



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



June 29, 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: Palmetto General Hospital (A-04-11-07025) and West Florida Hospital (A-04-11-08010)

Attached, for your information are advance copies of two of our final reports for hospital compliance reviews. We will issue these reports to Palmetto General Hospital and West Florida 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 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

July 5, 2012

Report Number: A-04-11-08010

Mr. Dennis A. Taylor
President & CEO
West Florida Hospital
8383 North Davis Highway
Pensacola, FL 32514

Dear Mr. Taylor:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of West Florida 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 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-04-11-08010 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
WEST FLORIDA HOSPITAL FOR
CALENDAR YEARS 2009 AND 2010**



Daniel R. Levinson
Inspector General

July 2012
A-04-11-08010

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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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 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.

West Florida Hospital (the Hospital) is a 547-bed acute care hospital located in Pensacola, Florida. Medicare paid the Hospital approximately \$117.5 million for 13,881 inpatient and 93,553 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 \$2,021,049 in Medicare payments to the Hospital for 208 claims that we judgmentally selected as potentially at risk for billing errors. These 208 claims had dates of service in CYs 2009 and 2010 and consisted of 200 inpatient and 8 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 151 of the 208 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare

billing requirements for the remaining 57 claims, resulting in overpayments totaling \$172,995 for CYs 2009 and 2010. Specifically, 55 inpatient claims had billing errors, resulting in overpayments totaling \$144,555, and 2 outpatient claims had billing errors, resulting in overpayments totaling \$28,440. 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 \$172,995,
- strengthen controls to ensure full compliance with Medicare requirements, and
- provide training to its staff members to improve understanding of Medicare billing requirements.

WEST FLORIDA HOSPITAL COMMENTS

In written comments on our draft report, West Florida Hospital concurred with our recommendations. West Florida Hospital stated that it has implemented corrective action plans and intends to be in compliance with all regulations, policies, and procedures of the Medicare Program. West Florida Hospital's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare 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.

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 group the services within each APC group.³ All services and items within an APC group are comparable clinically and require comparable resources.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC). This transition occurred 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.

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 claims paid in excess of charges,
- inpatient transfers,
- inpatient psychiatric facility interrupted stays,
- inpatient psychiatric facility emergency department adjustments,
- inpatient claims with same day discharges and readmissions,
- inpatient claims for short stays,
- inpatient claims billed with high-severity level DRG codes, 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.

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.

West Florida Hospital

West Florida Hospital (the Hospital) is a 547-bed acute care hospital located in Pensacola, Florida. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$117.5 million for 13,881 inpatient and 93,553 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 \$2,021,049 in Medicare payments to the Hospital for 208 claims that we judgmentally selected as potentially at risk for billing errors. These 208 claims had dates of service in CYs 2009 and 2010 and consisted of 200 inpatient and 8 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 September 2011 through February 2012.

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 208 claims (200 inpatient and 8 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 151 of the 208 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 57 claims, resulting in overpayments totaling \$172,995 for CYs 2009 and 2010. Specifically, 55 inpatient claims had billing errors, resulting in overpayments totaling \$144,555, and 2 outpatient claims had billing errors, resulting in overpayments totaling \$28,440.

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 55 of the 200 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$144,555.

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 11 of 200 sampled inpatient claims, the Hospital submitted claims to Medicare with incorrect diagnosis codes that resulted in incorrect DRG codes. The Hospital stated that these errors occurred due to inconsistent application of official coding guidelines and because coders did not always initiate queries when the medical record documentation was unclear or conflicting. As a result, the Hospital received overpayments totaling \$57,992.

Incorrectly Billed as Inpatient or Without a Valid Physician Order

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if, “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” 42 CFR § 424.13(a) states that “Medicare Part A pays for inpatient hospital services ... only if a physician certifies and recertifies,” among other things, the reasons for continued hospitalization.

For 7 of 200 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for inpatient claims that either did not have a valid physician’s order to admit the beneficiary to inpatient care or should have been billed as outpatient. The Hospital stated that these errors occurred because of human error and high staff turnover. As a result, the Hospital received overpayments totaling \$46,683.

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 3 of 200 sampled inpatient claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. In each of these instances, the original claim and the claim involving subsequent readmission were related to the same medical condition and thus 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.

The Hospital stated that these errors occurred because of human error. As a result, the Hospital received overpayments totaling \$13,423.

Incorrectly Billed Transfers

Federal regulations (42 CFR § 412.4(c)) state that a discharge of a hospital inpatient is considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to a skilled nursing facility or 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. 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 4 of 200 sampled inpatient claims, 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 as a transfer either to a skilled nursing facility or to home under a written plan of care for the provision of home health services. However, the Hospital incorrectly coded the discharge status to home; thus the Hospital should have received the per diem payment instead of the full DRG. The Hospital indicated that it has policies in place to correctly assign the discharge status code based on information available in the patient's medical record and believes that human error caused these incorrect codings. As a result, the Hospital received overpayments totaling \$14,420.

