

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF GOOD SAMARITAN  
MEDICAL CENTER FOR  
CALENDAR YEARS  
2010 AND 2011**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



David Lamir  
Regional Inspector General

February 2014  
A-01-13-00501

# *Office of Inspector General*

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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

***Good Samaritan Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of approximately \$840,000 over 2 years.***

### WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 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 Good Samaritan Medical Center (Good Samaritan) 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.

Good Samaritan, which is part of the Steward Health Care System, is a 245-bed acute care hospital located in Brockton, Massachusetts. Medicare paid Good Samaritan approximately \$123 million for 12,592 inpatient and 60,674 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$2,178,804 in Medicare payments to Good Samaritan for 262 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 225 inpatient and 37 outpatient claims.

### WHAT WE FOUND

Good Samaritan complied with Medicare billing requirements for 50 of the 262 inpatient and outpatient claims we reviewed. However, Good Samaritan did not fully comply with Medicare billing requirements for the remaining 212 claims, resulting in net overpayments of \$840,067 for CYs 2010 and 2011. Specifically, 183 inpatient claims had billing errors, resulting in net overpayments of \$757,453, and 29 outpatient claims had billing errors, resulting in overpayments of \$82,614. These errors occurred primarily because Good Samaritan 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 Good Samaritan:

- refund to the Medicare contractor \$840,067, consisting of \$757,453 in net overpayments for 183 incorrectly billed inpatient claims and \$82,614 in overpayments for 29 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **GOOD SAMARITAN MEDICAL CENTER COMMENTS AND OUR RESPONSE**

In written comments on our draft report, Good Samaritan concurred with most of our findings and recommendations. However, Good Samaritan disagreed that it incorrectly billed 11 claims as inpatient and stated that it would appeal these claims. We maintain that these claims did not comply with Medicare billing requirements.

Good Samaritan also stated that it has developed corrective action plans to address the identified errors. We acknowledge Good Samaritan'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) 2012, Medicare paid hospitals \$148 billion, which represents 43 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 Good Samaritan Medical Center (Good Samaritan) 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.<sup>1</sup> All services and items within an APC group are comparable clinically and require comparable resources.

### **Hospital Claims at Risk for Incorrect Billing**

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

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level DRG codes,
- inpatient transfers,
- inpatient psychiatric facility (IPF) emergency department adjustments,
- inpatient claims paid in excess of charges,
- outpatient dental services,
- outpatient manufacturer credit for a replaced medical device,
- outpatient claims billed during inpatient stays,
- outpatient drugs, and
- outpatient claims billed with modifier -59.

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)).

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<sup>1</sup> 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).

### **Good Samaritan Medical Center**

Good Samaritan, which is part of the Steward Health Care System, is a 245-bed acute care hospital located in Brockton, Massachusetts. Medicare paid Good Samaritan approximately \$123 million for 12,592 inpatient and 60,674 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

### **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$2,178,804 in Medicare payments to Good Samaritan for 262 claims that we judgmentally selected as potentially at risk for billing errors. These 262 claims consisted of 225 inpatient and 37 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 25 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 Good Samaritan 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**

Good Samaritan complied with Medicare billing requirements for 50 of the 262 inpatient and outpatient claims we reviewed. However, Good Samaritan did not fully comply with Medicare billing requirements for the remaining 212 claims, resulting in net overpayments of \$840,067 for CYs 2010 and 2011. Specifically, 183 inpatient claims had billing errors, resulting in net overpayments of \$757,453, and 29 outpatient claims had billing errors, resulting in overpayments of \$82,614. These errors occurred primarily because Good Samaritan 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**

Good Samaritan incorrectly billed Medicare for 183 of 225 selected inpatient claims, which resulted in net overpayments of \$757,453.

### **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 103 of the 225 selected claims, Good Samaritan incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Good Samaritan officials stated that the majority of these errors occurred because Good Samaritan 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, Good Samaritan received overpayments of \$563,904.<sup>2</sup>

### **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 25 of the 225 selected claims, Good Samaritan billed Medicare separately for related discharges and readmissions within the same day. Good Samaritan officials stated that these errors occurred primarily because there was no report to identify all inpatients readmitted within 24 hours; therefore, Good Samaritan did not review these cases. As a result of these errors, Good Samaritan received net overpayments of \$165,399.

