



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



May 15, 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 Reviews for Calendar Years 2009 and 2010:
Piedmont Hospital (A-04-11-00081), Regional Medical Center at Memphis
(A-04-11-00082), and South Miami Hospital (A-04-11-07023)

Attached for your information are advance copies of our final reports on our most recent hospital compliance reviews. We will issue these reports to Piedmont Hospital, Regional Medical Center at Memphis, and South Miami Hospital within 5 business days.

These reports are part 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 Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750, or through email at Lori.Pilcher@oig.hhs.gov.

Attachment

cc:
Daniel Converse
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION IV
61 FORSYTH STREET, SW, SUITE 3T41
ATLANTA, GA 30303

May 17, 2012

Report Number: A-04-11-00081

Ms. Tracy Field, J.D.
Executive Vice President, Compliance
Piedmont Healthcare, Inc.
2001 Peachtree Road, N.E., Suite 445
Atlanta, GA 30309

Dear Ms. Field:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Piedmont Hospital 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 Eric Bowen, Audit Manager, at (404) 562-7789 or through email at Eric.Bowen@oig.hhs.gov. Please refer to report number A-04-11-00081 in all correspondence.

Sincerely,

/Lori S. Pilcher/
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 355
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
PIEDMONT HOSPITAL FOR CALENDAR
YEARS 2009 AND 2010**



Daniel R. Levinson
Inspector General

May 2012
A-04-11-00081

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.

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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.

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 and the severity 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.

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.

Piedmont Hospital (the Hospital) is a 481-bed acute care hospital located in Atlanta, Georgia. Medicare paid the Hospital approximately \$225 million for 23,182 inpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$5,479,446 in Medicare payments to the Hospital for 62 inpatient claims that we identified as potentially at risk for billing errors. These 62 claims had dates of service in CYs 2009 and 2010.

OBJECTIVE

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

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 60 of the 62 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining two claims, resulting in overpayments totaling \$129,653 for CYs 2009 and 2010. Overpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$129,653 in overpayments for two incorrectly billed inpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

PIEDMONT HOSPITAL COMMENTS

In written comments on our draft report, the Hospital agreed with our recommendations and described corrective actions that it had taken or planned to take in response to our recommendations. Piedmont Hospital's comments are included in their entirety as the Appendix.

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| PIEDMONT HOSPITAL COMMENTS | |

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.

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 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 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 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 claims with payments greater than \$150,000,
- inpatient short stays, 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.”

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.

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.

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.

Piedmont Hospital

Piedmont Hospital (the Hospital) is a 481-bed acute care hospital located in Atlanta, Georgia. Medicare paid the Hospital approximately \$225 million for 23,182 inpatient 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 services on selected claims.

Scope

Our audit covered \$5,479,446 in Medicare payments to the Hospital for 62 inpatient claims that we identified as potentially at risk for billing errors. These 62 claims had dates of service in CYs 2009 and 2010.

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 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 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 from October 2011 to January 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 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;
- identified 62 inpatient claims 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 the Hospital provided 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 case management protocol, included in the Hospital's *Utilization Review Plan*, for inpatient stays;
- 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 the Hospital's 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 60 of the 62 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining two claims, resulting in overpayments totaling \$129,653 for CYs 2009 and 2010. Overpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

The areas listed below do not include those without findings.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 2 of 62 selected inpatient claims. These errors resulted in overpayments totaling \$129,653.

Inpatient Claims With Payments Greater Than \$150,000

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." Additionally, the Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For 1 of the 22 selected claims, the Hospital billed Medicare with an incorrect DRG code. The Hospital had previously identified the error and rebilled the claim under a different DRG code. However, the Medicare contractor rejected the adjusted claim as a duplicate because of a technical misunderstanding by the Hospital's billing department, which coded the adjusted bill as an original bill. As a result of this error, the Hospital received an overpayment totaling \$126,367.

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 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." Additionally, the Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For 1 of the 20 selected claims, the Hospital billed Medicare with an incorrect DRG code. The Hospital stated that a coder made an error and assigned the incorrect DRG. This error occurred because the coder assigned the DRG based on test results rather than physician notes in the record. As a result of this error, the Hospital received an overpayment totaling \$3,286.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$129,653 in overpayments for two incorrectly billed inpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

PIEDMONT HOSPITAL COMMENTS

In written comments on our draft report, the Hospital agreed with our recommendations and described corrective actions that it had taken or planned to take in response to our recommendations. Piedmont Hospital's comments are included in their entirety as the Appendix.

APPENDIX



April 5, 2012

VIA FEDERAL EXPRESS

Ms. Lori S. Pilcher
Regional Inspector General
For Audit Services
Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, Georgia 30303

**Re: Piedmont Hospital
DRAFT Report No.: A-04-11-00081**

Dear Ms. Pilcher:

We have received the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft Report entitled *Medicare Compliance Review of Piedmont Hospital for Calendar Years 2009 and 2010*, dated March 9, 2012 (the "Report"). We appreciate the opportunity to review the Report, and Piedmont Hospital ("Piedmont" or the "Hospital") offers the following comments on the Report and the OIG's recommendations.

Specifically, the Report makes two recommendations:

- **Recommendation 1:** Refund to the Medicare contractor \$129,653 in overpayments for 2 incorrectly billed inpatient claims.

Piedmont agrees with this recommendation. Refunds were processed.

- **Recommendation 2:** Strengthen controls to ensure full compliance with Medicare requirements.

Piedmont has extensive internal controls to ensure accurate billing including training and continuing education, policies and procedures, internal and external audit programs to ensure compliance with Medicare requirements. Nevertheless, to further strengthen our coding and financial compliance, appropriate personnel were re-educated on the requirements for identifying a claim as one that has been adjusted versus an original bill. In addition, retraining focused on the need to monitor claims rejected for duplicate billings to ensure the root cause of the rejection.

Regional Inspector General for Audit Services

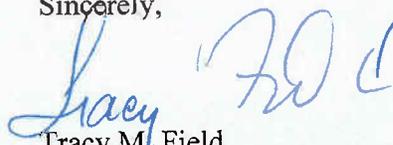
April 5, 2012

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With regard to the coder accuracy, Piedmont conducted focused training with appropriate staff.

Thank you again for the opportunity to review the Report and comment. Piedmont Hospital has devoted substantial effort to ensure Medicare requirements are satisfied in our operations, and we will continue to review and strengthen our processes.

Sincerely,



Tracy M. Field
Executive Vice President, Compliance
Piedmont Healthcare, Inc.