

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW
OF CHRISTUS SANTA ROSA
HOSPITAL FOR THE
PERIOD JANUARY 1, 2010,
THROUGH JUNE 30, 2012**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Office of Inspector General

<https://oig.hhs.gov>

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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.

INTRODUCTION

Christus Santa Rosa Hospital did not fully comply with Medicare requirements for billing inpatient short stays, resulting in overpayments of at least \$1,192,275 over 2½ years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that are at risk for noncompliance with Medicare billing requirements. For this review, we focused on inpatient stays of 1 day or less (short stays). Our previous work at other hospitals found that a significant proportion of inpatient short stays would more appropriately be billed as outpatient or outpatient with observation services, which generally result in lower reimbursement than inpatient stays.

OBJECTIVE

Our objective was to determine whether Christus Santa Rosa Hospital (the Hospital) complied with Medicare requirements for billing inpatient short stays.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for beneficiaries after they are discharged from hospitals. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers Medicare.

CMS contracts with Medicare Administrative Contractors (MACs) to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). 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.

Medicare Requirements for Hospital Claims and Payments

Medicare provides Part A coverage for medically ordered inpatient hospital services. Factors to be considered when making the decision to admit include such things as: (1) the severity of signs and symptoms exhibited by the patient, (2) the medical predictability of something adverse happening to the patient, and (3) the need for diagnostic studies that appropriately are Part B outpatient services to assist in assessing whether the patient should be admitted.¹

CHRISTUS SANTA ROSA HOSPITAL

The Hospital is an accredited, comprehensive inpatient and outpatient services hospital serving South Texas. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$10 million for 1,790 inpatient short-stay claims with dates of service from January 1, 2010, through June 30, 2012 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our review covered \$1,987,423 in Medicare payments to the Hospital for 342 inpatient short-stay claims with dates of service during the audit period that we identified as potentially at risk for billing errors. We selected a stratified random sample of 100 claims for review. We submitted all sampled claims to an independent medical review contractor to determine whether the services were medically necessary. This report focuses on one selected risk area and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement. Appendix A contains the details of our audit scope and methodology, Appendix B contains our sample design and methodology, and Appendix C contains our sample results and estimates.

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

The Hospital complied with Medicare inpatient billing requirements for 30 of the 100 short-stay claims we reviewed. However, the Hospital did not fully comply with Medicare inpatient billing requirements for the remaining 70 claims.

The Social Security Act (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” (§ 1862(a)(1)(A)).

¹ The *Medicare Benefit Policy Manual* (Publication No. 100-02), chapter 1, § 10, “Inpatient Hospital Services Covered Under Part A.”

In addition, the Act precludes payment to any provider of services without information necessary to determine the amount due the provider (§ 1815(a)).

The Act also 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” (§ 1814(a)(3)).

Federal regulations state: “Medicare Part A pays for inpatient hospital services . . . only if a physician certifies” the need for such services (42 CFR § 424.13(a)).

The Hospital incorrectly billed Medicare Part A for inpatient beneficiary stays that should have been billed as outpatient or outpatient with observation services (61 errors). Specifically, our independent medical review contractor determined that inpatient admission was not medically necessary for these beneficiaries. Additionally, the Hospital incorrectly billed Medicare for DRG codes that were not supported by the medical record (7 errors) or the medical record did not include a signed and dated physician order (2 errors). As a result of these errors, the Hospital received overpayments of \$446,289.²

Based on our sample results, we estimated that the Hospital received at least \$1,192,275 in overpayments from Medicare. The Hospital did not provide a cause for the overpayments because it did not agree that it had made these billing errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$1,192,275 in estimated overpayments for the audit period and
- strengthen controls to ensure full compliance with Medicare requirements for billing short stays.

CHRISTUS SANTA ROSA HOSPITAL COMMENTS

In written comments on our draft report, the Hospital disagreed with our first recommendation. Specifically, the Hospital disagreed with our findings on 56 of the 70 inpatient short-stay claims and stated: “Immediately upon learning of the medical contractor’s results, CSRH [the Hospital] had the claims at issue re-reviewed. . . . Independent physician experts concluded that CSRH

² The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. 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 and adjudicated by the MAC prior to the issuance of our draft report.

had properly billed 56 of the 70 claims that were deemed noncompliant by the OIG.” The Hospital added that it intends to dispute the claims at issue through the MAC appeals process.

