

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF AIBONITO MENNONITE  
GENERAL HOSPITAL, INC., FOR  
CALENDAR YEARS  
2010 AND 2011**

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**James P. Edert  
Regional Inspector General**

**June 2013  
A-02-12-01032**

# *Office of Inspector General*

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

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

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for the Hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and 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.

Aibonito Mennonite General Hospital, Inc., (the Hospital) is a 150-bed acute care hospital located in Aibonito, Puerto Rico. Medicare paid the Hospital approximately \$8 million for 2,737 inpatient and 10,834 outpatient claims for services provided to beneficiaries during calendar years 2010 and 2011 (audit period) based on CMS's National Claims History data.

Our audit covered \$1,647,558 in Medicare payments to the Hospital for 423 claims that we judgmentally selected as potentially at risk for billing errors. These 423 claims had dates of service in our audit period and consisted of 409 inpatient and 14 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 354 of the 423 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 69 claims, resulting in overpayments for inpatient claims of \$279,471 for our audit period. These overpayments occurred because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements within the selected risk areas that contained errors.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$279,471 in overpayments for 69 incorrectly billed inpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AIBONITO MENNONITE GENERAL HOSPITAL COMMENTS**

In its written comments on our draft report, the Hospital concurred with our findings and recommendations and described corrective actions it had taken or planned to take to address them.

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# INTRODUCTION

## BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

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

### **Hospital Inpatient Prospective Payment System**

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>1</sup> 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.<sup>2</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis techniques. Examples of these types of claims at risk for noncompliance included the following:

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<sup>1</sup> In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

<sup>2</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

- inpatient and outpatient claims paid in excess of charges, and
- inpatient claims billed with high severity level DRG codes.

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 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.” In addition, § 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, § 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, § 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

### **Aibonito Mennonite General Hospital**

Aibonito Mennonite General Hospital, Inc., (the Hospital) is a 150-bed acute care hospital located in Aibonito, Puerto Rico. Medicare paid the Hospital approximately \$8 million for 2,737 inpatient and 10,834 outpatient claims for services provided to beneficiaries during calendar years 2010 and 2011 (audit period) 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 \$1,647,558 in Medicare payments to the Hospital for 423 claims that we judgmentally selected as potentially at risk for billing errors (see Appendix A). These 423

claims had dates of service in our audit period and consisted of 409 inpatient and 14 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not subject claims to 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. 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 the Hospital for Medicare reimbursement.

We conducted our fieldwork during October and November 2012.

## **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 our audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 423 claims (409 inpatient and 14 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;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- 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 objectives.

## **FINDINGS AND RECOMMENDATIONS**

The Hospital complied with Medicare billing requirements for 354 of the 409 inpatient and all outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 69 inpatient claims, resulting in overpayments of \$279,471 for our audit period. These overpayments occurred because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements within the selected risk areas that contained errors. For a detailed list of the risk areas that we reviewed and associated billing errors, see Appendix A.

### **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 69 of the 409 selected inpatient claims, which resulted in overpayments of \$279,471.

#### **Incorrectly Billed as Inpatient**

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 37 of the 409 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient with observation services. The Hospital attributed the incorrect billing to human error. As a result of these errors, the Hospital received overpayments of \$102,337.<sup>3</sup>

#### **Incorrectly Billed 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.” In addition, the Manual, chapter 1,

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<sup>3</sup> The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

§ 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately ....”

For 32 of the 409 selected claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated these errors occurred because of misinterpretation of coding guidelines or human error. As a result of these errors, the Hospital received overpayments of \$177,134.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$279,471 in overpayments for 69 incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AIBONITO MENNONITE GENERAL HOSPITAL COMMENTS**

In its written comments on our draft report, the Hospital concurred with our findings and recommendations and described corrective actions it had taken or planned to take to address them. The Hospital’s comments are included as Appendix B.

# **APPENDIXES**

**APPENDIX A: RESULTS OF REVIEW BY RISK AREA**

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Over-payments</b>	<b>Value of Over-payments</b>
<b>Inpatient</b>				
Claims Paid in Excess of Charges	67	\$246,378	37	\$102,337
Claims Billed With High Severity Level Diagnosis Related Group Codes	342	1,362,126	32	177,134
<b>Inpatient Totals</b>	<b>409</b>	<b>\$1,608,504</b>	<b>69</b>	<b>\$279,471</b>
<b>Outpatient</b>				
Claims Paid in Excess of Charges	14	\$39,054	0	\$0
<b>Outpatient Totals</b>	<b>14</b>	<b>\$39,054</b>	<b>0</b>	<b>\$0</b>
<b>Inpatient and Outpatient Totals</b>	<b>423</b>	<b>\$1,647,558</b>	<b>69</b>	<b>\$279,471</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 the Hospital. 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 B: AIBONITO MENNONITE GENERAL HOSPITAL COMMENTS**



**HOSPITAL GENERAL  
MENNONITA INC.**

*Sirviendo con Amor Cristiano*



*Certification by the  
Joint Commission on Accreditation  
of Healthcare Organizations*

April 22, 2013

Report Number: A-02-12-01032

Department Of Health Human Services  
Office of Inspector General  
Office Of Audit Services Region II  
Jacob K Javitts Federal Building  
26 Federal Plaza, Room 3900  
New York, NY 10278

James P. Edert  
Regional Inspector General  
For Audit Services

Dear Mr. Edert

In compliance with your request concerning the Medicare Compliance Review of our hospital for calendar years 2010 and 2011, we include our comments and the description of the corrective actions taken and planned. We are in concurrence with your recommendation:

**Risk Areas Reviewed and Billing Errors**

Risk Areas	Error Billing vs Sample Claims	Corrective Action Taken
<p><b>Inpatient claims paid in excess of charges 2010 and 2011: Level of Care – Inpatient to Observation Status</b></p>	<p><b>37/67</b></p>	<p><b>We are doing concurrent evaluations with Admission and Utilization Review Personnel. We have been more emphatic in requesting review to the physicians in order establish the level of care (Inpatient vs. Observation Status).</b></p> <p><b>We are doing retrospective evaluation with Information Management Information Personnel requesting review to the physician in order establish the level of care (Inpatient vs. Observation Status), including the use of code 44.</b></p> <p><b>We have repeatedly educated our physicians about assigning the correct level of care.</b></p>

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Page 2. April 22, 2013 James P. Edert Regional Inspector General For Audit Services  
Report Number: A-02-12-01032

### Risk Areas Reviewed and Billing Errors

Risk Areas	Error Billing vs Sample Claims	Corrective Action Taken
<b>Inpatient Claims Billed with High Severity Level Diagnosis Related Groups Codes 2010 and 2011</b>	<p align="center">32/342</p>	<p>We added another level of review in order to address the issue of validating our codes and meeting the coding standard ( concurrent and retrospectively)</p> <p>We created a review form to validate the documentation in the record in order to perform a concurrent and retrospective review. This will improve our compliance and help improve our documentation and validation of codes. Enclosed example form. *</p> <p>Our personnel are doing more queries concurrently and retrospective.</p> <p>We have repeatedly educated our physicians on improving the documentation of the record and the need for more detailed information</p> <p>We will perform internal audit following the guidelines used in the review. This will be done every 3 months.</p>
<b>Inpatient Total</b>	<p align="center"><b>69/409</b></p>	

Sincerely;



Pedro L. Meléndez Rosario, MHSA  
Executive Director  
Mennonite General Hospital, Inc.

\* Office of Inspector General note: We did not include the example of the Hospital's patient review form and accompanying documentation because of its length.