



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



Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

January 4, 2012

Report Number: A-04-11-07021

Mr. Frank Nask
President and Chief Executive Officer
North Broward Hospital District, d.b.a. Broward Health
303 SE 17th Street
Fort Lauderdale, FL 33316

Dear Mr. Nask:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Broward General Medical Center for Calendar Years 2008 and 2009*. 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 Denise R. Novak, Audit Manager, at (305) 536-5309, extension 10, or through email at Denise.Novak@oig.hhs.gov. Please refer to report number A-04-11-07021 in all correspondence.

Sincerely,

/Lori S. Pilcher/
Regional Inspector General
for Audit Services

Enclosure

cc: Ms. Deborah Breen
VP of Financial Operations
North Broward Hospital District, d/b/a/Broward Health
303 SE 17th Street, 6th Floor
Fort Lauderdale, FL 33316

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
BROWARD GENERAL MEDICAL CENTER
FOR CALENDAR YEARS 2008 AND 2009**



Daniel R. Levinson
Inspector General

January 2012
A-04-11-07021

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:

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at <http://oig.hhs.gov>

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

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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

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

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

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Broward General Medical Center (the Hospital) is a 716-bed hospital located in Fort Lauderdale, Florida. Medicare paid the Hospital approximately \$141.7 million for 13,344 inpatient and 39,355 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 and 2009 based on CMS's National Claims History data.

Our audit covered \$8,018,723 in Medicare payments to the Hospital for 160 claims that we selected as potentially at risk for billing errors. These claims had dates of service in CYs 2008 and 2009 and consisted of 140 inpatient and 20 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 148 of the 160 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for

selected inpatient claims. Specifically, of 160 sampled claims, 12 inpatient claims had billing errors, resulting in overpayments totaling \$137,483 for CYs 2008 and 2009. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$137,483 in overpayments and
- strengthen controls to ensure full compliance with Medicare billing requirements.

BROWARD GENERAL MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and provided information on actions that it planned to take to implement our 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 contracts with Medicare contactors to, among other things, process and pay claims submitted by hospitals.¹

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.² The OPPS was 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. At the time of our fieldwork, most, but not all, of the MACs were fully operational; for jurisdictions where the MACs were 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 transfers,
- inpatient claims with same day discharge and readmission,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient hospital-acquired conditions and “present on admission”⁴ indicator reporting,
- inpatient claims paid in excess of charges,
- inpatient claims with payments greater than \$150,000, and
- outpatient claims with payments greater than \$25,000.

For 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 payment.

⁴ “Present on admission” refers to diagnoses that are present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are also considered present on admission. Acute care hospitals are required to complete the present on admission indicator field on the Medicare inpatient claim for every diagnosis billed.

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.

Broward General Medical Center

Broward General Medical Center (the Hospital) is a 716-bed hospital located in Fort Lauderdale, Florida. Medicare paid the Hospital approximately \$141.7 million for 13,344 inpatient and 39,355 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 and 2009 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 \$8,018,723 in Medicare payments to the Hospital for 160 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2008 and 2009 and consisted of 140 inpatient and 20 outpatient claims.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not use medical 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 allowed 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 March and April 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- extracted the Hospital's inpatient and outpatient paid claims data from CMS's National Claims History file for CYs 2008 and 2009;
- 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 160 claims (140 inpatient and 20 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 the Hospital provided to support the sampled claims;
- requested that the Hospital conduct its own review of some of the selected sampled claims to determine whether the services were billed correctly;
- 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 adjustment; 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 148 of the 160 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient claims. Specifically, of 160 sampled claims, 12 inpatient claims had billing errors, resulting in overpayments totaling \$137,483 for CYs 2008 and 2009. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

We did not identify any errors in the 20 sampled outpatient claims. Of the 140 sampled inpatient claims, 12 claims had billing errors resulting in overpayments of \$137,483:

- For inpatient short stays, the Hospital incorrectly billed Medicare for inpatient claims that lacked a valid physician order to admit beneficiaries to inpatient care (six errors). Additionally, the Hospital incorrectly billed Medicare for beneficiary stays that it should

have billed as outpatient or outpatient with observation services (two errors). (These eight errors totaled \$126,657 in overpayments.)

- For inpatient transfers, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers (three errors totaling \$10,826 in overpayments).
- For inpatient claims with hospital-acquired conditions, the Hospital incorrectly reported the hospital-acquired conditions as present on admission (one error that did not result in an overpayment).