Additionally, the Hospital disagreed with the decision to extrapolate the results. It stated: “As acknowledged in the draft report, some portion of the alleged overpayment may be properly billable under Medicare Part B. . . . As such, the amount of the actual overpayment based on the sample claims reviewed is yet to be determined.” The Hospital requested that we not refer the estimated overpayment to the MAC for collection. The Hospital stated that an MAC may only base a notice of overpayment on extrapolated results when “there has been a prior determination of sustained or high level of payment error or documentation that educational intervention has failed to correct the payment error.”

Concerning our second recommendation, the Hospital discussed steps it had taken to ensure that its inpatient short-stay billings are consistent with the existing regulations.

The Hospital’s comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital’s comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether the claims met medical necessity requirements. The contractor examined all of the medical records and documentation originally submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractor’s conclusions, we determined that 61 claims should have been billed as outpatient or outpatient with observation services, 7 claims were not supported by the medical records, and 2 claims did not include a signed and dated physician order in the medical record.

In response to the Hospital’s concerns regarding its ability to rebill for certain services that were denied as part of this review, we acknowledge its comments; however, the rebilling issue is beyond the scope of our audit. After the completion of our audit, CMS issued the final regulations on payment policies (78 Fed. Reg. 160 (Aug. 19, 2013)). The Hospital should contact its MAC for rebilling instructions. In addition, we maintain that the statistical sampling and estimation techniques planned and used for this review are statistically valid methodologies that we use to identify overpayments. The statutory provision cited by the Hospital that prohibits the use of extrapolation applies only to MACs; it does not apply to OIG. Therefore, we continue to recommend that the Hospital refund to the Medicare program \$1,192,275 in estimated overpayments for the audit period.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

AUDIT SCOPE

Our review covered \$1,987,423 in Medicare payments to the Hospital for 342 inpatient short-stay claims with dates of service from January 1, 2010, through June 30, 2012, that we identified as potentially at risk for billing errors. We selected a stratified random sample of 100 claims for review.

We evaluated compliance with selected inpatient short-stay billing requirements and submitted all sampled claims to an independent medical review contractor to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to inpatient short stays 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 one selected risk area and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

Our fieldwork included contacting the Hospital, located in San Antonio, Texas, from January through July 2013.

AUDIT METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient short-stay claim data from CMS's National Claims History file with dates of service during our audit period;
- used computer matching, data mining, and data analysis techniques to identify claims that were potentially at risk for noncompliance with selected Medicare requirements;
- selected a stratified random sample of 100 claims totaling \$754,583 for detailed review (Appendix B);
- 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 medical record documentation provided by the Hospital to support the sampled claims;

- used an independent medical review contractor to determine whether the 100 sampled claims met medical necessity requirements;
- discussed the incorrectly billed claims with Hospital personnel to attempt 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 estimate the Medicare overpayments to the Hospital (Appendix C); 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.

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

Population

The population consisted of selected inpatient short stays paid to the Hospital for claims with dates of service during our audit period.

Sampling Frame

We extracted the Hospital's inpatient short-stay claim data from CMS's National Claims History file. The database contained 1,790 claims with dates of service during our audit period. We performed data analysis to identify claims we felt were most at risk for improper payment. As a result, the sampling frame included 342 claims totaling \$1,987,423.

Sample Unit

The sample unit was a claim.

Sample Design

We used a stratified random sample. We stratified the sample frame into three strata based on the payment amounts.

Sample Size

We selected 100 claims for review as follows:

Strata	Payment Amount Range	Claims in Sample Frame	Claims in Sample
1	\$0.00 through \$4,344.99	141	33
2	\$4,345.00 through \$8,512.99	155	33
3	\$8,513.00 and over	46	34
	TOTAL	342	100

Source of Random Numbers

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

Method of Selecting Sample Units

We consecutively numbered the claims within each stratum. After generating the random numbers for each stratum, we selected the corresponding frame items.

