

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**BAPTIST MEDICAL CENTER SOUTH
COMPLIED WITH MOST MEDICARE
REQUIREMENTS FOR BILLING
INPATIENT AND OUTPATIENT
SERVICES FOR CALENDAR YEARS 2009
AND 2010**

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Office of Inspector General

<https://oig.hhs.gov>

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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, intended to be 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 hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis of claims. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Baptist Medical Center South (the Hospital) is a 454-bed, faith-based, not-for-profit medical center located in Montgomery, Alabama. Medicare paid the Hospital approximately \$140 million for 13,772 inpatient and 49,539 outpatient claims for services provided to beneficiaries during calendar years (CYs) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$19,605,843 in Medicare payments to the Hospital for 2,536 claims that were potentially at risk for billing errors. We selected a stratified random sample of 222 claims with payments totaling \$2,995,571 for review. These 222 claims had dates of service in CYs 2009 and 2010 and consisted of 163 inpatient claims and 59 outpatient claims.

OBJECTIVE

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

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 179 of the 222 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 43 claims resulting in net overpayments totaling \$242,514. Specifically, 33 inpatient claims had billing errors resulting in net overpayments totaling \$115,089, and 10 outpatient claims had billing errors resulting in overpayments totaling \$127,425.

These overpayments occurred primarily because the technical requirements of coding and complicated medical record interpretations resulted in coding errors, and the Hospital did not have adequate controls in place to ensure full compliance with Medicare requirements within the selected risk areas that contained errors.

Based on our stratified random sample results, we estimated that the Hospital received overpayments totaling at least \$1,784,982 for CYs 2009 and 2010.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$1,784,982 in estimated overpayments for CY 2009 and 2010 claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare requirements.

BAPTIST MEDICAL CENTER SOUTH COMMENTS

In written comments on our draft report, the Hospital did not agree entirely with our first recommendation. It agreed that it did not fully comply with Medicare billing requirements for 43 of the 222 sampled inpatient and outpatient claims with net overpayments totaling \$242,514 and stated that it is processing the necessary adjustments through its Medicare Administrative Contractor. However, the Hospital disagreed with our extrapolating the sample results to the sampling frame and recommending a refund of \$1,784,982 in estimated overpayments for CYs 2009 and 2010. The Hospital stated that extrapolation was not in concert with conversations that occurred with onsite auditors and lacked notice and due process and that OIG had not, to date, used extrapolation in previously published compliance reviews. In regard to our second recommendation, the Hospital discussed steps it had taken or planned to take to strengthen its internal controls to ensure compliance with Medicare billing requirements.

OFFICE OF INSPECTOR GENERAL RESPONSE

During the course of the audit, we discussed with a Hospital official our plans to use statistical sampling. As the hospital compliance review initiative has matured, we have refined our audit methodologies. Some reviews use statistical sampling and estimation techniques to draw conclusions about a larger portion of a hospital's claims while other reviews use judgmental

sampling. Each hospital review is unique, and the sampling method used in each of these reviews will vary. For this reason, we review different risk areas at different hospitals and use both statistical and nonstatistical methods for selecting our samples.

We acknowledge that most previously published compliance reviews did not use statistical sampling and estimation. However, we maintain that the statistical sampling and estimation techniques planned and used for this review are statistically valid methodologies that we have used successfully to identify overpayments. Therefore, we continue to recommend that the Hospital refund to the Medicare program \$1,784,982 in estimated overpayments for the audit period.

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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.

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, intended to be 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. 106-113.¹ 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.² All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis of claims. Examples of the types of claims at risk for noncompliance included:

¹ In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

- inpatient short stays,
- inpatient claims paid in excess of charges,
- outpatient claims with payments greater than \$25,000,
- inpatient claims billed with high-severity-level DRG codes, and
- inpatient and outpatient manufacturer credits for replaced medical devices.

For the 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 types of 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 or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” In addition, 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 the 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.

Baptist Medical Center South

Baptist Medical Center South (the Hospital) is a 454-bed, faith-based, not-for-profit medical center located in Montgomery, Alabama. Medicare paid the Hospital approximately \$140 million for 13,772 inpatient and 49,539 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 types of claims.