### **Incorrect Discharge Status**

Hospitals must bill inpatient discharges as transfers when (1) the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge and (2) the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to home under a home health agency’s written plan of care for home health services that begin within 3 days after the date of discharge (42 CFR §§ 412.4(b) and (c)). A hospital that transfers an inpatient under the above circumstances is generally 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)).

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<sup>2</sup> Good Samaritan 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.

For 5 of the 225 selected claims, Good Samaritan incorrectly billed Medicare for patient discharges that should have been billed as transfers. For these claims, Good Samaritan 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, Good Samaritan incorrectly coded the discharge status to “home” or “to another type of health care institution not defined elsewhere.” Thus, Good Samaritan received a full DRG payment rather than a per diem payment for these claims. Good Samaritan officials stated that the errors occurred because coding staff did not always validate the discharge status code that was entered by the Unit Coordinator at the time of the patient’s discharge. As a result of these errors, Good Samaritan received net overpayments of \$13,895.

### **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, 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 225 selected claims, Good Samaritan billed Medicare for incorrect DRG codes. Good Samaritan officials attributed this incorrect billing to human error. As a result of these errors, Good Samaritan received overpayments of \$8,824.

### **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.

For 47 of the 225 selected claims, Good Samaritan incorrectly coded the source-of-admission for beneficiaries who were admitted to its IPF upon discharge from its acute care section. Good Samaritan officials stated that these errors occurred because patient access staff was not fully educated to select and enter the proper source-of-admission code. Additionally, coding staff did not always validate the entered source-of-admission code. As a result of these errors, Good Samaritan received overpayments of \$5,431.

## **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

Good Samaritan incorrectly billed Medicare for 29 of 37 selected outpatient claims, which resulted in overpayments of \$82,614.

### **Incorrect Billing for Dental Services**

The Act states: “No payment may be made under Medicare 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 ....” (§ 1862(a)(12)).

For 8 of the 37 selected claims, Good Samaritan incorrectly billed Medicare for the treatment or removal of teeth. Good Samaritan officials stated these errors occurred because the coding staff was unaware that Medicare did not cover the dental services. As a result of these errors, Good Samaritan received overpayments of \$52,470.

### **Manufacturer Credit for a Replaced Medical Device Not Reported**

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.<sup>3</sup>

For 1 of the 37 selected claims, Good Samaritan received full credit for a replaced device but did not properly report the “FB” modifier and reduced charges on its claim. Good Samaritan officials stated that this error occurred because it did not have procedures to identify device replacements covered under warranty and because personnel were not sufficiently educated on proper use of the “FB” modifier. As a result of this error, Good Samaritan received an overpayment of \$21,662.

### **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 17 of the 37 selected claims, Good Samaritan 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. Good Samaritan officials stated that these errors occurred because its billing software was not programmed to identify all outpatient services provided during inpatient stays. Additionally, officials attributed the overpayments to inadequate review by hospital staff prior to billing and staff misunderstanding of the billing requirements. As a result of these errors, Good Samaritan received overpayments of \$3,601.

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

### **Incorrectly Billed Number of Units**

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). 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 1 of the 37 selected claims, Good Samaritan submitted a service to Medicare with an incorrect number of units. Good Samaritan officials attributed this incorrect billing to human error. As a result of this error, Good Samaritan received an overpayment of \$2,796.

### **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 2 of the 37 selected claims, Good Samaritan incorrectly billed Medicare for HCPCS codes with modifier -59 for services that were already included in the payments for other services billed on the same claim. Good Samaritan officials stated that these errors occurred because coding staff did not understand how to properly use the edits in the coding software and did not correctly validate the use of the modifier. As a result of these errors, Good Samaritan received overpayments of \$2,085.

## **RECOMMENDATIONS**

We recommend that Good Samaritan:

- refund to the Medicare contractor \$840,067, consisting of \$757,453 in net overpayments for 183 incorrectly billed inpatient claims and \$82,614 in overpayments for 29 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

### **GOOD SAMARITAN MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, Good Samaritan concurred with most of our findings and recommendations. However, Good Samaritan disagreed that it incorrectly billed 11 claims as inpatient and stated that it would appeal these claims. We maintain that these 11 claims did not comply with Medicare billing requirements.

