

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW
OF ROBERT PACKER HOSPITAL FOR
CALENDAR YEARS 2009 THROUGH 2011**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Brian P. Ritchie
Assistant Inspector General

May 2014
A-03-12-00003

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Robert Packer Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$1.9 million over 3 years.

WHY WE DID THIS REVIEW

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

The objective of this review was to determine whether Robert Packer Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

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

The Hospital, which is a part of the Guthrie Healthcare System, is a 254-bed teaching hospital located in Sayre, Pennsylvania. Medicare paid the Hospital approximately \$210 million for services provided to beneficiaries during CYs 2009 through 2011 based on CMS's National Claims History data.

Our audit covered \$5,100,582 in Medicare payments to the Hospital for 279 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 229 inpatient and 50 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 180 of the 279 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 99 claims, resulting in overpayments of \$1,876,257 for CYs 2009 through 2011. Specifically, 94 inpatient claims had billing errors, resulting in overpayments of \$1,868,121 and 5 outpatient claims had billing errors, resulting in overpayments of \$8,136. These errors occurred primarily because the Hospital did not have

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

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$1,876,257, consisting of \$1,868,121 in overpayments for 94 incorrectly billed inpatient claims and \$8,136 in overpayments for 5 incorrectly billed outpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements

ROBERT PACKER HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital agreed that 16 of the 99 claims were billed incorrectly and described the actions it had taken and planned to take to address them. However, the Hospital disagreed that the remaining 83 claims were billed incorrectly. The Hospital disputed \$1,743,105 of the overpayment amount and said that it “intends to exercise its administrative appeal rights should CMS ultimately decide to request payment refunds related to these claims.” The Hospital said that it had a vigorous process to review and confirm the appropriateness of inpatient admissions, which included the review of certain cases by an independent, nationally recognized physician organization. The Hospital said that a majority of the inpatient admissions included in the sample were reviewed by this organization at the time the patients received services and that the remaining sample claims were subsequently reviewed by this organization.

After reviewing the hospital’s comments, we maintain that our findings are correct. For the claims for which the Hospital had an independent review, we included the results of those reviews as part of the medical record provided to our review contractor at the time of our audit. The contractor determined that the claims did not meet Medicare coverage criteria for inpatient admissions. The Hospital provided no new information or medical reviews to document that the 83 claims were billed correctly.

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INTRODUCTION

WHY WE DID THIS REVIEW

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

OBJECTIVE

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

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

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

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

Hospital Claims at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims paid in excess of charges,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient same-day discharges and readmissions,
- inpatient transfers,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- outpatient claims paid in excess of \$25,000,
- outpatient claims billed with evaluation and management (E&M) services,
- outpatient claims billed with modifier -59, and
- outpatient surgeries billed with units greater than one.

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

Medicare Requirements for Hospital Claims and Payments

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

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

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). In addition, the Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Robert Packer Hospital

The Hospital, which is a part of the Guthrie Healthcare System, is a 254-bed teaching hospital located in Sayre, Pennsylvania. Medicare paid the Hospital approximately \$210 million for services provided to beneficiaries during CYs 2009 through 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$5,100,582 in Medicare payments to the Hospital for 279 claims that we judgmentally selected as potentially at risk for billing errors. These 279 claims consisted of 229 inpatient and 50 outpatient claims with dates of service during CYs 2009 through 2011 (audit period). We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 96 claims to focused medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

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

FINDINGS

The Hospital complied with Medicare billing requirements for 180 of the 279 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 99 claims, resulting in overpayments of \$1,876,257 for the audit period. Specifically, 94 inpatient claims had billing errors, resulting in overpayments of \$1,868,121, and 5 outpatient claims had billing errors, resulting in overpayments of \$8,136. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

Appendix B summarizes, by risk areas reviewed, the overpayments identified in this report.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 94 of 229 selected inpatient claims, which resulted in overpayments of \$1,868,121.

Incorrectly Billed as Inpatient

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

For 81 of the 229 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. For 5 of the 81 claims, Hospital officials said the cause was human error. For the remaining 76 claims, Hospital officials did not provide a cause for these errors because they disagreed with our finding. As a result of these errors, the Hospital received overpayments of \$1,736,061.²

Incorrectly Billed Diagnosis-Related Group Codes

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, §1862(a)(1)(A)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 8 of the 229 selected inpatient claims, the Hospital billed Medicare for incorrect DRG codes. For 3 of the 8 claims, Hospital officials said the cause was human error. For the remaining 5 claims, Hospital officials did not provide a cause for these errors because they disagreed with our finding. As a result of these errors, the Hospital received overpayments of \$92,845.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). The Manual states that, to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code “FD” (chapter 3, § 100.8).

