



January 3, 2012

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 MetroWest Medical Center for Calendar Years 2009 and 2010 (A-01-11-00513) and Medicare Compliance Review of Broward General Medical Center for Calendar Years 2008 and 2009 (A-04-11-07021)

Attached, for your information, are advance copies of our final reports for two of our hospital compliance reviews. We will issue these reports to MetroWest Medical Center and Broward General Medical Center 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.

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:

MetroWest Medical Center

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

Broward General Medical Center

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

Attachment

cc:

Jacquelyn White, Director
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services



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
(617) 565-2684

January 4, 2012

Report Number: A-01-11-00513

Mr. Roger Wiseman
Chief Financial Officer
MetroWest Medical Center
115 Lincoln Street
Framingham, MA 01701

Dear Mr. Wiseman:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of MetroWest Medical Center for Calendar Years 2009 and 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 David Lamir, Audit Manager, at (617) 565-2704 or through email at David.Lamir@oig.hhs.gov. Please refer to report number A-01-11-00513 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, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



Daniel R. Levinson
Inspector General

January 2012
A-01-11-00513

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.

Office of Evaluation and Inspections

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.

Office of Investigations

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.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

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 inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, 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.

MetroWest Medical Center (the Hospital) is a 450-bed healthcare system that includes two acute care hospitals, Framingham Union Hospital, located in Framingham, Massachusetts, and Leonard Morse Hospital, located in Natick, Massachusetts. Medicare paid the Hospital approximately \$127 million for 13,665 inpatient and 153,448 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$1,672,835 in Medicare payments to the Hospital for 161 claims that we judgmentally selected as potentially at risk for billing errors. These 161 claims had dates of service in CYs 2009 and 2010 and consisted of 118 inpatient and 43 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 124 of the 161 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, 37 claims had billing errors that resulted in overpayments totaling \$229,343 for CYs 2009 and 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 \$229,343, consisting of \$188,895 in overpayments for 27 incorrectly billed inpatient claims and \$40,448 in overpayments for 10 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

METROWEST MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations. 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 employs 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 inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned 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 with high severity level DRGs,
- inpatient psychiatric interrupted stays,
- inpatient and outpatient claims involving manufacturer credits for replaced medical devices,
- inpatient and outpatient claims paid in excess of charges,
- outpatient surgeries billed with units greater than one, and
- outpatient services billed during skilled nursing facility (SNF) stays.

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.

MetroWest Medical Center

MetroWest Medical Center (the Hospital) is a 450-bed healthcare system that includes two acute care hospitals, Framingham Union Hospital, located in Framingham, Massachusetts, and Leonard Morse Hospital, located in Natick, Massachusetts. Medicare paid the Hospital approximately \$127 million for 13,665 inpatient and 153,448 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit covered \$1,672,835 in Medicare payments to the Hospital for 161 claims that we judgmentally selected as potentially at risk for billing errors. These 161 claims had dates of service in CYs 2009 and 2010 and consisted of 118 inpatient and 43 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 and subjected a limited number of claims to focused medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. 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 April and May 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 CYs 2009 and 2010;

- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2009 and 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 161 claims (118 inpatient and 43 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 selected sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- utilized CMS and Medicare contractor medical review staff to determine whether a limited selection of sampled claims met medical necessity requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Hospital officials.

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

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 124 of the 161 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, 37 claims had billing errors that resulted in overpayments totaling \$229,343 for CYs 2009 and 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 118 sampled inpatient claims, 27 claims had billing errors, resulting in overpayments totaling \$188,895:

- For inpatient claims for short stays, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services (16 errors totaling \$104,268).
- For inpatient claims with same-day discharges and readmissions, the Hospital billed Medicare separately for related discharges and readmissions within the same day (three errors) and incorrectly billed Medicare Part A for readmissions that should have been billed as outpatient or outpatient with observation services (two errors) (five errors totaling \$37,208 in overpayments).
- For inpatient claims with high severity level DRGs, the Hospital incorrectly billed Medicare Part A for claims that did not have valid physician orders to admit beneficiaries for inpatient care (five errors totaling \$34,652 in overpayments).
- For inpatient claims paid in excess of charges, the Hospital billed Medicare with an incorrect DRG (one error resulting in a \$12,767 in overpayment).