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

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered \$2,178,804 in Medicare payments to Good Samaritan for 262 claims that we judgmentally selected as potentially at risk for billing errors. These 262 claims consisted of 225 inpatient and 37 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 25 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of Good Samaritan'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 Good Samaritan for Medicare reimbursement.

Our fieldwork included contacting Good Samaritan in Brockton, Massachusetts, from January through September 2013.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Good Samaritan'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 262 claims (225 inpatient and 37 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 Good Samaritan to support the selected claims;
- requested that Good Samaritan conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed Good Samaritan's procedures for submitting Medicare claims;
- used an independent medical review contractor to determine whether 25 selected claims met medical necessity requirements;
- discussed the incorrectly billed claims with Good Samaritan'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 Good Samaritan 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**

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Under/Over-payments</b>	<b>Value of Net Over-payments</b>
<b>Inpatient</b>				
Short Stays	98	\$550,151	87	\$439,969
Same-Day Discharges and Readmissions	25	411,305	25	165,399
Claims Billed With High Severity Level Diagnosis-Related Group Codes	40	325,738	20	125,799
Transfers	4	47,821	4	20,855
Psychiatric Facility Emergency Department Adjustments	48	487,627	47	5,431
Claims Paid in Excess of Charges	10	238,736	0	0
<b>Inpatient Totals</b>	<b>225</b>	<b>\$2,061,378</b>	<b>183</b>	<b>\$757,453</b>
<b>Outpatient</b>				
Dental Services	8	\$52,470	8	\$52,470
Manufacturer Credit for a Replaced Medical Device	1	24,525	1	21,662
Claims Billed During Inpatient Stays	17	4,405	17	3,601
Drugs	1	6,023	1	2,796
Claims Billed With Modifier -59	10	30,003	2	2,085
<b>Outpatient Totals</b>	<b>37</b>	<b>\$117,426</b>	<b>29</b>	<b>\$82,614</b>
<b>Inpatient and Outpatient Totals</b>	<b>262</b>	<b>\$2,178,804</b>	<b>212</b>	<b>\$840,067</b>

**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 Good Samaritan. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

## APPENDIX C: GOOD SAMARITAN MEDICAL CENTER COMMENTS



December 20, 2013

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

RE: Audit Report A-01-13-00501, Medicare Compliance Review of Good Samaritan Medical Center for Calendar Years 2010 and 2011

Dear Mr. Lamir:

Good Samaritan Medical Center, a Steward Family Hospital, Inc. (“Good Samaritan” or the “Hospital”) has reviewed the November 20, 2013 Draft Report (the “Report”) provided by the Department of Health and Human Services (DHHS), Office of the Inspector General (OIG) entitled “Medicare Compliance Review of Good Samaritan Medical Center for Calendar Years 2010 and 2011.”<sup>1</sup> We are appreciative of the opportunity to respond to your Report in writing.

The Hospital understands the OIG’s designated responsibility to ensure compliance with these regulations and is dedicated to strict adherence to all Medicare billing regulations and guidelines. As outlined in the Report, the claims reviewed were judgmentally selected by the OIG and flagged as potentially at risk for billing errors based on generally identified risk areas for hospitals.

The following represents a summary of issues identified during the review process, along with highlights of how the Hospital addressed these issues operationally, to promote ongoing compliance with Medicare’s billing requirements:

### **Incorrectly Billed as Inpatient**

The audit determined that 103 inpatient claims from the OIG’s judgmentally selected sample should have instead been billed as outpatient or observation services. Of the 103 claims, the Hospital agrees that 92 may not meet certain standards of review, including the OIG’s current assessment methods, and is in the process of re-billing those 92 claims for appropriate payment, as noted in the Report. The Hospital respectfully disagrees with the Medical Review Findings for the remaining 11 claims, and will appeal these claims following Medicare procedures.

