



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-04-11-07023

Ms. Beth Gillis
Assistant Vice President of Compliance
Baptist Health South Florida
6855 Red Road
Coral Gables, FL 33143

Dear Ms. Gillis:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of South Miami 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 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-04-11-07023 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
SOUTH MIAMI HOSPITAL
FOR CALENDAR YEARS
2009 AND 2010**



Daniel R. Levinson
Inspector General

May 2012
A-04-11-07023

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.

Office of Investigations

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 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. For beneficiary stays incurring extraordinarily high costs, section 1886(d)(5)(A) of the Act provides for additional payments (called outlier payments) to Medicare-participating hospitals.

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.

South Miami Hospital (the Hospital) is a 381-bed acute care hospital located in South Miami, Florida. Medicare paid the Hospital approximately \$116 million for 9,695 inpatient and 43,524 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 \$4,285,321 in Medicare payments to the Hospital for 69 inpatient and 76 outpatient claims that we identified as potentially at risk for billing errors. These 145 claims had dates of service in CYs 2009 and 2010 (2 of these claims involved an anticancer drug and had dates of service in CY 2011).

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 85 of the 145 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, of 145 sampled claims, 60 claims had errors, resulting in overpayments totaling \$468,323 for CYs 2009 and 2010. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims. Additionally, we set aside \$21,292 of the Hospital's liability insurance claim as it awaits adjudication by a Medicare Secondary Payer Recovery Contractor (MSPRC).

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$468,323 in overpayments,
- strengthen controls to ensure full compliance with Medicare billing requirements, and
- follow the MSPRC's final determination regarding the \$21,292 set aside.

SOUTH MIAMI HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations. The Hospital also stated that it had taken immediate corrective actions to identify additional claims that it billed incorrectly using Healthcare Common Procedure Coding System code J9171. We acknowledge the Hospital's efforts to conduct its own review of additional claims outside of our original sample. However, because the Hospital identified the billing problem as a result of our audit, we expanded our original sample to include additional claims. The Hospital also asked for clarification on the exact amount of the overpayment and asked for contact information to resolve the amount we set aside. The Medicare contractor will advise the Hospital whether any adjustments to the overpayment amount are appropriate. We provided the Hospital with the contact information requested. The Hospital's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System.....	1
Hospital Payments at Risk for Incorrect Billing.....	2
Medicare Requirements for Hospital Claims and Payments	2
South Miami Hospital.....	3
OBJECTIVE, SCOPE, AND METHODOLOGY	3
Objective.....	3
Scope.....	3
Methodology.....	3
FINDINGS AND RECOMMENDATIONS	4
BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS	5
Inpatient Claims Billed With High Severity Level Diagnosis-Related Group Codes ...	5
Inpatient Short Stays	6
Inpatient Claims With Payments Greater Than \$150,000	6
BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS	7
Outpatient Claims With Payments Greater Than \$25,000.....	7
Outpatient Claims for Anticancer Drug Billed With HCPCS Code J9171	7
Outpatient Manufacturer Credits for Replaced Medical Devices.....	7
Outpatient Claims Billed With Modifier -59	8
RECOMMENDATIONS	8
SOUTH MIAMI HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	9
APPENDIX	
SOUTH MIAMI 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. 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. For beneficiary stays incurring extraordinarily high costs, section 1886(d)(5)(A) of the Act provides for additional payments (called outlier payments) to Medicare-participating hospitals.

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

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.

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.

identify and group the services within each APC group. All services and items within an APC group are comparable clinically and require comparable resources.

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 billed with high severity level DRG codes,
- inpatient short stays,
- inpatient claims with payments greater than \$150,000,
- inpatient hospital-acquired conditions and present on admission indicator reporting,
- inpatient claims for blood clotting factor drugs,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims with payments greater than \$25,000,
- outpatient claims for the anticancer drug billed with HCPCS code J9171, and
- outpatient claims billed with modifier -59.

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.

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.

South Miami Hospital

South Miami Hospital (the Hospital) is a 381-bed acute care hospital located in South Miami, Florida. Medicare paid the Hospital approximately \$116 million for 9,695 inpatient and 43,524 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 \$4,285,321 in Medicare payments to the Hospital for 145 claims that we judgmentally selected as potentially at risk for billing errors. These 145 claims had dates of service in CYs 2009 and 2010 and consisted of 69 inpatient and 76 outpatient claims (2 of these claims involved an anticancer drug and had dates of service in CY 2011).

