



January 30, 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 Kendall Regional Medical Center for Calendar Years 2009 and 2010 (A-04-11-07022) and Medicare Compliance Review of Springhill Medical Center for Calendar Years 2008 and 2009 (A-04-11-03067)

Attached, for your information, are advance copies of our final reports for two of our hospital compliance reviews. We will issue these reports to Kendall Regional Medical Center and Springhill 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 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:
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

February 1, 2012

Report Number: A-04-11-07022

Mr. Ricardo Pavon
Chief Financial Officer
Kendall Regional Medical Center
11750 Bird Road
Miami, FL 33175

Dear Mr. Pavon:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Kendall Regional Medical Center for Calendar Years 2009 and 2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact 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-04-11-07022 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 235
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



Daniel R. Levinson
Inspector General

February 2012
A-04-11-07022

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.

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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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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
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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.

Kendall Regional Medical Center (the Hospital) is a 412-bed acute care hospital located in Miami, Florida. Medicare paid the Hospital approximately \$89 million for 17,220 inpatient and 18,992 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$2,233,628 in Medicare payments to the Hospital for 108 claims that we selected as potentially at risk for billing errors. These claims had dates of service in CYs 2009 and 2010 and consisted of 65 inpatient and 43 outpatient claims.

OBJECTIVE

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

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 84 of the 108 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected

inpatient and outpatient claims. Specifically, of 108 sampled claims, 24 claims had billing errors, resulting in overpayments totaling \$90,222 for CYs 2009 and 2010. 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 contractor \$90,222 in overpayments and
- strengthen controls to ensure full compliance with Medicare billing requirements.

KENDALL REGIONAL MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with most of our findings. Regarding our recommendations, the Hospital stated that it would refund the full amount of the overpayments and provided information on actions that it had taken to strengthen controls to ensure full compliance with Medicare billing requirements.

The Hospital's comments are included in their entirety as the Appendix.

OFFICE OF THE INSPECTOR GENERAL RESPONSE

The Hospital did not provide any additional information that would cause us to modify the finding related to inpatient transfers. The Hospital provided reasons for the errors but is ultimately responsible for coding the bill based on its discharge plan for the patient, or if it finds out subsequently that hospital or postacute care occurred, it is responsible for either coding the original bill as a transfer or submitting an adjustment bill. We strongly encourage the Hospital to strengthen its controls in this area.

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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 contractors¹ 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, 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) codes³ and descriptors to identify and group the services within each APC group. 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 continued to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever was 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 transfers,
- outpatient claims with payments greater than \$25,000,
- outpatient claims billed with Modifier 59,
- inpatient and outpatient claims paid in excess of charges,
- inpatient claims with payments greater than \$150,000,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims for blood clotting factor drugs, and
- inpatient hospital-acquired conditions and “present on admission”⁴ indicator reporting.

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.

Kendall Regional Medical Center

Kendall Regional Medical Center (the Hospital) is a 412-bed acute care hospital located in Miami, Florida. Medicare paid the Hospital approximately \$89 million for 17,220 inpatient and 18,992 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit covered \$2,233,628 in Medicare payments to the Hospital for 108 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2009 and 2010 and consisted of 65 inpatient and 43 outpatient claims.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements 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 April of 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 2009 and 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 108 claims (65 inpatient and 43 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation the Hospital provided to support the sampled claims;
- requested that the Hospital conduct its own review of the selected sampled claims to determine whether the services were billed correctly;
- 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 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 84 of the 108 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, of 108 sampled claims, 24 inpatient and outpatient claims had billing errors, resulting in overpayments totaling \$90,222 for CYs 2009 and 2010. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

Of the 65 sampled inpatient claims, 14 claims had billing errors resulting in overpayments totaling \$78,815:

- For inpatient transfers, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers (10 errors totaling \$39,605 in overpayments).
- For inpatient claims paid in excess of charges, the Hospital billed Medicare with incorrect DRG codes (four errors totaling \$39,210 in overpayments).

Of the 43 sampled outpatient claims, 10 claims had billing errors resulting in overpayments totaling \$11,407:

- For outpatient claims with payments greater than \$25,000, the Hospital billed Medicare with incorrect HCPCS codes (one error totaling \$7,045 in overpayments).
- For outpatient claims billed with modifier 59, the Hospital incorrectly billed for HCPCS codes that did not require modifier 59 (six errors totaling \$3,403 in overpayments).
- For outpatient claims paid in excess of charges, the Hospital submitted claims to Medicare with incorrect HCPCS codes (three errors totaling \$959 in overpayments).

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 14 of 65 sampled inpatient claims. These errors resulted in overpayments totaling \$78,815.