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."

For 2 of 200 sampled inpatient claims, the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required. The Hospital stated that these errors were caused by a lack

of communication and documentation between hospital departments. Additionally, coordination and communication between the departments were not completed in a timely manner. As a result, the Hospital received overpayments totaling \$10,000.

Incorrect Source-of-Admission for Inpatient Psychiatric Stays

Pursuant to 42 CFR § 412.424, CMS adjusts the Federal per diem rate upward for the first day of a Medicare beneficiary's inpatient psychiatric facility (IPF) stay to account for the costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary used emergency department services. However, the IPF should not receive the additional payment if the beneficiary was discharged from the acute-care section of the same hospital.

The Manual, chapter 3, section 190.6.4.1, states that source-of-admission "D" is reported by IPFs to identify IPF patients who have been transferred to the IPF from the same hospital. An IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 28 of 200 sampled inpatient claims, the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to the IPF upon discharge from the acute care section of the same hospital. The patient access registrar normally determines the correct admission source. However, the Hospital stated that the source-of-admission was miscoded because of human error in selecting the admission source code. As a result, the Hospital received overpayments totaling \$2,037.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 2 of 8 sampled outpatient claims, resulting in overpayments totaling \$28,440.

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 OPPS. 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 2 of 8 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 these errors were caused by a lack of communication and documentation between hospital

departments. Additionally, coordination and communication between the departments were not completed in a timely manner. As a result, the Hospital received an overpayment totaling \$28,440.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$172,995,
- strengthen controls to ensure full compliance with Medicare requirements, and
- provide training to its staff members to improve understanding of Medicare billing requirements.

WEST FLORIDA HOSPITAL COMMENTS

In written comments on our draft report, West Florida Hospital concurred with our recommendations. West Florida Hospital stated that it has implemented corrective action plans and intends to be in compliance with all regulations, policies, and procedures of the Medicare Program. West Florida Hospital's comments are included in their entirety as the Appendix.

APPENDIX



May 31, 2012

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 West Florida Hospital
For Calendar Years 2009 and 2010

Dear Ms. Pilcher:

This letter is provided in response to your correspondence dated May 2, 2012, regarding the above referenced audit of selected Medicare inpatient and outpatient claims submitted by West Florida Hospital (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 seven (7) areas cited in the audit report:

- Inpatient-Incorrect Diagnosis-Related Groups
- Inpatient-Incorrectly Billed as Inpatient Without a Valid Physician Order
- Inpatient-Incorrectly Billed Discharges With Subsequent Readmissions
- Inpatient-Incorrectly Billed Transfers
- Inpatient-Incorrect Reporting of Medical Device Credits
- Inpatient-Incorrect Source-of-Admission for Psychiatric Stays
- Outpatient-Reporting of Medical Device Credits

1) INPATIENT INCORRECT DIAGNOSIS-RELATED GROUPS

The audit report concluded that the Hospital billed Medicare with incorrect DRG codes on eleven (11) of the sampled claims, and recommends that the Hospital Refund overpayments related to these claims in the amount of \$57,992.00.

West Florida
HOSPITAL

West Florida
REHABILITATION
INSTITUTE

West Florida
PAVILION

A. State of Concurrence:

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

B. Corrective Action Taken or Planned:

This incorrect coding occurred due to inconsistent application of official coding guidelines and because coders did not always initiate queries when the medical record documentation was unclear or conflicting. 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.

2) INPATIENT INCORRECTLY BILLED WITHOUT A VALID PHYSICIAN ORDER

The audit report concluded that the Hospital incorrectly billed Medicare Part A for inpatient claims that either did not have a valid physician's order to admit the beneficiary to inpatient care or should have been billed as outpatient on seven (7) of the sampled claims, and recommends that the Hospital Refund overpayments related to these claims in the amount of \$46,683.00.

A. State of Concurrence:

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

B. Corrective Action Taken or Planned:

This incorrect coding occurred due to human error and high staff turnover. The Hospital implemented a plan which included:

1. All inpatient and observation/outpatient cases that have a bed assignment will have a review completed by the unit case manager.
2. The medical record will be reviewed for status order and physician signature on this order. Any discrepancy in status order will be clarified by the physician.
3. The InterQual admission criteria review will be completed and documented for all Medicare inpatient admissions. If the criteria is not met for the patient status ordered, the case will be referred to the physician advisor for review.

3) INPATIENT INCORRECTLY BILLED DISCHARGES WITH SUBSEQUENT READMISSIONS

The audit report concluded that the Hospital did not combine the original and subsequent stay on a single claim for discharges and readmissions within the same day on three (3) of the sampled claims, and recommends that the Hospital Refund overpayments related to these claims in the amount of \$13,423.00.

