



November 30, 2011

TO: Peter Budetti
Deputy Administrator and Director
Center for Program Integrity
Centers for Medicare & Medicaid Services

Deborah Taylor
Director and Chief Financial Officer
Office of Financial Management
Centers for Medicare & Medicaid Services

FROM: /Brian P. Ritchie/
Assistant Inspector General for the
Centers for Medicare & Medicaid Audits

SUBJECT: Medicare Compliance Review of Norwood Hospital for the Period July 2008 Through June 2010 (A-01-11-00510) and Medicare Compliance Review of Tallahassee Memorial HealthCare, Inc., for Calendar Years 2009 and 2010 (A-04-11-08003)

Attached, for your information, are advance copies of our final reports for two of our hospital compliance reviews. We will issue these reports to Norwood Hospital and Tallahassee Memorial HealthCare, Inc. within 5 business days.

These reports are part of a series of the Office of Inspector General's hospital compliance initiative, designed to review multiple issues concurrently at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services. The two attached reports are the seventh and eighth reports issued in this initiative.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or your staff may contact the respective Regional Inspectors General for Audit Services:

Norwood Hospital

Michael J. Armstrong, Regional Inspector General for Audit Services, Region I,
(617) 565-2689, Michael.Armstrong@oig.hhs.gov

Page 2 – Peter Budetti, Deborah Taylor

Tallahassee Memorial Hospital

Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV,
(404) 562-7750, Lori.Pilcher@oig.hhs.gov

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

November 30, 2011

Report Number: A-01-11-00510

Ms. Karen Murray
Vice President, Chief Compliance Officer
Steward HealthCare System
30 Perwal Street
Westwood, MA 02090

Dear Ms. Murray:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Norwood Hospital for the Period July 2008 Through June 2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kimberly Rapoza, Audit Manager, at (617) 565-2695 or through email at Kimberly.Rapoza@oig.hhs.gov. Please refer to report number A-01-11-00510 in all correspondence.

Sincerely,

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

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF NORWOOD
HOSPITAL FOR THE PERIOD
JULY 2008 THROUGH JUNE 2010**



Daniel R. Levinson
Inspector General

November 2011
A-01-11-00510

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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

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

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. 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 payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Norwood Hospital (the Hospital) is a 264-bed acute care facility located in Norwood, Massachusetts. Medicare paid the Hospital approximately \$78 million for 9,646 inpatient and 43,541 outpatient claims for services provided to beneficiaries from July 2008 through June 2010 based on CMS's National Claims History data.

Our audit covered \$1,204,371 in Medicare payments to the Hospital for 198 claims that we judgmentally selected as potentially at risk for billing errors. These 198 claims had dates of service from July 2008 through June 2010 and consisted of 123 inpatient and 75 outpatient claims.

OBJECTIVE

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

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 99 of the 198 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, 99 claims had errors, resulting in overpayments totaling \$206,836 from July 2008 through June 2010. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$206,836, consisting of \$185,682 in overpayments for 48 incorrectly billed inpatient claims and \$21,154 in overpayments for 51 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

NORWOOD HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that it has begun refunding the overpayments to Medicare, strengthened controls to ensure full compliance with Medicare requirements, and developed corrective action plans to address our audit findings. The Hospital's comments are included in their entirety as the Appendix.

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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.¹

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, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.² The OPPS 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.³ All services and items within an APC group are comparable clinically and require comparable resources.

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

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

³ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Hospital Payments at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims paid in excess of charges,
- outpatient claims billed with modifier -59,
- outpatient claims billed during inpatient stays,
- outpatient evaluation and management services billed with surgical services,
- outpatient claims paid in excess of charges, and
- outpatient dental services.

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

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

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items 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.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may

process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

Norwood Hospital

Norwood Hospital (the Hospital) is a 264-bed acute care hospital located in Norwood, Massachusetts. Medicare paid the Hospital approximately \$78 million for 9,646 inpatient and 43,541 outpatient claims for services provided to beneficiaries from July 2008 through June 2010 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit covered \$1,204,371 in Medicare payments to the Hospital for 198 claims that we judgmentally selected as potentially at risk for billing errors. These 198 claims had dates of service from July 2008 through June 2010 and consisted of 123 inpatient and 75 outpatient claims.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not use medical reviews to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital during May and June 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for July 2008 through June 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 198 claims (123 inpatient and 75 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Hospital officials.

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

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 99 of the 198 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, 99 claims had errors, resulting in overpayments totaling \$206,836 from July 2008 through June 2010. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements.