For 3 of the 229 selected inpatient claims, the Hospital received reportable credits from manufacturers for replaced devices but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required. Hospital officials stated that the errors occurred because procedures coordinating functions among departments were not followed properly. As a result of these errors, the Hospital received overpayments of \$28,007.

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on

² 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 and adjudicated by the Medicare administrative contractor prior to the issuance of our report.

the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 2 of the 229 selected inpatient claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. Hospital officials did not provide a cause for these errors because they disagreed with our finding. As a result of these errors, the Hospital received overpayments of \$11,208.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 5 of 50 selected outpatient claims, which resulted in overpayments of \$8,136.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

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

For 2 of the 50 selected outpatient claims, the Hospital submitted the claims to Medicare with incorrect HCPCS codes. Hospital officials stated that these errors occurred because medical documentation was misinterpreted by the coders. As a result of these errors, the Hospital received overpayments of \$7,672.

Incorrectly Billed Evaluation and Management Services

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

For 3 of the 50 selected outpatient claims, the Hospital incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative work of the procedures. Hospital officials stated that these errors occurred because coding staff did not always understand the billing requirements for E&M services. As a result of these errors, the Hospital received overpayments of \$464.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$1,876,257, consisting of \$1,868,121 in overpayments for 94 incorrectly billed inpatient claims and \$8,136 in overpayments for 5 incorrectly billed outpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

ROBERT PACKER HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital agreed that 16 of the 99 claims were billed incorrectly and described the actions it had taken and planned to take to address them. However, the Hospital disagreed that the remaining 83 claims were billed incorrectly. The Hospital disputed \$1,743,105 of the overpayment amount and said that it “intends to exercise its administrative appeal rights should CMS ultimately decide to request payment refunds related to these claims.” The Hospital said that it had a vigorous process to review and confirm the appropriateness of inpatient admissions, which included the review of certain cases by an independent, nationally recognized physician organization. The Hospital said that a majority of the inpatient admissions included in the sample were reviewed by this organization at the time the patients received services and that the remaining sample claims were subsequently reviewed by this organization. The Hospital’s comments are included in their entirety as Appendix C.

After reviewing the hospital’s comments, we maintain that our findings are correct. For the claims for which the Hospital had an independent review, we included the results of those reviews as part of the medical record provided to our review contractor at the time of our audit. The contractor determined that the claims did not meet Medicare coverage criteria for inpatient admissions. The Hospital provided no new information or medical reviews to document that the 83 claims were billed correctly.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$5,100,582 in Medicare payments to the Hospital for 279 claims that we judgmentally selected as potentially at risk for billing errors. These 279 claims consisted of 229 inpatient and 50 outpatient claims with dates of service during CYs 2009 through 2011 (audit period).

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 and subjected 96 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. 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 from September 2012 through August 2013 at the Hospital in Sayre, Pennsylvania.

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 the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 279 claims (229 inpatient and 50 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for submitting Medicare claims;
- used CMS's Medicare contractor medical review staff and an independent contractor to determine whether 96 selected 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 objectives.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-Payments	Value of Over-Payments
Inpatient				
Short Stays	133	\$2,425,048	73	\$1,591,467
Claims Billed With High Severity Level DRG Codes	33	550,511	10	125,344
Inpatient Claims Paid in Excess of Charges	6	189,928	3	73,449
Manufacturer Credits for Replaced Medical Devices	29	611,034	6	66,653
Same-Day Discharges and Readmissions	14	106,347	2	11,208
Transfers	3	195,155	0	0
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	11	99,203	0	0
Inpatient Totals	229	\$4,177,226	94	\$1,868,121
Outpatient				
Claims Paid in Excess of \$25,000	12	\$336,869	2	\$7,672
Claims Billed with Evaluation and Management Services	6	62,959	3	464
Claims Billed With Modifier -59	23	433,906	0	0
Manufacturer Credits for Replaced Medical Devices	6	68,603	0	0
Outpatient Surgeries Billed With Units Greater Than One	3	21,019	0	0
Outpatient Totals	50	\$923,356	5	\$8,136
Inpatient and Outpatient Totals	279	\$5,100,582	99	\$1,876,257

