurred because coding staff did not always understand the billing requirements for E&M services. As a result of these errors, St. Elizabeth's received overpayments of \$391.

Incorrectly Billed Evaluation and Management Services

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

For 6 of the 76 selected claims, St. Elizabeth's incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. The incorrectly billed E&M services were primarily associated with injections of the anemia management drug Epogen (i.e., epoetin alfa). St. Elizabeth's officials stated that these errors occurred because coding staff did not always understand the billing requirements for E&M services. As a result of these errors, St. Elizabeth's received net overpayments of \$311.

Incorrect Healthcare Common Procedure Coding System Code

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 3 of the 76 selected claims, St. Elizabeth's submitted claims to Medicare with incorrect HCPCS codes. St. Elizabeth's attributed the HCPCS coding error to human error. As a result, St. Elizabeth's received net overpayments of \$145.

RECOMMENDATIONS

We recommend that St. Elizabeth's:

- refund to the Medicare contractor \$1,209,936, consisting of \$1,153,960 in net overpayments for 168 incorrectly billed inpatient claims and \$55,976 in net overpayments for 57 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

ST. ELIZABETH'S MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, St. Elizabeth's concurred with most of our findings and recommendations. However, St. Elizabeth's disagreed that it incorrectly billed eight claims as inpatient and stated that it intends to appeal the claims at issue. We maintain these claims did not comply with Medicare billing requirements.

St. Elizabeth's also stated that it has developed corrective action plans to address the identified errors. We acknowledge St. Elizabeth's efforts to implement stronger controls. St. Elizabeth's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$3,160,718 in Medicare payments to St. Elizabeth's for 282 claims that we judgmentally selected as potentially at risk for billing errors. These 282 claims consisted of 206 inpatient and 76 outpatient claims with dates of service in CYs 2010 or 2011.

We focused our review on the risk areas that we had identified as a result of prior Office of Inspector General reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 14 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of St. Elizabeth'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 St. Elizabeth's for Medicare reimbursement.

Our fieldwork included contacting St. Elizabeth's in Brighton, Massachusetts, from January through July 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted St. Elizabeth'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 282 claims (206 inpatient and 76 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 St. Elizabeth's to support the selected claims;
- requested that St. Elizabeth's conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed St. Elizabeth's procedures for submitting Medicare claims;
- used an independent medical review contractor to determine whether 14 selected claims met medical necessity requirements;
- discussed the incorrectly billed claims with St. Elizabeth's 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 St. Elizabeth's officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Under / Over-payments	Value of Net Over-payments
Inpatient				
Short Stays	100	\$947,827	93	\$849,870
Claims Billed With High Severity Level Diagnosis-Related Group Codes	38	522,624	17	125,433
Same-Day Discharges and Readmissions	27	724,200	24	123,290
Claims Paid Greater Than Charges	5	203,854	3	46,790
Manufacturer Credits for Replaced Medical Devices	6	186,851	1	5,007
Psychiatric Facility Emergency Department Adjustments	30	382,329	30	3,570
Inpatient Totals	206	\$2,967,685	168	\$1,153,960
Outpatient				
Claims With Payments Greater Than \$25,000	1	\$29,529	1	\$23,524
Manufacturer Credits for Replaced Medical Devices	6	102,429	2	14,565
Claims Billed During Inpatient Stays	24	9,458	24	9,458
Claims Billed With Modifier -59	20	46,544	15	7,751
Claims Billed With Evaluation and Management Services	25	5,073	15	678
Outpatient Totals	76	\$193,033	57	\$55,976
Inpatient and Outpatient Totals	282	\$3,160,718	225	\$1,209,936

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 St. Elizabeth’s. 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.

St. Elizabeth's Medical Center

A STEWARD FAMILY HOSPITAL



October 29, 2013

Mr. David Lamir
Acting Regional Inspector General for Audit Services
Office of Audit Services, Region 1
JFK Federal Building
15 New Sudbury St, Room 2425
Boston, MA 02203

RE: Audit Report A-01-12-00528, Medicare Compliance Review of Steward St. Elizabeth's Medical Center of Boston, Inc. for Calendar Years 2010 and 2011

Dear Mr. Lamir:

Steward St. Elizabeth's Medical Center of Boston, Inc. ("St. Elizabeth's Medical Center" or the "Hospital") is in receipt of the October 9, 2013 draft report provided by the Department of Health and Human Services, Office of the Inspector General ("OIG") entitled "Medicare Compliance Review of St. Elizabeth's Medical Center for Calendar Years 2010 and 2011" (the "Report").¹

The Hospital is committed to compliance with all applicable regulations. We understand the important role of the OIG to ensure compliance with these regulations and appreciate the opportunity to provide response to the draft report related to a review of our hospital.

Corrective action plans have been developed to address the issues raised by the audit report findings, including targeting weaker areas with additional education, monitoring, coding and case management quality assurance, workflow redesign, updated policies and procedures, and new technology applications.