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

### **Good Samaritan Medical Center**

235 North Pearl Street, Brockton, Massachusetts 02301 Tel: 508- 427-3000 [www.steward.org](http://www.steward.org)  
*Medicare Compliance Review of Good Samaritan Medical Center (A-01-13-00501)*

The Hospital has enhanced its Utilization Review Policy and has worked to increase care management staffing levels to make the most accurate level of care determinations in a more timely manner. Good Samaritan is also working with its medical staff and employees, through its hospital committees, to ensure that efforts to better educate and communicate leads to more accurate admission decisions.

#### **Incorrectly Billed as Separate Inpatient Stays**

The Hospital has an enhanced policy that describes revenue cycle procedures to identify all inpatients readmitted to the Hospital within 24 hours and assign those claims for clinical review prior to claim submission. Care coordination staff completes the clinical review to determine if the inpatient admissions are related. If they are related, the appropriate combining of claims is completed by the Patient Financial Services staff. The applicable staff has been trained on these enhanced procedures.

#### **Incorrect Discharge Status**

For the five (5) claims identified in the audit, it was determined that the Hospital's coding staff did not appropriately validate the patients' discharge disposition code at the time of the discharge. The Hospital's Health Information Management (HIM) leadership has provided additional in-person education to the coding staff regarding the proper review and validation of patient discharge disposition coding.

#### **Incorrectly Billed Diagnosis-Related Group Code**

The staff members who coded the three (3) incorrectly coded claims were provided with remedial education. All coding staff received education on the issues related to the incorrectly coded claims.

#### **Incorrect Source-of-Admission Code**

The Hospital implemented a procedure that requires the Patient Access staff to review a report which identifies all patients discharged from the Hospital's acute care bed and admitted to the Hospital's Inpatient Psychiatric Facility (IPF) bed in order to verify that the claim was properly coded with source of admission D. Patient Access staff and coders have been educated on the report and verification process, and monitoring is in place.

#### **Incorrect Billing for Dental Services**

Dental procedures at the Hospital are generally performed only in emergency circumstances. The dental claims that were subject to this audit were determined to have been elective procedures where the patient required full anesthesia, and no coding validation occurred. The Hospital has expanded its billing edit software to identify any dental procedures that are performed in the Hospital, and has provided its coders with education to ensure that covered dental procedures are properly charged, including correct modifier selection as appropriate.

#### **Manufacturer Credit for a Replaced Medical Device Not Reported**

As noted in the Report, one (1) claim was found in error. The Hospital has implemented a procedure to capture and report claims related to medical devices. Determination of explanted device warranty status occurs via direct communication with the device manufacturer, and claims are adjusted

accordingly. The procedure enhances the communication of any received credit between the Hospital departments notified of the credit and Patient Financial Services to ensure that the claim is resubmitted with the appropriate credit modifier.

#### **Incorrectly Billed Outpatient Services Provided During an Inpatient Stay**

The Hospital has implemented a revised policy that enables it to meet regulatory requirements with respect to outpatient services provided within 72 hours of an inpatient admission. As part of this policy, billing software and process flow improvements have led to better identification of claims that may require review and adjustment prior to claim submission. Daily worklists of outpatient claims that fall within the 3 day window of an inpatient admission are routed to Health Information Management personnel for relatedness review, and claims that require bundling are then routed to Patient Financial Services personnel who combine the services and submit the final claim.

#### **Incorrectly Billed Number of Units**

For the one (1) claim found to be in error, the Hospital re-educated all Pharmacy staff on the type of error identified in this claim.

#### **Incorrectly Billed Services with Modifier -59**

For the two (2) claims found in error, the Hospital provided additional education to coding staff related to their identification of procedures or services that are separate and/or distinct from other services performed on the same day. Good Samaritan has verified that its billing software identifies any potentially inappropriate use of the modifier, and that the coding department's lead coder reviews the errors and any trends with the clinical department coding team that coded the original claim to ensure proper modifier use.

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

Good Samaritan Medical Center takes its obligations to comply with all laws and regulations seriously and appreciates the opportunity to provide this response to the Report. The Hospital extends its thanks to the OIG audit team for their politeness and open communication during the review process.

The remediation efforts outlined in this letter have been set up to promote continued compliance with Medicare regulations associated with patient care billing. The Hospital is committed to ensuring follow through and maintenance of these efforts.

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

Sincerely,

*Jeffrey H. Liebman*

Jeffrey H. Liebman  
President