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 C: ROBERT PACKER HOSPITAL COMMENTS

GUTHRIE

Robert Packer Hospital
One Guthrie Square
Sayre, PA 18840-1698
Tel 570.888.6666

January 17, 2014

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106

RE: Audit Report A-03-12-00003, Medicare Compliance Review of Robert Packer Hospital
for Calendar Years 2009 Through 2011

Dear Mr. Virbitsky:

Robert Packer Hospital ("the Hospital") appreciates the opportunity to provide comments on the Office of the Inspector General's ("OIG") draft report entitled "*Medicare Compliance Review of Robert Packer Hospital for Calendar Years 2009 Through 2011*" (the "Draft Report"). The Hospital has a proud tradition of caring – for its patients, its staff and the communities it services. The Hospital also strives to deliver care compassionately and to act with integrity in everything it does. Consistent with its tradition of caring, the Hospital maintains a culture that promotes strict adherence to applicable federal, state, and local laws and regulations.

The OIG reviewed selected claims in twelve areas determined to be at risk for noncompliance with Medicare billing requirements based on prior OIG Compliance Reviews of payments to hospitals. The OIG audit covered \$5,100,582 in Medicare payments to the Hospital during calendar years 2009 through 2011 based on 279 claims (229 inpatient and 50 outpatient claims) that were judgmentally selected by OIG as potentially at risk for billing errors. As a result of the review, the OIG identified 99 claims that it believed were billed incorrectly, resulting in overpayments amounting to \$1,876,257.

As described in greater detail below, the Hospital disagrees with the OIG's determination that 83 of the 99 were billed incorrect, and the Hospital disputes \$1,743,105 of the total overpayments calculated by the OIG. Regarding the remaining 16 claims, the Hospital agrees with the OIG's determination and has refunded Medicare payments attributable to these 16 claims through the normal claims adjudication process.

www.guthrie.org

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

A) Incorrectly Billed as Inpatient

The OIG Draft Report indicates that 81 claims were incorrectly billed as inpatient admissions based on a medical review performed by consultants engaged by the OIG. The OIG's consultants determined that 76 of the 81 claims, which total \$1,693,916 of the claimed overpayments, were not reasonable and necessary for the diagnosis or treatment of the patient's illness or injury.

The Hospital disagrees with the findings of the OIG's consultants. The Hospital has implemented a vigorous process to review and confirm the appropriateness of inpatient admissions at the Hospital, a process that includes the review of certain cases by an independent, nationally recognized physician organization to confirm the appropriateness of inpatient admissions at the time the patient received services at the Hospital. A majority of the inpatient admissions included in the sample were reviewed by this independent physician organization at the time the patient received services at the Hospital and deemed to be appropriate inpatient admissions. The remaining claims were subsequently reviewed by this independent physician organization and found to have been appropriate inpatient admissions.

The Hospital intends to exercise its administrative appeal rights should the Centers for Medicare & Medicaid Services ("CMS") ultimately decide to request payment refunds related to these 76 claims. The Hospital has developed a robust system to review and confirm the appropriateness of inpatient admission decisions at the Hospital. The Hospital is constantly exploring ways to improve the effectiveness of its policies and procedures and it will look for opportunities to improve its procedures to review and confirm the appropriateness of inpatient admissions. However, the Hospital examined these procedures as a result of the OIG's findings and did not identify a need to substantially modify the process at this time.

The Hospital agrees with the OIG's findings that 5 claims were incorrectly billed as a result of human error. To address these billing errors, the Hospital has refunded \$42,145 to the Medicare contractor related to these claims through the normal claims adjudication process, and intends to furnish additional education and training to those Case Management and/or Utilization Management staff involved in these errors.

B) Incorrectly Billed Diagnostic Related Group Codes

The OIG Draft Report indicates 8 inpatient claims were billed as inpatient admissions with incorrect DRG codes. The Hospital disagrees with the OIG's findings that 5 of the 8 claims were billed incorrectly and intends to exercise its administrative appeal rights should CMS ultimately decide to request payment refunds related to these claims. The Hospital agrees that 3 of the 8 claims were incorrectly billed as a result of human error. With respect to these 3 claims, the Hospital has undertaken the following corrective actions:

- The Hospital has refunded \$55,153 to the Medicare contractor related to these claims through the normal claims adjudication process.
- The Hospital intends to furnish additional education and training to the Coding Staff responsible for coding compliance.
- The Hospital implemented a process to identify for further review those patients whose primary procedure may be unrelated to the principal diagnosis.

