



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



April 12, 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 Bay Medical Center for Calendar Years 2009 and 2010 (A-04-11-08006) and Medicare Compliance Review of Kent County Hospital for Calendar Years 2009 and 2010 (A-01-11-00537)

Attached, for your information are advance copies of two of our final reports for hospital compliance reviews. We will issue these reports to Bay Medical Center and Kent County Hospital 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:

Bay Medical Center

Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV
(404) 562-7750, email – Lori.Pilcher@oig.hhs.gov

Page 2 – Peter Budetti and Deborah Taylor

Kent County Hospital

Michael J. Armstrong, Regional Inspector General for Audit Services, Region I
(617) 565-2684, email – Michael.Armstrong@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

April 16, 2012

Report Number: A-04-11-08006

Mr. Steven M. Johnson
Chief Executive Officer
Bay Medical Center
615 North Bonita Avenue
Panama City, FL 32401

Dear Mr. Johnson:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Bay 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 Truman Mayfield, Audit Manager, at (850) 942-8900, extension 22, or through email at Truman.Mayfield@oig.hhs.gov. Please refer to report number A-04-11-08006 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 BAY
MEDICAL CENTER FOR CALENDAR YEARS
2009 AND 2010**



Daniel R. Levinson
Inspector General

April 2012
A-04-11-08006

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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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.

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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.

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.

Bay Medical Center (the Hospital) is a 323-bed acute care hospital located in Panama City, Florida. Medicare paid the Hospital approximately \$173.2 million for 16,824 inpatient and 160,149 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 \$2,937,881 in Medicare payments to the Hospital for 197 claims that we judgmentally selected as potentially at risk for billing errors. These 197 claims had dates of service in CYs 2009 and 2010 and consisted of 182 inpatient and 15 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 149 of the 197 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare

billing requirements for the remaining 48 claims, resulting in overpayments totaling \$289,846 for CYs 2009 and 2010. Specifically, 43 inpatient claims had billing errors, resulting in net overpayments totaling \$271,373, and 5 outpatient claims had billing errors, resulting in net overpayments totaling \$18,473. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims, and its staff did not fully understand Medicare billing requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$289,846,
- strengthen controls to ensure full compliance with Medicare requirements, and
- provide training to its staff members to improve understanding of Medicare billing requirements.

BAY MEDICAL CENTER COMMENTS

In written comments on our draft report, Bay Medical Center concurred with our recommendations. Bay Medical Center stated that it had corrected all amounts identified as errors in the report and had submitted amended claims to its fiscal intermediary in accordance with CMS guidelines. Bay Medical Center further stated that it had strengthened its controls and provided additional training to accounts payable department staff, coders, and case management personnel. Bay Medical Center'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 contractors to, among other things, process and pay claims submitted by hospitals.¹

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for 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 involving 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 is 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

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.

group the services within each APC group.³ 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 identified included payments for claims billed for:

- inpatient transfers,
- inpatient claims for blood clotting factor drugs,
- inpatient claims with same day discharge and readmission,
- inpatient claims for short stays,
- inpatient claims billed with high-severity level DRG codes,
- inpatient claims paid in excess of charges, and
- inpatient and outpatient claims involving manufacturer credits for replaced medical devices.

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.

³ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

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.

Bay Medical Center

Bay Medical Center (the Hospital) is a 323-bed acute care hospital located in Panama City, Florida. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$173.2 million for 16,824 inpatient and 160,149 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010.

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 \$2,937,881 in Medicare payments to the Hospital for 197 claims that we judgmentally selected as potentially at risk for billing errors. These 197 claims had dates of service in CYs 2009 and 2010 and consisted of 182 inpatient and 15 outpatient claims.

We focused our review on the risk areas 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. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on select risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We performed fieldwork at the Hospital from June through November 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 replaced 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 a judgmental sample of 197 claims (182 inpatient and 15 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 provided by the Hospital 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 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 149 of the 197 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in overpayments totaling \$289,846 for CYs 2009 and 2010. Specifically, 43 inpatient claims had billing errors, resulting in net overpayments totaling \$271,373, and 5 outpatient claims had billing errors, resulting in net overpayments totaling \$18,473.

Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims, and its staff did not fully understand Medicare billing requirements.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 43 of the 182 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$271,373.

Incorrectly Billed Discharges With Subsequent Readmissions

The Manual, chapter 3, section 40.2.5, states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay on a single claim.