The following represents a summary of identified errors by category, along with highlights of a corrective action plan already initiated by staff at St. Elizabeth's Medical Center:

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Incorrectly Billed as Inpatient

Of the 107 claims from the OIG's judgmentally selected sample, which the OIG found to be in error, the Hospital agrees that 99 likely do not meet the current standards of review utilized by

¹ Many of the claims subject to the Report were filed prior to the acquisition of the Hospital on November 6, 2010. The current operator, Steward St. Elizabeth's Medical Center of Boston, Inc., is a new entity that did not assume the liabilities of the prior owner with respect to participation in the Medicare program or violations of law. Nothing herein should be deemed as a waiver of any rights of the Hospital to reject such liabilities of the prior owner.

the OIG. As indicated in the report, the Hospital is working to re-bill claims from the sample in which the OIG and the Hospital have agreed, under the OIG's current review methodology, likely should have been billed as outpatient or outpatient with observation services.

The Hospital has enhanced its internal controls. The Utilization Review Policy was revised and case management staffing levels were increased to better assess physician level of care determinations in a timelier manner than during the time of claim submission for this review period.

The Hospital respectfully disagrees with the Medical Review Findings for the remaining 8 claims based on intense review of the cases, and plans to appeal these claims to the extent allowed by Medicare policy.

Incorrectly Billed as Separate Inpatient Stays

The Hospital has enhanced its procedures for identifying all inpatients readmitted to the Hospital within 24 hours of discharge, including Care Management and Health Information Management department review and timely follow up by the Patient Financial Services department to address any necessary claim bundling. Billing software is used to generate a daily report identifying same day readmissions and foster improved communication among these departments. The Hospital has trained appropriate staff on the enhanced procedures.

Incorrectly Billed Diagnosis-Related Group Code

The staff members who coded the claims identified in error were provided with remedial education. All coding staff received education on the appropriate use of DRG 981. A process was put into place whereby claims assigned with DRG 981 are peer reviewed by another coder to ensure that the selection of this code is appropriate. Additionally, a process was established whereby a monthly DRG 981 usage report is run and reviewed by Health Information Management department leadership for potential errors and corrections.

Manufacturer Credits for Replaced Medical Devices Not Obtained

For the one claim found to be billed in error, the Hospital reviewed and improved its procedure to better identify claims impacted by medical device warranty credits. The procedure enhances the work flow related to manufacturer warranty coverage determinations and the assignment of the medical device credit value codes and condition codes. While the Hospital reserves its rights to challenge the application of the prudent buyer principle in this context, as well as the argument that warranty credits not received should be treated the same as credits received but not reported, the Hospital seeks to resolve the claims in question.

Incorrect Source-of-Admission Code

The Hospital enhanced its procedures and provided its registration and coding staff with education to ensure a better understanding of the proper source of admission code assignment for beneficiaries who are transferred from an acute care bed and admitted to a hospital inpatient

psychiatric facility bed. A custom report has also been developed and will be reviewed by Patient Access staff to identify possible source of admission code errors.

Incorrect Provider Number Used

For the one claim that was found in error, the Hospital provided remedial education to the coding staff.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Incorrectly Billed Charges

Human error was determined has the reason for this one claim error. The process, which was manual charge entry during the period of time under review, has since been changed, eliminating the manual entry of charges, thereby reducing human error and streamlining the process of charging for services rendered.

Manufacturer Credit for Replaced Medical Device Not Reported or Obtained

For the two claims found to be in error, the Hospital reviewed and improved its procedure to better identify claims impacted by medical device warranty credits. The procedure enhances the work flow related to manufacturer warranty coverage determinations and the assignment of the medical device credit modifiers and condition codes. While the Hospital reserves its rights to challenge the argument that warranty credits not received should be treated the same as credits received but not reported, the Hospital seeks to resolve the claims in question.

Incorrectly Billed Outpatient Services Provided During an Inpatient Stay

The Hospital has revised its Medicare 3 Day Payment Window Policy to reflect the current regulatory requirements and staff has been provided the necessary education and training. Additionally, billing software improvements have led to enhanced reporting that identifies accounts that require additional review and potential adjustment prior to claim submission.

Incorrectly Billed Services With Modifier -59

The Hospital provided education to coding staff related to the identification of services and procedures that are separate and distinct from others performed on the same day. Some errors identified under this category were found to be related to an inaccurate charge description in place at the time. The charge description master (CDM) error has been corrected.

Insufficiently Documented Services and Incorrectly Billed E & M Services

The majority of the claim errors related to a specific department misunderstanding of a requirement that does not allow billing of a level 1 evaluation & management service on the same day as an injection or an infusion. The department's staff has been trained and is reviewing each charge for accuracy while the Hospital completes the process of building an edit into the billing software to prevent future potential for human error.

Incorrect Healthcare Common Procedure Coding System Code

For the three claims found to be in error, the Hospital provided education to the coding staff involved in the incorrect assignment of the HCPCS codes.

Nothing herein should be deemed an admission by the Hospital of any regulatory violation; and the Hospital reserves the right to appeal any and all claims denied by Medicare Administrative Contractors.

St. Elizabeth's Medical Center remains committed to strengthening internal controls to promote ongoing compliance with Medicare billing requirements. We are confident that our corrective actions will address the identified errors.

We appreciate the professionalism of the OIG audit team during the process and the learning opportunity for all involved in this Medicare Compliance Review.

Please feel free to contact me if you have questions or require additional information.

Sincerely,

Kevin R. Hannifan
President