Scope

Our audit covered \$19,605,843 in Medicare payments to the Hospital for 2,536 claims that were potentially at risk for billing errors. We selected a stratified random sample of 222 claims with payments totaling \$2,995,571 for review. These 222 claims had dates of service in CYs 2009 and 2010 and consisted of 163 inpatient claims and 59 outpatient claims.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and did not include a focused 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 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 from July to November 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 stratified random sample of 222 claims (163 inpatient and 59 outpatient) totaling \$2,995,571 for detailed review (Appendix A);

- 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 DRG, HCPCS, and admission status codes for 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;
- used the results of the sample review to calculate the estimated Medicare overpayment to the Hospital (Appendix B); 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 objectives.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 179 of the 222 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 43 claims resulting in net overpayments totaling \$242,514. Specifically, 33 inpatient claims had billing errors resulting in net overpayments totaling \$115,089, and 10 outpatient claims had billing errors resulting in overpayments totaling \$127,425.

These overpayments occurred primarily because the technical requirements of coding and complicated medical record interpretations resulted in coding errors, and the Hospital did not have adequate controls in place to ensure full compliance with Medicare requirements within the selected risk areas that contained errors.

Based on our stratified random sample results, we estimated that the Hospital received overpayments totaling at least \$1,784,982 for CYs 2009 and 2010. See Appendix A for details

on our sample design and methodology and Appendix B for details on our sample results and estimates.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 33 of 163 inpatient claims that we reviewed. These errors resulted in net overpayments totaling \$115,089.

Incorrectly Billed as Inpatient

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 15 of 163 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital indicated that these errors occurred because the technical requirements of coding and complicated medical record interpretations resulted in coding errors. As a result, the Hospital received overpayments totaling \$102,263.³

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 or to improve the functioning of a malformed body member.” Chapter 1, section 80.3.2.2, of the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately....”

For 14 of 163 inpatient claims, the Hospital submitted claims to Medicare with incorrect DRG codes. Two of these incorrectly coded claims resulted in underpayments. The Hospital indicated that these errors occurred because the technical requirements of coding and complicated medical record interpretations resulted in coding errors. As a result, the Hospital received net overpayments totaling \$6,892.

Incorrect Reporting of Medical Device Credits

Federal regulations (42 CFR § 412.89) require a reduction in the IPPS 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 correctly bill for a replacement device that was provided with a credit, the hospital

³ The Hospital may be able to bill Medicare Part B for some services related to some of these incorrect Medicare Part A 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 billed or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

must code its Medicare claims with a combination of condition code 49 or 50, along with value code “FD.”

Prudent Buyer Principle

Pursuant to 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services....” The CMS *Provider Reimbursement Manual* (PRM), part 1, section 2102.1, states:

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.A of the PRM further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties for medical devices. 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/manufacturer for full or partial credits 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 4 of 163 inpatient claims, the Hospital either received a reportable medical device credit from a manufacturer for a malfunctioning device but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required (1 error) or did not obtain a credit for a replaced device that was available under the terms of the manufacturer’s warranty (3 errors). Three of these claims also contained DRG errors.⁴ The Hospital stated that these errors occurred because it did not have a formal process in place to ensure that it requested, received, and reported all available credits. As a result, the Hospital received net overpayments totaling \$5,934. The Hospital implemented new procedures during our review to ensure that it properly requests and reports manufacturer credits.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 10 of 59 outpatient claims that we reviewed. These errors resulted in overpayments totaling \$127,425.

⁴ For sampled claims that contained more than one type of error, the total claim overpayment was used for error estimation. We did not estimate errors on the same claim twice.

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.

Billing Requirements for Medical Device Credits

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, 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 modifier “FB” and reduced 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. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.

Medicare providers are expected to pursue free replacement or reduced charges for replaced medical devices under warranty.⁵

For 10 of 59 outpatient claims, the Hospital either received full credit for replaced devices but did not report the “FB” modifier and reduced charges on its claims (3 errors) or did not obtain a credit for a replaced device that was available under the terms of the manufacturer’s warranty (7 errors). The Hospital stated that these errors occurred because it did not have a formal process in place to ensure that it requested, received, and reported all available credits. As a result, the hospital received overpayments totaling \$127,425. The Hospital implemented new procedures for ensuring the proper requesting and reporting of manufacturers’ credits during our review.

OVERALL ESTIMATE OF OVERPAYMENTS

Based on our stratified random sample results, we estimated that the Hospital received overpayments totaling at least \$1,784,982 for CYs 2009 and 2010. See Appendix A for details on our sample design and methodology and Appendix B for details on our sample results and estimates.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$1,784,982 in estimated overpayments for CY 2009 and 2010 claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare requirements.

⁵ 42 CFR § 413.9 and the PRM, part 1, sections 2102.1, 2103.A, and 2103.C.4.