For 17 of 182 sampled inpatient claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. For example, a patient was treated to declot a fistula then discharged to receive dialysis. Upon treatment for dialysis, the fistula reclotted and the patient was readmitted for declotting. In all 17 sampled claims, the original claim and the claim involving subsequent readmission were related to the same medical condition(s) and should have been billed as a continuous stay. However, the Hospital did not adjust the original claim by combining the original and subsequent admissions onto a single claim, as the Manual requires.

The Hospital stated that these errors occurred for the following reasons:

- For eight claims, the Hospital moved the patients to another location within the hospital for a different type of care but billed the relocations as transfers and readmissions due to a billing system problem.
- For six claims, the Hospital's physician advisor had concluded that the admissions should have been combined. The information was put into the computerized system, but there was no notation in the billing system notifying the Hospital's Billing Department staff that a prior determination was made by the physician advisor to combine the admissions.
- For three claims, human error resulted in the Hospital's physician advisor not being notified for a determination regarding the readmission.

As a result, the Hospital received overpayments totaling \$103,711.

Incorrect Diagnosis-Related Groups

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 to improve the functioning of a malformed body member. 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 182 sampled inpatient claims, the Hospital submitted claims to Medicare with incorrect DRG codes. The Hospital stated that these incorrect claims occurred because of coding errors, such as selecting incorrect procedure or diagnosis codes that were not supported by the medical records and improperly interpreting guidance for selecting a principal diagnosis. Additionally, some of these claims were coded based on the Coding Clinic⁴ in effect at the time service was rendered. A revised Coding Clinic was issued that changed the way to code a service. Although it is the Hospital's practice to retroactively rebill claims that were rendered incorrect by a retroactive change in the Coding Clinic, a few claim corrections were missed. As a result, the Hospital was underpaid a total of \$12,504 (2 claims) and received overpayments totaling \$75,026 (12 claims).

Missing or Unauthenticated Admission Orders

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, "with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment"

For 10 of 182 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for inpatient claims that did not have a valid physician's order to admit the beneficiary to inpatient care. The Hospital stated that these errors occurred because key controls broke down due to inadequate followup by the staff or due to physicians failing to include a signed admission order in the medical records. As a result, the Hospital received overpayments totaling \$104,571.

Incorrect Reporting of Medical Device Credits

Federal regulations (42 CFR § 412.89) require reductions in the inpatient prospective payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

The Manual, chapter 3, section 100.8, states that to bill correctly for a replacement device that was provided with a credit, the hospital must code its Medicare claims with a combination of condition codes 49 or 50 along with value code "FD."

⁴ The American Hospital Association's *Coding Clinic* is a quarterly publication that provides answers and clarifications for all kinds of ICD-9-CM coding questions.

For 1 of 182 sampled inpatient claims, the Hospital received a reportable medical device credit for a replaced right ventricle lead from a manufacturer. However, the Hospital did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required. The Hospital stated that this error was caused by human error, staff turnover, and the education process. As a result, the Hospital received an overpayment totaling \$5,800.

Incorrect Billing for Costs of Furnishing Blood Clotting Factor Drugs

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. Chapter 3, section 20.7.3.A, states that hospitals receive an add-on payment for the costs of furnishing blood clotting factors to certain Medicare beneficiaries and that the provider must use revenue code 636 so that the clotting factor charges are not included in the cost outlier computations.

For 1 of 182 sampled inpatient claims, the Hospital submitted a claim to Medicare with incorrect revenue code 250 instead of revenue code 636, which caused the clotting factor charges to be included in the cost outlier computations. The difference between the cost outlier and the add-on payment computations resulted in an underpayment. The Hospital stated that this error occurred because both its software program and the internal spreadsheet did not include specific details for calculating the additional payment when blood clotting factor drugs are administered to Hemophilia patients. As a result, the Hospital received an underpayment totaling \$5,231.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 5 of 15 sampled outpatient claims, resulting in overpayments totaling \$18,473.

Incorrect Healthcare Common Procedure Coding System Codes

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 4 of 15 sampled outpatient claims, the Hospital billed Medicare with incorrect HCPCS codes. The Hospital stated that these coding errors occurred because the coders did not realize the procedures charged did not meet the criteria for coding, and the description of the service in the medical record was not clear. As a result, the Hospital received overpayments totaling \$1,557.

Incorrect Reporting of Medical Device Credits

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.