Of 43 sampled outpatient claims, 10 claims had billing errors, resulting in overpayments totaling \$40,448:

- For outpatient claims involving manufacturer credits for replaced medical devices, the Hospital received full credit for replaced devices but did not report the “FB” modifier (two errors) or reduce the charges on its claims (one error) (three errors totaling \$35,296 in overpayments).
- For outpatient claims paid in excess of charges, the Hospital submitted claims to Medicare for services that were not provided (three errors) and had incorrect HCPCS codes (one error) (four errors totaling \$3,745 in overpayments).
- For outpatient claims involving surgeries billed with units greater than one, the Hospital billed Medicare with an incorrect number of surgical units of service performed (one error resulting in a \$1,329 overpayment).
- For outpatient claims billed during SNF stays, the Hospital incorrectly billed Medicare Part B rather than the appropriate SNFs for services that were subject to the consolidated billing provisions of the Act and that had been included in the Medicare Part A prospective payments to the SNFs (two errors totaling \$78 in overpayments).

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 27 of the 118 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$188,895.

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 diagnosing or treating illness or injury or for improving 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 16 of the 45 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare requirements. The Hospital billed these claims incorrectly because of one or more of the following: the claims did not have valid physician orders to admit beneficiaries for inpatient care (10 claims); inpatient care was not the appropriate level of care for the services provided, as determined by complex medical review (five claims); and the claims did not meet the Hospital’s inpatient admission criteria (three claims).

The Hospital attributed the patient admission errors to inadequate internal controls over its case management department’s processes and procedures. Specifically, case management did not always have the opportunity to review patient stays of short duration or admission criteria was improperly applied due to human error. As a result, the Hospital received overpayments totaling \$104,268.⁴

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 3 of the 25 sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. For an additional 2 of the 25 sampled claims, the Hospital incorrectly billed Medicare Part A for inpatient readmissions that should have been billed as outpatient or outpatient with observation services. The Hospital attributed the patient

⁴ The Hospital may bill Medicare Part B for a limited range of services related to some of these 16 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.

admission errors to inadequate internal controls over its case management department's processes and procedures. As a result, the Hospital received overpayments totaling \$37,208.

Inpatient Claims for High Severity Level Diagnosis-Related Groups

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 5 of the 25 sampled claims, the Hospital billed Medicare for inpatient claims that did not have valid physician orders to admit beneficiaries for inpatient care. The Hospital attributed the patient admission errors to inadequate internal controls over its case management department's processes and procedures. As a result, the Hospital received overpayments totaling \$34,652.

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 diagnosing or treating illness or injury or for improving the functioning of a malformed body member."

For 1 of the 27 sampled claims, the Hospital billed Medicare for an incorrect DRG code. The Hospital stated that the incorrectly coded claim occurred because of human error. As a result, the Hospital received an overpayment of \$12,767.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 10 of 43 sampled outpatient claims, which resulted in overpayments totaling \$40,448.

Outpatient Manufacturer Credits for Replaced Medical Devices

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

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual explains how a provider should report no-cost and reduced-cost devices under the OPPS. 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.

For 2 of the 13 sampled claims, the Hospital received full credit for a replaced device but did not report the "FB" modifier. For one additional claim, the Hospital did not reduce the charges on

its claim, resulting in an excessive outlier payment. The Hospital stated that these errors occurred because staff did not follow procedures in place to report manufacturer credits. As a result, the Hospital received overpayments totaling \$35,296.

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 3 of the 11 sampled claims, the Hospital submitted claims to Medicare for services that were not provided. For one additional claim, the Hospital used a generic “unlisted procedure” HCPCS code when it should have used a more specific code. The Hospital stated that these errors occurred because staff did not follow the existing protocol to validate HCPCS codes and units of service. As a result, the Hospital received overpayments totaling \$3,745.