BAPTIST MEDICAL CENTER SOUTH COMMENTS

In written comments on our draft report, the Hospital did not agree entirely with our first recommendation. It agreed that it did not fully comply with Medicare billing requirements for 43 of the 222 sampled inpatient and outpatient claims with net overpayments totaling \$242,514 and stated that it is processing the necessary adjustments through its Medicare Administrative Contractor. However, the Hospital disagreed with our extrapolating the sample results to the sampling frame and recommending a refund of \$1,784,982 in estimated overpayments for CYs 2009 and 2010. The Hospital stated that extrapolation was not in concert with conversations that occurred with onsite auditors and lacked notice and due process and that OIG had not, to date, used extrapolation in previously published compliance reviews. In regard to our second recommendation, the Hospital discussed steps it had taken or planned to take to strengthen its internal controls to ensure compliance with Medicare billing requirements. The Hospital's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

During the course of the audit, we discussed with a Hospital official our plans to use statistical sampling. As the hospital compliance review initiative has matured, we have refined our audit methodologies. Some reviews use statistical sampling and estimation techniques to draw conclusions about a larger portion of a hospital's claims while other reviews use judgmental sampling. Each hospital review is unique, and the sampling method used in each of these reviews will vary. For this reason, we review different risk areas at different hospitals and use both statistical and nonstatistical methods for selecting our samples.

We acknowledge that most previously published compliance reviews did not use statistical sampling and estimation. However, we maintain that the statistical sampling and estimation techniques planned and used for this review are statistically valid methodologies that we have used successfully to identify overpayments. Therefore, we continue to recommend that the Hospital refund to the Medicare program \$1,784,982 in estimated overpayments for the audit period.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population is inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during CYs 2009 and 2010.

SAMPLING FRAME

According to CMS's National Claims History (NCH) data, Medicare paid the Hospital \$139,892,596 for 13,772 inpatient and 49,539 outpatient claims for services provided to beneficiaries during CYs 2009 and 2010.

We downloaded a database of claims from the NCH data totaling \$78,611,199 for 6,617 inpatient and 17,187 outpatient claims in 30 high-risk categories.

From this initial sampling frame we selected claims from 5 high-risk categories consisting of 6,026 claims totaling \$61,307,775 for further refinement.

We then removed the following:

- all \$0 paid claims,
- all claims under review by the Recovery Audit Contractor, and
- all duplicate claims within individual high-risk categories.

We assigned each claim that appeared in multiple high-risk categories to just one category based the following hierarchy: Inpatient and Outpatient Manufacturer Credits for Replaced Medical Devices, Inpatient Short Stays, and Inpatient Claims Paid in Excess of Charges. The resulting database contained 2,536 unique Medicare claims in 5 high-risk categories totaling \$19,605,843, from which we drew our sample.

Medicare High-Risk Areas Sampled

Medicare High-Risk Area	Number of Claims	Amount of Payments
1. Inpatient Short Stays	2,037	\$13,793,351
2. Inpatient Claims Paid in Excess of Charges	60	853,665
3. Outpatient Claims With Payments Greater Than \$25,000	30	853,893
4. Inpatient Claims Billed With High-Severity-Level DRG Codes	357	3,167,728
5. Inpatient and Outpatient Manufacturer Credits for Replaced Medical Devices	52	937,206
Total	2,536	\$19,605,843

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into five strata based on the Medicare risk category.

SAMPLE SIZE

We selected 222 claims as follows:

Sampled Claims by Stratum

Stratum	Medicare High-Risk Area	Sample Size
1	Inpatient Short Stays	60
2	Inpatient Claims Paid in Excess of Charges	30
3	Outpatient Claims With Payments Greater Than \$25,000	30
4	Inpatient Claims Billed With High-Severity-Level DRG Codes	50
5	Inpatient and Outpatient Manufacturer Credits for Replaced Medical Devices	52
	Total Sampled Claims	222

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata 1, 2, and 4. After generating the random numbers for these strata, we selected the corresponding frame items. We selected all claims in strata 3 and 5.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of improper Medicare payments in our sampling frame for the Hospital for CYs 2009 and 2010.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
Stratum 1	2,037	\$13,793,351	60	\$327,778	17	\$86,842
Stratum 2	60	853,665	30	438,234	5	26,769
Stratum 3	30	853,893	30	853,893	0	0
Stratum 4	357	3,167,728	50	438,460	5	13,138
Stratum 5	52	937,206	52	937,206	16	115,765
Total	2,536	\$19,605,843	222	\$2,995,571	43	\$242,514

ESTIMATES

Estimated Value of Overpayments for CY 2009 and 2010
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	\$3,064,066
Lower limit	1,784,982 ¹
Upper limit	4,383,056

¹ In accordance with OAS policy, we did not use the results from strata 2 and 4 in calculating the estimated overpayments. Instead, we added the actual overpayments from strata 2 and 4 (\$39,907) to the lower limit (\$1,745,075), which resulted in an adjusted lower limit of \$1,784,982.