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 discharge of a hospital inpatient is also considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(c)). 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 10 of the 17 sampled claims for inpatient transfers, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers. For these claims, the Hospital should have coded the discharge status either as a transfer to another hospital or to home under a written plan of care for the provision of home health services. However, the Hospital incorrectly coded the discharge status as left against medical advice or discharged to home; thus the Hospital should have received the per diem payment instead of the full DRG. The Hospital stated that these errors occurred because the medical record documentation did not indicate that the beneficiaries were going to be transferred to another hospital, a fact that remained unknown until subsequent communications with the MAC, or that the beneficiaries were going to receive

services from home health agencies within 3 days of discharge. As a result, the Hospital received overpayments totaling \$39,605.

Inpatient Claims Paid in Excess of Charges

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” In addition, 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 four of the eight sampled claims, the Hospital billed Medicare with incorrect DRG codes. The Hospital stated that the incorrect coding occurred because of human error. As a result, the Hospital received overpayments totaling \$39,210.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 10 of 43 sampled outpatient claims. These errors resulted in overpayments totaling \$11,407.

Outpatient Claims With Payments Greater Than \$25,000

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. Additionally, the Manual, chapter 1, section 80.3.2.2, “In order to be processed correctly and promptly, a bill must be completed accurately.”

For one of the six sampled claims, the Hospital submitted a claim to Medicare with an incorrect HCPCS code. For this claim, the Hospital used the procedure code for initial insertion of a cardiac device rather than using the procedure code for replacement of a cardiac device, the procedure actually performed. The Hospital stated that the incorrect claim occurred because of human error. As a result, the Hospital received an overpayment of \$7,045.

Outpatient Claims Billed With Modifier 59

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 23, section 20.9.1.1, states: “The ‘59’ modifier is used to indicate a distinct procedural service.... This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).”

For 6 of the 24 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that did not require modifier 59. These errors occurred because the staff misunderstood the billing requirements for modifier 59. As a result, the Hospital received overpayments totaling \$3,403.

Outpatient Claims Paid in Excess of Charges

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. Additionally, the Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For three of the five sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes. The Hospital stated that these errors occurred because of human error. As a result, the Hospital received overpayments totaling \$959.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$90,222 in overpayments and
- strengthen controls to ensure full compliance with Medicare billing requirements.

KENDALL REGIONAL MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with most of our findings. Regarding our recommendations, the Hospital stated that it would refund the full amount of the overpayments and provided information on actions that it had taken to strengthen controls to ensure full compliance with Medicare billing requirements.

The Hospital stated that it did not concur with some of our findings related to inpatient transfers. The Hospital stated that these errors occurred because the medical record documentation did not indicate that the beneficiaries were going to be transferred to another hospital, which was unknown until subsequent communications with the MAC, or that the beneficiaries were going to receive home health services within 3 days of discharge.

The Hospital's comments are included in their entirety as the Appendix.

OFFICE OF THE INSPECTOR GENERAL RESPONSE

The Hospital did not provide any additional information that would cause us to modify the finding related to inpatient transfers. The Hospital provided reasons for the errors but is ultimately responsible for coding the bill based on its discharge plan for the patient, or if it finds out subsequently that hospital or postacute care occurred, it is responsible for either coding the original bill as a transfer or submitting an adjustment bill.⁵ We strongly encourage the Hospital to strengthen its controls in this area.

⁵ 63 Fed. Reg. 40979, 40980 (July 31, 1998).

APPENDIX



11750 Bird Road, Miami, Florida 33175-3530
Phone: (305) 223-3000

December 7, 2011

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

Re: Medicare Compliance Review of Kendal Regional Medical Center
For Calendar Years 2009 and 2010

Dear Ms. Pilcher:

This letter is provided in response to your correspondence dated October 19, 2011, regarding the above referenced audit of selected Medicare inpatient and outpatient claims submitted by Kendall Regional Medical Center (the "Hospital").

Per the instructions in your letter, provided below are the Hospital's statements of concurrence or non-concurrence, and corrective action taken or planned for the following five (5) areas cited in the audit report:

- Inpatient Transfers
- Inpatient Claims Paid in Excess of Charges
- Outpatient Claims with Payments Greater than \$25,000
- Outpatient Claims Billed with Modifier 59
- Outpatient Claims Paid in Excess of Charges

1) INPATIENT TRANSFERS

The Audit report concluded that the Hospital incorrectly billed Medicare on ten (10) claims for patient discharges that should have been billed as transfers and recommends that the Hospital refund overpayments related to these claims in the amount of \$39,605.00.

A. Statement of Non-Concurrence:

The Hospital respectfully declines to concur with the finding of noncompliance related to 6 of the 10 claims for the following reasons:

These errors occurred because the medical record documentation at the time of discharge was based on the healthcare decisions of the physician, patient and/or family members. The medical record did not indicate that the beneficiaries were going to be transferred to another hospital, a fact that remained unknown until subsequent communications with the MAC, or that the beneficiaries were going to receive services from home health agencies within 3 days of discharge. As a result, \$30,594.00 of the \$39,605.00 was beyond the Hospital's control.