Outpatient Surgeries Billed With Units Greater Than One

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

For 1 of the 10 sampled claims, the Hospital submitted a claim to Medicare with an incorrect number of surgical units of service performed. The Hospital stated that this error occurred because staff did not follow the existing protocol to validate HCPCS codes and units of service. As a result, the Hospital received an overpayment of \$1,329.

Outpatient Services Billed During Skilled Nursing Facility Stays

Under the consolidated billing provisions of sections 1862(a)(18) and 1842(b)(6)(E) of the Act, SNFs are responsible for billing Medicare for most services, including outpatient hospital services, provided to a SNF resident during a Part A covered stay. Pursuant to the interim final rule implementing the SNF consolidated billing requirement, outside suppliers, including outpatient hospitals, must bill according to the consolidated billing provisions for services furnished to SNF residents and must be paid by the SNF rather than by Medicare Part B.

For two out of the nine sampled claims, the Hospital incorrectly billed Medicare Part B rather than the appropriate SNFs for services that were subject to the consolidated billing provisions of the Act and that had been included in the Medicare Part A prospective payments to the SNFs. In each of these cases, the Medicare program paid twice for the same service: once to the SNF through the Part A prospective payment and again to the Hospital through Part B. These errors occurred because the Hospital did not determine that the beneficiaries were in SNF stays covered under Part A at the time of admission. As a result of these errors, the Hospital received overpayments totaling \$78.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$229,343, consisting of \$188,895 in overpayments for 27 incorrectly billed inpatient claims and \$40,448 in overpayments for 10 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

METROWEST MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX



**APPENDIX: METROWEST MEDICAL
CENTER COMMENTS**

METROWEST MEDICAL CENTER

Framingham Union Hospital • Leonard Morse Hospital

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508-383-1000

67 Union Street
Natick, MA 01760-6099
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November 22, 2011

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

RE: Report Number: A-01-11-00513

Dear Mr. Armstrong:

On behalf of MetroWest Medical Center, I am providing comments to the report entitled "Medical Compliance Review of MetroWest Medical Center for Calendar Years 2009 and 2010". I appreciate the opportunity to respond to the draft report.

As noted in the draft report, the Office of Inspector General (OIG) reviewed 161 claims that were judgmentally selected as potentially at risk for billing errors. These claims covered 8 specific areas that were determined to be at risk for non-compliance and covered \$1,672,835 in Medicare payments to MetroWest Medical Center.

MetroWest Medical Center concurs with OIG's recommendations stated below:

- Refund to the Medicare contractor \$229,343, consisting of \$188,895 in overpayments for 27 incorrectly billed inpatient claims and \$40,448 in overpayments for 10 incorrectly billed outpatient claims, and
- Strengthen controls to ensure full compliance with Medicare requirements.

Our responses to the OIG's recommendations are as follows:



MetroWest Medical Center is partnering with Floating Hospital for Children to bring advanced care to your community.

1. Refund to the Medicare contractor for overpayments of \$229,343. MetroWest Medical Center has refunded the first amount of \$35,425.56 for medical devices in October 2011 through the claims adjustment process. The remaining refund of \$193,917.44 will be refunded through the OIG's recommended claims adjustment process after the final report has been issued.

2. Strengthen controls to ensure full compliance with Medicare requirements. MetroWest Medical Center regularly conducts monitoring and auditing of controls. In addition, MetroWest Medical Center conducts coding and compliance education on a routine basis. In order to strengthen these efforts and address the issues raised by the OIG's findings, we have implemented several measures, including the following:
 - Provided additional training and monitoring on the application of InterQual criteria to enhance consistent application and proficiency;
 - Simplified, clarified, and streamlined processes and documentation and communication;
 - Provided additional coding education and training and monitoring, including monthly coding and billing compliance audits;
 - Provided additional education to all physicians on admission status, including daily consultation with Physician Advisor on re-admissions and 1 Day Stays.

MetroWest Medical Center takes these obligations very seriously, and will continue to monitor and audit claims and institute additional controls as indicated above.

Sincerely,

A handwritten signature in black ink, appearing to read "Roger Wiseman". The signature is written in a cursive style with a horizontal line extending to the right.

Roger Wiseman

Chief Financial Officer

MetroWest Medical Center