Of 123 sampled inpatient claims, 48 claims had billing errors, resulting in overpayments totaling \$185,682:

- For inpatient claims with short stays, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services (22 errors). Additionally, 1 claim did not have a valid physician order to admit the beneficiary for inpatient care (22 errors totaling \$80,456).
- For inpatient claims with same-day discharges and readmissions, the Hospital billed Medicare separately for related discharges and readmissions within the same day (11 errors totaling \$51,086 in overpayments).
- For inpatient claims billed with high severity level DRG codes, the Hospital billed Medicare with incorrect DRG codes (11 errors totaling \$26,048 in overpayments).
- For inpatient claims paid in excess of charges, the Hospital billed Medicare with incorrect DRG codes (four errors totaling \$28,092 in overpayments).

Of 75 sampled outpatient claims, 51 claims had billing errors, resulting in overpayments totaling \$21,154:

- For outpatient claims billed with modifier -59, the Hospital incorrectly billed Medicare for HCPCS codes that did not require modifier -59 (12 errors) or for services that were insufficiently documented in the medical records (9 errors) (21 errors totaling \$1,307 in overpayments).
- For outpatient claims billed during an inpatient stay, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays that should have been included on the Hospital's inpatient (Part A) bills to Medicare (8 errors) or for services that were billed with incorrect dates of service (3 errors) (11 errors totaling \$2,541 in overpayments).
- For outpatient evaluation and management service claims billed with surgical services, the Hospital incorrectly billed Medicare for services that were part of the usual preoperative and postoperative care associated with the procedure (11 errors totaling \$885 in overpayments).
- For outpatient claims paid in excess of charges, the Hospital submitted claims to Medicare with incorrect HCPCS codes (five errors totaling \$2,693 in overpayments).
- For outpatient dental services, the Hospital incorrectly billed Medicare for services that did not meet required exceptions for coverage of outpatient dental services (three errors totaling \$13,728 in overpayments).

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 48 of the 123 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$185,682.

Inpatient Short Stays

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if, “with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual’s medical treatment”

For 22 of the 51 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Additionally, one of these claims did not have a valid physician order to admit the beneficiary for inpatient care. The Hospital attributed the patient admission errors to inadequate internal controls over case management for monitoring short stays. The Hospital stated that human error caused the invalid physician order. As a result of these errors, the Hospital received overpayments totaling \$80,456.⁴

Inpatient Same-Day Discharges and Readmissions

The Manual, chapter 3, section 40.2.5, states:

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

For 11 of the 15 sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that the errors occurred because of insufficient internal controls to evaluate whether the stays were related. As a result of these errors, the Hospital received overpayments totaling \$51,086.

⁴ The Hospital may bill Medicare Part B for a limited range of services related to some of these 22 incorrect Medicare Part A short-stay claims. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the MAC prior to the issuance of our report.

Inpatient Claims Billed With High Severity Level Diagnosis-Related Group Codes

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

For 11 of the 40 sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that the errors occurred because staff did not query physicians to obtain clarification of diagnoses, select diagnosis codes that were supported by the medical records, or properly interpret guidance related to the selection of a principal diagnosis. As a result of these errors, the Hospital received overpayments totaling \$26,048.

Inpatient Claims Paid in Excess of Charges

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

For 4 of the 17 sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that the errors occurred because of coding errors, such as selecting incorrect procedure or diagnosis codes that were not supported by the medical records and improperly interpreting guidance for selecting a principal diagnosis. As a result of these errors, the Hospital received overpayments totaling \$28,092.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 51 of the 75 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$21,154.

Outpatient Claims Billed With Modifier -59

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

For 21 of the 36 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that did not require modifier -59 (12 errors) or for services that were insufficiently documented in the medical records (9 errors). The Hospital stated these errors occurred primarily because of human error, including staff misinterpreting the billing requirements for modifier -59. As a result of these errors, the Hospital received overpayments totaling \$1,307.

Outpatient Claims Billed During Inpatient Stays

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

For all of the 11 sampled claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during an inpatient stay that should have been included on the Hospital's inpatient (Part A) bills to Medicare (8 errors) or for services that were billed with incorrect dates of service (3 errors). The majority of these errors were for ambulance services. The Hospital attributed these errors to human error, including a misunderstanding of certain billing requirements. As a result of these errors, the Hospital received overpayments totaling \$2,541.

Outpatient Evaluation and Management Services Billed With Surgical Services

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

For all of the 11 sampled claims, the Hospital incorrectly billed Medicare for services that were part of the usual preoperative and postoperative care associated with the procedure. The Hospital stated that these errors occurred because staff incorrectly selected evaluation and management services as a separately billable service when they should have billed only for the procedure. As a result of these errors, the Hospital received overpayments totaling \$885.

Outpatient Claims Paid in Excess of Charges

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. Additionally, the Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 5 of the 14 sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes. The Hospital stated that these overpayments occurred because of human error, including not properly interpreting coding guidance. As a result of these errors, the Hospital received overpayments totaling \$2,693.