OIG Audit Response

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B. Correction Action Taken or Planned:

1. As a quality improvement measure, the HIM Department established a pre-bill review of inpatient accounts. Discharge dispositions were included in quality reviews performed by External Vendor.
2. Coding staff continue to work with Case Management identifying discharge disposition discrepancies as well as continue to monitor internal web based tool.
3. Case management and coders were retrained on the need for accurate and timely documentation of the expected discharge disposition of the patient. They were reminded of the intent and importance of discharge disposition documentation.
4. Case management and coders were re-educated on HCA's Medicare Post Acute Transfer Rule manual and completed the assigned web-based training course entitled "Transfer Rule – HCA-CO-BIL-178-HP – The Medicare Post Acute Care Transfer Rule."

2) INPATIENT CLAIMS PAID IN EXCESS OF CHARGES

The audit report concluded that the Hospital billed Medicare with incorrect DRG codes on four (4) of the sampled claims, and recommends that the Hospital Refund overpayments related to these claims in the amount of \$39,210.00.

A. State of Concurrence:

The Hospital concurs with the findings of the audit report for these claims and the recommended refund.

B. Correction Active Taken or Planned:

This incorrect coding occurred as a result of human error. The Hospital implemented a plan which included:

1. Coders were in-serviced regarding error and retraining was performed.
2. Coders received additional coding courses to enhance their coding knowledge.
3. External Vendor was contracted for quality review of inpatient accounts, focused on areas of opportunity. External Vendor review included coder education.

3) OUTPATIENT CLAIMS WITH PAYMENTS GREATER THAN \$25,000.00

The audit report concluded that one of the sampled claims was submitted with an incorrect HCPCS code, and recommends that the Hospital refund an overpayment in the amount of \$7,045.00.

A. State of Concurrence:

The Hospital concurs with the findings of the audit report for these claims and the recommended refund.

OIG Audit Response

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B. Correction Active Taken or Planned:

This incorrect coding occurred as a result of human error. The Hospital implemented a plan which included:

1. Coders were in-serviced regarding error and retraining was performed.
2. Coders received additional coding courses to enhance their coding knowledge.
3. External Vendor was contracted to perform a quality review of 100 outpatient records with regard to areas of opportunity and any identified trends. External Vendor review included coder education.

4. OUTPATIENT CLAIMS WITH MODIFIER 59

The audit report concluded that the Hospital incorrectly billed Medicare for six (6) claims with HCPCS codes that did not require Modifier 59, and recommended that the Hospital refund overpayments related to these claims in the amount of \$3,403.00.

A. State of Concurrence:

The Hospital concurs with the findings of the audit report for these claims and the recommended refund.

B. Correction Active Taken or Planned:

The incorrect addition of Modifier 59 to the HCPCS codes on the subject claims was the result of the coding staff misunderstanding when to appropriately assign modifier 59 to a HCPCS code. The Hospital implemented a plan which included:

1. Coders were in-serviced regarding error and retraining was performed.
2. Coders received additional coding courses to enhance their coding knowledge and application of modifier 59.
3. External Vendor was contracted to perform a quality review of 100 outpatient records with regards to areas of opportunity and any identified trends. External Vendor review included coder education.

5. OUTPATIENT CLAIMS PAID IN EXCESS OF CHARGES

The audit report concluded that the Hospital billed Medicare with incomplete or inaccurate information on three claims with incorrect HCPCS codes, and recommends that the Hospital refund overpayments related to these claims in the amount of \$959.00.

A. State of Concurrence:

The Hospital concurs with the findings of the audit report for these claims and the recommended refund.

OIG Audit Response
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B. Correction Active Taken or Planned:

This incorrect coding occurred as a result of human error. The Hospital implemented a plan which included:

1. Coders were in-serviced regarding error and retraining was performed.
2. Coders received additional coding courses to enhance their coding knowledge.
3. External Vendor was contracted to perform a quality review of 100 outpatient records with regard to areas of opportunity and any identified trends. External Vendor review included coder education.

CONCLUSION:

Kendall Regional Medical Center is committed to full compliance with all laws, Regulations, policies and procedures required for its participation in the Medicare program. Accordingly, the Hospital will comply with the Recommendations of the audit report by promptly submitting an overpayment refund in the amount of \$90,222.24 and strengthening its controls in the area of Medicare billing compliance as specified in this responsive letter.

If you require further information, please do not hesitate to contact the undersigned at 305-227-5500.

Respectfully Submitted,



Ricardo Pavon
Chief Financial Officer

RP/MGN