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 July 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;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers 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 an initial judgmental sample of 125 claims, which we expanded during the audit to 145 claims (69 inpatient and 76 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 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 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 objective.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 85 of the 145 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, of 145 sampled claims, 60 claims had errors, resulting in overpayments totaling \$468,323 for CYs 2009 and 2010. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of

Medicare claims. Additionally, we set aside \$21,292 of the Hospital's liability insurance claim as it awaits adjudication by a Medicare Secondary Payer Recovery Contractor (MSPRC).

Of the 69 sampled inpatient claims, 11 had billing errors resulting in overpayments totaling \$57,261:

- For inpatient claims billed with high severity level DRG codes, the Hospital billed Medicare with incorrect DRG codes (six errors totaling \$41,817 in overpayments).
- For inpatient short stays, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient (three errors totaling \$14,449 in overpayments).
- For inpatient claims with payments greater than \$150,000, the Hospital submitted claims to Medicare with incorrect charges that resulted in incorrect outlier payments (two errors totaling \$995 in overpayments).

Of the 76 sampled outpatient claims, 49 had billing errors resulting in overpayments totaling \$411,062:

- For outpatient claims with payments greater than \$25,000, the Hospital submitted claims to Medicare with incorrect HCPCS codes (14 errors totaling \$1,488 in overpayments).
- For outpatient claims for the anticancer drug billed with HCPCS code J9171, the Hospital submitted claims to Medicare with incorrect units of service (24 errors totaling \$368,437 in overpayments).
- For outpatient manufacturer credits for replaced medical devices, the Hospital did not obtain a credit for a replaced device that was available under the terms of the manufacturer's warranty (one error totaling \$24,125 in overpayments).
- For outpatient claims billed with modifier -59, the Hospital incorrectly billed for HCPCS codes that did not require modifier -59 (7 errors totaling \$14,874 in overpayments) or contained incorrect HCPCS codes (3 errors totaling \$2,138 in overpayments).

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 11 of 69 sampled inpatient claims. These errors resulted in overpayments totaling \$57,261.

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 or services that "are not reasonable and necessary for 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.”

The *Medicare Secondary Payer Manual*, Pub. No. 100-05, chapter 2, section 40, states, “Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan (including a self-insured plan).” In addition, section 40.1 states, “Medicare has a statutory direct right of recovery from the liability insurance as well as any entity that has received payment directly or indirectly from the proceeds of a liability insurance payment.”

For 6 of the 32 sampled claims billed with high severity level DRGs, the Hospital billed Medicare with incorrectly coded DRGs. The Hospital stated that the incorrect coding occurred because of human error. As a result, the Hospital received overpayments totaling \$41,817.

Additionally, we set aside \$21,292 for potential adjudication by an MSPRC. This set aside corresponds to a claim in which the Hospital may have primary payer responsibility because the admission resulted from an injury sustained while the patient was in the Hospital emergency department.

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.”

For 3 of the 11 sampled claims, the Hospital incorrectly billed Medicare for inpatient stays that it should have billed as outpatient. The Hospital attributed the incorrect admissions to human error. As a result, the Hospital received overpayments totaling \$14,449.⁴

Inpatient Claims With Payments Greater Than \$150,000

The Manual, chapter 3, section 10, states that a hospital may bill only for services provided. 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 the two sampled claims, the Hospital submitted claims to Medicare with incorrect charges that resulted in incorrect outlier payments. For one claim, the Hospital did not bill for units of service or supplies that were supported by the medical records, which resulted in an underpayment. For the other claim, the Hospital billed for units of service and supplies that were not supported by the medical records, which resulted in an overpayment. The Hospital attributed these incorrect charges to human error. As a result, the Hospital received net overpayments totaling \$995.

⁴ The Hospital may bill Medicare Part B for a limited range of services related to some of the incorrectly billed Medicare Part A short stay claims. For two of three claims, we were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been adjudicated by the MAC prior to issuance of our report.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 49 of 76 sampled outpatient claims. These errors resulted in overpayments totaling \$411,062.