CMS guidance in *Transmittal 1103*, dated November 3, 2006, and the Manual explain how a provider should report no-cost and reduced-cost devices under the OPDS. For services furnished on or after January 1, 2007, CMS requires the provider to report the “FB” modifier and reduce charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device.

For 1 of 15 sampled outpatient claims, the Hospital received a full credit for a replaced device but did not report the “FB” modifier or reduce charges on its claim. The Hospital stated that this error occurred due to human error, staff turnover, and the education process. As a result, the Hospital received an overpayment totaling \$16,916.

RECOMMENDATIONS

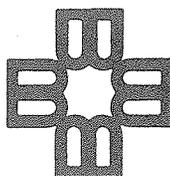
We recommend that the Hospital:

- refund to the Medicare contractor \$289,846,
- strengthen controls to ensure full compliance with Medicare requirements, and
- provide training to its staff members to improve understanding of Medicare billing requirements.

BAY MEDICAL CENTER COMMENTS

In written comments on our draft report, Bay Medical Center concurred with our recommendations. Bay Medical Center stated that it had corrected all amounts identified as errors in the report and had submitted amended claims to its fiscal intermediary in accordance with CMS guidelines. Bay Medical Center further stated that it had strengthened its controls and provided additional training to accounts payable department staff, coders, and case management personnel. Bay Medical Center’s comments are included in their entirety as the Appendix.

APPENDIX



BAY MEDICAL CENTER

February 22, 2012

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

Re:Report No. A-04-11-08006

Dear Ms. Pilcher:

On behalf of Bay Medical Center (“Bay”) and Steven M. Johnson, Chief Executive Officer of Bay, please accept these comments to the Department of Health & Human Services (“DHHS”), Office of Inspector General (“OIG”) draft report entitled Medicare Compliance Review of Bay Medical Center for Calendar Years 2009-2010.

Bay constantly strives to eliminate billing errors. While Bay would have preferred that no errors were identified, we note that our error rate is extremely low for these types of claims that otherwise have been universally identified by DHHS/OIG as suspected of having high error rates.

We concur with the three report recommendations and note the following with regard to those recommendations:

1. We agree that Bay was overpaid as stated in the Report by \$289,846. During our self-audit, however we identified \$130,061.27 of this amount prior to OIG’s review. All of the amounts identified as errors in the report have been corrected and amended claims have been submitted to our fiscal intermediary, First Coast Services Options (“FCSO”) in accordance with CMS guidelines. It is our understanding that this process will be completed as soon as the final report to this examination is issued by the OIG and transmitted to FCSO.

2. With regard to the recommendation to strengthen controls, Bay devotes a significant amount of resources to maintain accurate and effective controls. We are constantly making improvements to our documentation and billing processes and related controls. We will continue to do so. The following corrective actions have been taken to strengthen controls:

615 North Bonita Avenue, Panama City, Florida 32401 • 850-769-1511

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As a result of the audit, Bay has strengthened its internal processes surrounding explanted medical devices, requiring the collaboration of clinical, billing and procurement departments. Additionally, we have reviewed and revised our PriceWaterhouseCoopers SMART software edits so as to flag charts that contain the erroneously coded DRGs & HCPC codes identified in the audit. With regard to same day re-admissions, we have developed new protocols so that there is better communication between our physician advisor and our billing department.

3. With regard to the recommendation to provide training to staff members, Bay continuously provides education and training to our staff involved in the coding and billing processes. We also provide automated tools and reference resources in order to maintain current knowledge of the ever changing and complex Medicare coding and billing requirements. We will continue to do so. The following corrective actions have been taken subsequent to the period covered by the OIG audit:

We have provided additional education to our accounts payable department staff regarding warranty credits for explanted devices. Similarly, we have provided additional education to our coders regarding the DRGs & HCPC codes that were identified in the audit. Additionally, case management personnel have been given additional education regarding inpatient admission criteria, as well as the proper documentation of patient discharge status. Lastly, we have developed a procedure to identify and manually review claims that include blood clotting factors.

It has always been and will continue to be our intent to file accurate, complete, and timely Medicare claims with the objective of having no errors or need for adjustments.

Thank you for assisting us by identifying areas for our continuous improvement activities and for the opportunity to provide this commentary.

Sincerely,



Steven M. Johnson, CEO

cc: Mike West, Corporate Compliance Officer, Bay Medical Center