Outpatient Dental Services

Section 1862(a)(12) of 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, except that payment may be made under Part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical

condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.

For all of the three sampled outpatient dental service claims, the Hospital incorrectly billed Medicare for services that did not meet required exceptions for coverage of outpatient dental services. The Hospital stated that these overpayments occurred because its systems did not have edits or other controls to identify dental procedures prior to the provision of services or submission of the claims. As a result of these errors, the Hospital received overpayments totaling \$13,728.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$206,836, consisting of \$185,682 in overpayments for 48 incorrectly billed inpatient claims and \$21,154 in overpayments for 51 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

NORWOOD HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that it has begun refunding the overpayments to Medicare, strengthened controls to ensure full compliance with Medicare requirements, and developed corrective action plans to address our audit findings. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: NORWOOD HOSPITAL COMMENTS



October 25, 2011

Michael J. Armstrong
Regional Inspector General for Auditing Services
Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

RE: **A-01-11-00510**

Dear Mr. Armstrong:

Norwood Hospital (The Hospital) is in receipt of the Draft OIG Audit Report entitled *Medicare Compliance Review of Norwood Hospital for the Period June 2008 to June 2010*¹. The Hospital generally agrees with the findings and as instructed by the OIG auditors, has begun the process of correcting and resubmitting the claims to the Medicare Administrative Contractor, NHIC, through the Fiscal Intermediary Standard System and to the appropriate secondary payers.

The Hospital is committed to compliance. Steward Health Care System dedicates resources to prevent billing errors, to monitor its adherence to federal, state and local laws and regulations and to promptly remedy identified deficiencies. The Hospital is implementing even stronger internal controls aimed at minimizing the risk of the identified errors from occurring in the future.

No systemic issues were identified by the auditors and 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.

¹ During the period under review, the Hospital was a part of Caritas Christi. As of November 6, 2010, the Hospital was acquired by Steward Health Care System.

Specific corrective actions for each area follow:

- *Inpatient Short Stays:* Case management implemented daily quality assurance reviews of one day stays, while new initiatives (staff alignment, process redesign, technology) are considered. Additional tools were provided to the Hospitalists in August 2011 with education planned. Revenue Cycle management created a standard operating procedure job aid for account adjustments related to level of care changes and Condition Code 44. This job aid was distributed to relevant staff and posted on a common drive for regular reference.
- *Inpatient Same Day Discharges and Readmissions:* Patient Access management, in conjunction with Revenue Cycle management, has enhanced the current procedure for identifying and billing patients who are readmitted the same day of a discharge.
- *Inpatient Claims Billed with High Severity Level Diagnosis Related Group Codes and Inpatient Claims Paid in Excess of Charges:* Existing Health Information Management (HIM) controls included management oversight, coder training, official guideline resources, software resources, quality assurance, and staff training. Subsequent to the period under review, HIM communicated the existing querying policies and procedures multiple times to staff to reinforce their understanding of the existing procedures. As part of the HIM education process, coders participated in a review of the audit findings with the Coding Manager at the time of the OIG field audit. Additional education has been provided to the staff on audited inpatient coding areas and the query policy.
- *Outpatient Claims Billed with Modifier -59:* Health Information Management arranged for coding staff to participate in a Modifier 59 training session. Specific feedback has been provided on the audit findings and Modifier 59 requirements to both coding staff and other involved departments.
- *Outpatient Claims Billed Prior to and During an Inpatient Stay:* Policies and procedures have been reviewed and revised by both Norwood Ambulance Services and Revenue Cycle management. Ambulance and Revenue Cycle staff has been educated on the updated policies and procedures.
- *Outpatient Evaluation & Management (E&M) Services Billed with Surgical Services:* Identified errors related to pain management services. Certain charge codes have been inactivated and policies and procedures have been developed to prevent charge entry staff from incorrectly selecting evaluation and management services as separately billable service when only the procedure should be billed. Management for the pain management services has developed an updated encounter form and facility guidelines. The new procedures and tools are in the process of being implemented.
- *Outpatient Claims Paid Greater Than Charges:* Existing HIM controls included management oversight, coder training, official guideline resources, software resources,

quality assurance, and staff training. Education has been provided to the HIM coding staff on proper coding of outpatient claims identified as errors in Audit Report.

- *Dental Services:* Patient Access management has provided education on Medicare's dental services exclusion of routine dental care to outpatient scheduling staff.

The Hospital, in conjunction with Steward Health Care System's Office of Corporate Compliance & Privacy, will continue to assess the audited areas and update internal controls as needed. Please feel free to contact me if you require any additional information.

Sincerely,

Karen Murray

Vice President, Chief Compliance Officer

cc: John Holiver, President, Norwood Hospital
James Renna, Steward Health Care, Chief Financial Officer
Rhonda Miller, Steward Health Care, Vice President, Central Billing Office