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, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 14 of the 18 sampled claims, the Hospital submitted claims to Medicare using incorrect HCPCS codes. The Hospital stated that these incorrect billings occurred because of human error. As a result, the Hospital received overpayments totaling \$1,488.

Outpatient Claims for Anticancer Drug Billed With HCPCS Code J9171

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. In addition, chapter 4, section 20.4, states, “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For 24 of the 28 sampled claims, the Hospital submitted claims to Medicare with incorrect service units for HCPCS code J9171 (Docetaxel injection, a drug used in the treatment of cancer). The Hospital stated that these errors occurred because the conversion factor used to calculate the service units associated with this drug was incorrect on the charge master.⁵ As a result, the Hospital received overpayments totaling \$368,437.

Outpatient Manufacturer Credits for Replaced Medical Devices

Federal regulations (42 CFR § 419.45) require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device.

Prudent Buyer Principle

Under 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services” CMS’s *Provider Reimbursement Manual*, part 1, section 2102.1, states:

⁵ A hospital charge master contains the prices of all services, goods, and procedures for which a separate charge exists. It is used to generate a patient’s bill.

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

Section 2103 of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example:

Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacture for full or partial credits or payments available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.

For one of the seven sampled claims, the Hospital did not obtain a credit for a replaced device that was available under the terms of manufacturer's warranty. The Hospital stated the incorrect billing occurred because of human error. As a result, the Hospital received an overpayment of \$24,125.

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 10 of the 23 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that did not require modifier -59 (7 claims) or contained incorrect HCPCS codes (3 claims). The Hospital stated that these incorrect billings occurred because of human error. As a result, the Hospital received overpayments totaling \$17,012.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$468,323 in overpayments,
- strengthen controls to ensure full compliance with Medicare billing requirements, and
- follow the MSPRC's final determination regarding the \$21,292 set aside.

SOUTH MIAMI HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations. The Hospital also stated that it had taken immediate corrective actions to identify additional claims that it billed incorrectly using HCPCS code J9171. We acknowledge the Hospital's efforts to conduct its own review of additional claims outside of our original sample. However, because the Hospital identified the billing problem as a result of our audit, we expanded our original sample to include additional claims. The Hospital also asked for clarification on the exact amount of the overpayment and asked for contact information to resolve the amount we set aside. The Medicare contractor will advise the Hospital whether any adjustments to the overpayment amount are appropriate. We provided the Hospital with the contact information requested. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX



**South Miami
Hospital**

BAPTIST HEALTH SOUTH FLORIDA

6855 Red Road
Miami, FL 33143
Tel: 786-662-7352
Fax: 786-662-7002
www.baptisthealth.net

March 5, 2012

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

Report Number: A-04-11-07023

Dear Ms. Pilcher:

Thank you for the opportunity to review and provide comments regarding the report entitled "Medicare Compliance Review of South Miami Hospital for Calendar Years 2009 and 2010." As your report indicates, the review was conducted for nine specific types of payments that have been identified as at risk for error. These payments were identified by the Office of Inspector General (OIG) using computer matching, data mining, and analysis techniques. After careful review of the draft report, South Miami Hospital would like to submit the following comments.

Executive Summary

The Executive Summary discusses the scope of the audit as payments to the hospital that are at risk for noncompliance with Medicare billing requirements. The original sample was distributed across nine risk areas where, according to the OIG, errors are likely. For three of these risk areas, no errors were identified. In fact, the vast majority, 79%, of the overpaid dollars can be attributed to one error that affected multiple claims in the sample; a sample that was expanded once the error was identified.

The Executive Summary states rather broadly that the "overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims." This statement could, in fact, be read as an assessment of all internal controls that exist related to Medicare billing and it is with this potential misperception that we respectfully take issue. It is not until further along, within the body of the complete report, that it is noted that the OIG "...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..." and that "This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted..." (See Scope.)

South Miami Hospital acknowledges the errors that were identified through this claim review and has taken the appropriate actions to remedy any weaknesses identified. The hospital respectfully submits, however, that the assessment of internal controls, as stated in the Executive Summary, should take into account the nature of the review, i.e. areas prone to error, and the fact that this review is not an "overall assessment" of all claims billed to the Medicare program.