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 12 of 140 sampled inpatient claims. These errors resulted in overpayments totaling \$137,483.

Inpatient Short Stays

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

For 8 of the 79 sampled claims for inpatient short stays, the Hospital incorrectly billed Medicare for inpatient claims that lacked a valid physician order to admit beneficiaries to inpatient care (6 errors). Additionally, the Hospital incorrectly billed Medicare for beneficiary stays that it should have billed as outpatient or outpatient with observation services (two errors). Hospital staff stated that the billing errors occurred because they did not identify the deficiencies in the medical records, and they did not communicate to appropriate billing staff the changes in patient status. As a result, the Hospital received overpayments totaling \$126,657.

Inpatient Transfers

Federal regulations (42 CFR § 412.4(b)) state that a discharge of a hospital inpatient is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge. A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient’s stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For three of the nine sampled claims for inpatient transfers, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers. For these claims, the Hospital should have coded the discharge status as a transfer to another hospital. However, the Hospital incorrectly coded the discharge status as discharged to home or to another type of health care institution; thus, the Hospital should have received the per diem payment instead of the full

DRG. The Hospital stated that these incorrect billings occurred because of human error in coding the appropriate discharge status. As a result, the Hospital received overpayments totaling \$10,826.

Inpatient Hospital-Acquired Conditions and Present on Admission Indicator Reporting

Section 1886(d)(4)(D) of the Act requires the Secretary to identify conditions that (a) are high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

For inpatient discharges on or after October 1, 2007, CMS requires the completion of a present on admission indicator for every diagnosis on an inpatient acute care hospital claim. Effective October 1, 2008, Medicare would no longer assign an inpatient hospital discharge to a higher paying DRG if a selected hospital-acquired condition was a secondary diagnosis that was not present upon admission.

For 1 of the 20 sampled claims for inpatient hospital-acquired conditions and present on admission indicator reporting, the Hospital incorrectly reported that a secondary diagnosis, represented by a hospital-acquired urinary tract infection (UTI), was present on admission. However, the medical record showed that, upon admission, the urinalysis was negative for a UTI. The Hospital stated that human error caused this incorrect claim. This error did not result in an overpayment because the DRG was part of a premajor diagnostic category in which the DRG is determined by the procedure code rather than by the diagnosis code.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$137,483 in overpayments and
- strengthen controls to ensure full compliance with Medicare billing requirements.

BROWARD GENERAL MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and provided information on actions that it planned to take to implement our recommendations. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX



Broward General Medical Center
Coral Springs Medical Center
Imperial Point Medical Center
North Broward Medical Center
Chris Evert Children's Hospital
Broward Health Weston
Community Health Services
Broward Health Physician Group

November 7, 2011

Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW
Suite 3T41
Atlanta, GA 30303

Audit Report Number: A-04-11-07021

Dear Ms. Pilcher:

Broward General Medical Center is in receipt of the draft report from the U. S. Department of Health and Human Services, Office of Inspector General (OIG) entitled Medicare Compliance Review of Broward General Medical Center for Calendar Years 2008 and 2009.

The OIG identified 12 inpatient claims that had billing errors, resulting in overpayments of \$137,483. Broward General Medical Center concurs with the OIGs findings on the 12 inpatient claims. Broward General Medical Center takes these findings very seriously and strives to comply with all CMS guidelines.

The OIG made two recommendations regarding the billing errors and our responses are listed below:

1. Refund to the Medicare program \$137,483 in overpayments: Broward General Medical Center is in the process of refunding the overpayments to the Medicare program and should complete the refund by November 30, 2011.
2. Strengthen controls to ensure full compliance with Medicare billing requirements: Broward General Medical Center has implemented additional staff training and increased the number of random audit functions to ensure full compliance with Medicare billing requirements. In addition, Broward General Medical Center is in the process of evaluating and planning for the CPOE initiative. This will also help to ensure documentation compliance within the electronic medical record. Completion of the implementation of CPOE is targeted for the fall of 2012. Communication between the clinical departments, Health Information Management and the Central Business Office have also been strengthened to ensure any errors are identified and corrected and rebilled when necessary.

Broward General Medical Center appreciates the opportunity to respond to the OIG audit. If you have any further questions, do not hesitate to call me.

Sincerely,

Deborah Breen
Vice President of Financial Operations