- The Hospital's compliance department will conduct additional audits of these cases to ensure continued compliance with CMS requirements.

C) Manufacturer Credits for Replaced Medical Devices Not Reported

OIG Draft Report indicates 3 inpatient claims were incorrectly billed due to the omission of proper value and condition codes for reportable credits from manufacturers for replaced devices. The Hospital agrees with the OIG's findings and has undertaken the following corrective actions with respect to these 3 claims:

- The Hospital has refunded \$27,718 to the Medicare contractor related to these claims through the normal claims adjudication process.
- The Hospital intends to furnish additional education and training to the billing clerks responsible for these transactions.
- The Hospital has implemented a Cardiac Catheterization Laboratory Six Sigma Process Improvement initiative that requires participation from all pertinent departments as well as device manufacturers.
- The Hospital's compliance department will conduct additional audits of these cases to ensure continued compliance CMS requirements.

D) Incorrectly Billed as Separate Inpatient Stays

The OIG Draft Report indicates 2 inpatient claims were incorrectly billed due to related discharge and admission within the same day. The Hospital disagrees with the OIG's findings and intends to exercise its administrative appeal rights should CMS ultimately decide to request payment refunds related to these claims.

The Hospital engaged an independent physician review organization to review the inpatient admissions reflected in the sample claims and the independent physician reviewer confirmed the Hospital's decision to treat the readmission as unrelated to the discharge. The Hospital believes it has complied with the Medicare billing requirements for these cases.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

According to the OIG Draft Report, the Hospital incorrectly billed 5 of the 50 selected outpatient claims, resulting in an overpayment of \$8,136.

A) Incorrectly Billed Healthcare Common Procedure Coding Systems Codes

The OIG Draft Report indicates 2 outpatient claims were billed with incorrect HCPC codes. The Hospital agrees with the OIG findings and attributes the incorrect billing to human error and misinterpretation of the clinical documentation. The Hospital has undertaken the following corrective actions with respect to these 2 claims:

- The Hospital has refunded \$7,672 to the Medicare contractor related to these claims through the normal claims adjudication process.
- The Hospital intends to furnish additional education and training to the Coding Staff responsible for coding compliance.

- The Hospital furnished additional education and training to physicians to ensure complete and specific documentation in the medical record to prevent any misunderstanding of the procedures completed.
- The Hospital's compliance department will conduct additional audits of these cases to ensure continued compliance CMS requirements.

B) Incorrectly Billed Evaluation and Management ("E&M") Services

The OIG Draft Report indicates 3 outpatient claims for E&M Services were incorrectly billed because they were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. The Hospital agrees with the OIG's findings and attributes the incorrect billing to human error. The Hospital has undertaken the following corrective actions with respect to these 3 claims:

- The Hospital has refunded \$464 to the Medicare contractor related to these claims through the normal claims adjudication process.
- The Hospital has re-educated the staff in the applicable departments regarding the circumstances under which E&M services may be billed on the same day as a procedure.
- With respect to other E&M services, the Hospital has taken steps to strengthen its internal review and audit processes related to these services.
- The Hospital has implemented an internal billing report that identifies the modifiers in use and their account application to assist the departments in ensuring use of the correct modifier.
- The Hospital's compliance department will conduct additional audits of these cases to ensure continued compliance CMS requirements.

* * *

Robert Packer Hospital takes its compliance obligations seriously and remains committed to implementing, monitoring, and where appropriate strengthening internal controls in order to maintain compliance with all CMS billing requirements.

We commend the OIG audit team who conducted this review for their professionalism, and we appreciate your consideration of these comments. Please do not hesitate to contact me should you need any additional information.

Sincerely,

/Lucia Saggiomo, CPA/

Vice President, Internal Audit and Compliance

cc. Joseph Scopelliti, Chief Executive Officer, Guthrie Health
 Richard Bennett, Chief Financial Officer, Guthrie Health
 Marie Droege, President, Guthrie Healthcare System
 Minh Dang, Chief Financial Officer, Robert Packer Hospital
 Roger Lathrop, Corporate Compliance Officer, GHS