March 5, 2012
Ms. Lori S. Pilcher
Page 2

Claims Sampled

The original sample requested by the OIG consisted of 125 inpatient and outpatient claims. At the direction of the OIG, South Miami Hospital conducted its own review of the sampled claims to determine whether the services were billed correctly. It was determined through this review that an error had been made when billing for the drug represented by HCPCS code J9171. South Miami Hospital took immediate corrective action, which included the identification of any claims outside of the OIG's sample that may have been overpaid. The hospital self-identified 12 additional claims. The hospital began the refund process for these accounts and voluntarily identified these errors to the OIG during the on-site review. The OIG then selected an additional sample of eight claims, for which no overpayments were identified.

Throughout the report, the sample is reported as 145, with no mention that a portion of this sample was voluntarily identified by the hospital and that this portion had been pre-determined as containing errors, thereby increasing the total number of claim exceptions. Likewise, prior to the OIG's review, the hospital had self-initiated refunds for these self-identified claims; an estimated \$180,000 of the total estimated overpayment.

Overpayment Amount

The draft report states that the hospital received \$468,323 in overpayments. According to the most recent schedule provided to the hospital by the OIG, the total amount of identified overpayments was \$466,332. We also note that since the time of the review, adjustments required under the Affordable Care Act have been applied by the Medicare Administrative Contractor to some of the accounts, affecting the amount paid by the Medicare program. Finally, as discussed above, at the time of the review re-payment requests were already underway for approximately \$180,000 of the total estimated by the OIG, leaving an estimated overpayment \$286,000. For these reasons, we respectfully request that the overpayment amount be referred to as an estimated overpayment. We also request an updated schedule of payment discrepancies.

Recommendations

In regard to the recommendations included in the draft report, South Miami Hospital offers the following comments.

- Refund to the Medicare program \$468,323 in overpayments

South Miami Hospital will take the appropriate actions to refund any overpayments received, taking into consideration that the total amount refunded may vary from the amount above, due to factors that may impact the actual amount due to the Medicare program.

- Strengthen controls to ensure full compliance with Medicare billing requirements

South Miami Hospital is committed to accurate submission of claims to the Medicare program. To this end, auditing, monitoring, and educational activities are conducted on a regular basis. These efforts focus on those areas that are identified as at risk by the OIG and other regulatory agencies. South Miami Hospital will continue to emphasize accurate claim submission as a part of the organization's corporate compliance program.

Analysis of the claims identified as errors demonstrates that 79% of the overpayments were related to a single error which occurred when establishing the conversion factor for the HCPCS drug J9171. This factor was needed in order to convert the units of the drug that were administered to the billing units reportable for the HCPCS code. To remedy this situation, the following steps were taken:

March 5, 2012
Ms. Lori S. Pilcher
Page 3

- The conversion factor in the charge master was immediately corrected.
 - Any claims outside of the OIG sample that may have been incorrectly paid were immediately identified and reviewed.
 - Steps were immediately taken to begin the process required to return any overpayments identified for the self-identified claims to the Medicare program.
 - All existing drug conversion factors loaded in the charge master were reviewed, including the conversion factors loaded for every drug reported with any HCPCS code.
 - The process for review and approval of drug conversion factors was reviewed and improved to include a two step process for validation of conversion factor calculation and entry.
 - Monitoring reports that identify any claims submitted with drug billing units exceeding a defined threshold were implemented and a process was defined for review of any items that meet the selection criteria.
- Follow the Medicare Secondary Payer Recovery Contractor (MSPRC) final determination regarding the \$21,292 set aside

South Miami Hospital will work with the MSPRC to achieve resolution regarding the \$21,292 set aside. To this end, please provide the contact information for the appropriate party at the MSPRC.

South Miami Hospital is committed to accurate submission of claim information to the Medicare program. Auditing, monitoring, and education regarding the complexities of billing for services rendered will continue as part of the organization's ongoing emphasis on implementing, testing, and monitoring the effectiveness of internal controls. When errors are discovered, the appropriate actions will continue to be taken to remedy the cause of the error and to return any inappropriate payments that may have been received. It is through these activities that South Miami Hospital will continue its commitment to processes which support the accurate submission of claim data.

If you need any further information or if I can provide any further assistance, do not hesitate to contact me.

Sincerely,

/Karen Brady/

Karen Brady
Corporate Vice President and Chief Compliance Officer