A. State of Concurrence:

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

B. Corrective Action Taken or Planned:

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

1. These accounts will continue to be identified daily, and are now being routed to the Revenue Integrity Department for review.
2. Revenue Integrity Department to do a Quarterly Focused Review to ensure process is working appropriately and will report results to facility CFO.

4) INPATIENT INCORRECTLY BILLED TRANSERS

The audit report concluded that the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers on four (4) of the sampled claims, and recommends that the Hospital Refund overpayments related to these claims in the amount of \$14,420.00.

A. State of Concurrence:

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

B. Corrective Action Taken or Planned:

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

1. As a quality improvement measure, the HIM department has established a pre-bill review of inpatient accounts. Discharge dispositions are included in quality reviews performed by External Vendor.
2. Continue to work with Case Management identifying discharge disposition discrepancies as well as continue to monitor the Data Exchange Tool.
3. Case Management, Coders, and Physicians will be retrained on the need for accurate and timely documentation of the expected discharge disposition of the

patient. They will be reminded of the intent and importance of discharged disposition documentation.

4. Case Management, Coders, and Physicians will be re-educated on the CMS regulations regarding the Post Acute Transfer Rule.

5) INPATIENT INCORRECTLY REPORTING OF MEDICAL DEVICE CREDITS

The audit report concluded that the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required on two (2) of the sampled claims, and recommends that the Hospital Refund overpayments related to these claims in the amount of \$10,000.00.

A. State of Concurrence:

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

B. Corrective Action Taken or Planned:

This incorrect reporting occurred due to errors that were caused by a lack of communication and documentation between hospital departments. The Hospital implemented a plan which included:

1. Hospital Revenue Integrity Department has established a standardized process for the facility to follow when a device has been provided at reduced cost to the facility.
2. The department responsible for obtaining the warranty/no cost/reduced cost device will submit a form to Revenue Integrity for each individual account where one of these devices is used. This form will indicate specifically what is being provided and the nature of the credit being received (whether it is a partial credit or replacement item under warranty, etc.).
3. Facility will hold monthly meeting with directors of Cath Lab, OR, Revenue Integrity, Supply Chain and the CFO to review invoices for AICD/pacemakers/leads utilized during a given month to review all devices that were placed to insure that invoices for these items received matches the charges present on individual accounts.

6) INPATIENT INCORRECT SOURCE-OF-ADMISSION FOR PSYCHIATRIC STAYS

The audit report concluded that the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to the IPF upon discharge from the acute care section of the same hospital on twenty-eight (28) of the sampled claims, and recommends that the Hospital Refund overpayments related to these claims in the amount of \$2,037.00.

A. State of Concurrence:

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

B. Corrective Action Taken or Planned:

This incorrect coding occurred as a result of human error in selecting the admission source code. The Hospital implemented a plan which included:

1. An HCA compliance edit has been put into place to capture potential admission source accounts. These accounts are identified and routed back to the facility patient access management staff for review daily.
2. All applicable patient access registration staff were re-educated regarding admission source D.
3. The Patient Access Admitting Supervisor reviews all internal transfers daily to ensure the correct admission source is selected.

7) OUTPATIENT REPORTING OF MEDICAL DEVICE CREDITS

The audit report concluded that the Hospital received a full credit for a replaced device but did not report the "FB" modifier or reduce charges on its claim on two (2) of the sampled claims, and recommends that the Hospital Refund overpayments related to these claims in the amount of \$28,440.00.

A. State of Concurrence:

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

B. Corrective Action Taken or Planned:

This error occurred as a result of lack of communication and documentation between hospital departments. The Hospital implemented a plan which included:

1. Hospital Revenue Integrity Department has established a standardized process for the facility to follow when a device has been provided at reduced cost to the facility.
2. The department responsible for obtaining the warranty/no cost/reduced cost device will submit a form to Revenue Integrity for each individual account where one of these devices is used. This form will indicate specifically what is being provided and the nature of the credit being received (whether it is a partial credit or replacement item under warranty, etc.).
3. Facility will hold monthly meeting with directors of Cath Lab, OR, Revenue Integrity, Supply Chain and the CFO to review invoices for AICD/pacemakers/leads utilized during a given month to review all devices that were placed to insure that invoices for these items received matches the charges present on individual accounts.

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We appreciate the OIG's audit review for the 2009 and 2010 years. It is West Florida Hospital's intent to be in compliance with all regulations and policies & procedures of the Medicare Program. West Florida Hospital acknowledges the overpayment of \$172,995 identified in the recommendations section of the audit report.

If you need additional information, please contact me at (850) 494-4125.

Sincerely,

/Randy Butler/

Randy Butler
Chief Financial Officer

RB:em