APPENDIX C: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Under / Over-payments	Value of Net Over-payments
Inpatient				
Short Stays	60	\$327,778	17	\$86,842
Claims Paid in Excess of Charges	30	438,234	5	26,769
Claims Billed With High-Severity-Level Diagnosis-Related Group Codes	50	438,460	5	13,138
Manufacturer Credits for Replaced Medical Devices	23	451,992	6	(11,660)
Inpatient Totals	163	\$1,656,464	33	\$115,089
Outpatient				
Manufacturer Credits for Replaced Medical Devices	29	\$485,214	10	\$127,425
Claims With Payments Greater Than \$25,000	30	853,893	0	0
Outpatient Totals	59	\$1,339,107	10	\$127,425
Inpatient and Outpatient Totals	222	\$2,995,571	43	\$242,514

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at Baptist Medical Center South. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX D: BAPTIST MEDICAL CENTER SOUTH COMMENTS



301 Brown Springs Road
Montgomery, AL 36117
334.273.4442

April 26, 2013

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

Dear Ms. Pilcher:

Baptist Medical Center South ("BMCS" or "Hospital") appreciates the opportunity to comment on the U.S. Department of Health and Human Services, Office of the Inspector General ("OIG") draft report entitled, *Baptist Medical Center South Complied with Most Medicare Requirements for Billing Inpatient and Outpatient Services for Calendar Years 2009-2010*. BMCS is committed to complying with all regulations and standards governing Federal health care programs, improving internal controls and proactively auditing and monitoring to minimize the risk of errors.

BMCS's responses to the OIG's specific findings and recommendations are set forth below. Unless otherwise stated, BMCS accepts the OIG's findings and is processing the necessary adjustments through its Medicare Administrative Contractor.

Inpatient Short Stays

OIG Finding:

For 15 of 163 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. As a result, the Hospital received overpayments totaling \$102,263.

Hospital Comments:

BMCS has continued to strengthen its controls in this area through education and utilization of a collaborative approach of physicians, case managers and secondary physician advisors to review cases in selection of the appropriate level of care and inpatient determination. BMCS and the Compliance Department will continue to provide education and monitor and audit inpatient short stay admissions and remediate identified errors.

Inpatient Claims Billed with High-Severity-Level DRG Codes

OIG Finding:

For 14 of 163 inpatient claims, the Hospital submitted claims to Medicare with incorrect DRG codes. Two of these incorrectly coded claims resulted in underpayments. As a result, the Hospital received net overpayments totaling \$6,892.

Hospital Comments:

BMCS has adequate policies and coding controls in place and will continue to provide coding education and monitoring in addition to the expansion of its clinical documentation improvement program. Additionally, this category is listed for focused review by the Compliance department as part of continued process improvement.

Inpatient and Outpatient Manufacturer Credits for Replaced Medical Devices

OIG Findings:

For 4 of 163 inpatient claims, the Hospital either received a reportable medical device credit from a manufacturer for a malfunctioning device but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required (1 error) or did not obtain a credit for a replaced device that was available under the terms of the manufacturer's warranty (3 errors). Three of these claims also contained DRG errors. As a result, the Hospital received net overpayments totaling \$5,934.

For 10 out of 59 outpatient claims, the Hospital either received full credit for replaced devices but did not report the "FB" modifier and reduced charges on its claims (3 errors) or did not obtain a credit for a replaced device that was available under the terms of the manufacturer's warranty (7 errors). As a result, the hospital received overpayments totaling \$127, 425.

Hospital Comments:

As identified in the OIG's report, BMCS has implemented controls and established an operational process for identification, classification and application of appropriate inpatient and outpatient manufacturer credits on medical devices. Additionally, education has been provided and the Cardiac Catherization Laboratory and Compliance department will continue to monitor and audit the process.

BMCS would like to respectfully note that the OIG's selection of extrapolation for this compliance review was not in concert with conversations that occurred with onsite auditors and lacked notice and due process. Additionally, the OIG has not, to date, utilized extrapolation as part of its audit methodology in previously published compliance reviews, including those for which error rates and overpayment amounts in each reviewed category were the same or higher than the BMCS findings.

Despite the above chosen methodology, BMCS takes seriously its obligations to appropriately interpret and bill services and appreciates the opportunity to learn from items highlighted in the review and will continue to use the outcomes for further process improvement.

Sincerely,

/Rebekah M. Stewart/

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Baptist Health

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