Estimation Methodology

We used the OIG/OAS statistical software for stratified random samples to estimate the total amount of Medicare overpayments paid to the Hospital during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	141	\$490,840	33	\$120,102	25	\$91,666
2	155	875,041	33	180,070	26	133,680
3	46	621,542	34	454,412	19	220,943
Total	342	\$1,987,423	100	\$754,583	70	\$446,289

Estimated Overpayments

(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	\$1,318,479
Lower Limit	\$1,192,275
Upper Limit	\$1,444,683

APPENDIX D: CHRISTUS SANTA ROSA HOSPITAL COMMENTS



January 8, 2014

Patricia Wheeler
Regional Inspector General for Audit Services
Office of Audit Services, Region VI
1100 Commerce Street, Room 623
Dallas, Texas 75242

Re: DRAFT- Medicare Compliance Review of CHRISTUS Santa Rosa Hospital for the Period January 1, 2010 through June 30, 2012. (Report Number: A-06-12-00068)

Dear Ms. Wheeler:

I write to respond to the Office of Inspector General (OIG) draft report titled: *Medicare Compliance Review of CHRISTUS Santa Rosa Hospital for the Period January 1, 2010, through June 30, 2012*. CHRISTUS Santa Rosa Hospital (CSRH) appreciates the opportunity to comment on the OIG's draft report. We are committed to complying with all regulations and standards governing federal health care programs and welcome the opportunity to comment on the report and embrace opportunities to improve our programs in order to minimize the risk of non-compliant claims.

Background:

OIG conducted a national initiative focused on certain risk areas for hospitals across the country. CSRH was not selected for review based on any improper billing or compliance practices. The OIG's national initiative has resulted in the publication of Medicare Compliance reports for nearly 70 hospitals across the country.

With regard to CSRH, the OIG focused its review on the Medicare requirements for billing inpatient short-stays. The audit covered 342 inpatient short-stay claims (\$1,987,423 in Medicare payments) which the OIG had identified as potentially at risk for billing errors. The OIG drew a sample of those claims (100)¹ and retained a medical review contractor to determine whether the services for those claims were medically necessary.

OIG Findings:

The OIG draft report found that CSRH complied with Medicare inpatient-billing requirements for 30 of the 100 short-stay claims reviewed. It further concluded that CSRH did not fully comply with Medicare inpatient-billing requirements for the remaining 70 claims because it incorrectly

¹ The draft report does not indicate how the OIG identified certain claims to be "at risk for billing errors." The lack of such information prevents CSRH from adequately analyzing the sampling methodology used in this case.

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billed Medicare Part A for inpatient beneficiary stays that should have been billed as outpatient or outpatient with observation services.

Based on these findings, the OIG concluded that CSRH received an overpayment of \$446,289. However, the OIG specifically acknowledged that the hospital may be able to bill Medicare Part B for all services that would have been reasonable and necessary had the beneficiary been treated as an outpatient. Thus, the actual amount of overpayment is yet to be determined.

As will be discussed in the section to follow, the uncertainty of the overpayment is relevant because the OIG findings include an extrapolated damages calculation of \$1,192,275.

CSRH Response to OIG Findings:

CSRH does not agree with all of the OIG's findings. Immediately upon learning of the medical review contractor's results, CSRH had the claims at issue re-reviewed by an independent, nationally recognized consultant which is made up of physician reviewers who are expert in Medicare rules and regulations. These independent physician experts concluded that CSRH had properly billed 56 of the 70 claims that were deemed noncompliant by the OIG. Consistent with those findings, CSRH maintains that only 14 of the 100 claims reviewed were improperly billed.

CSRH will refund the overpayment due on the Medicare Part A claims; and, to the extent possible, it will re-submit the 14 claims for payment under Medicare Part B. With regard to the remaining 56 claims, CSRH requests that the OIG reconsider those findings for the reasons set forth below.

According to the CSRH experts, the government's medical review contractor's process appears inconsistent with Generally Accepted Government Auditing standards. Most notably, CSRH's consultant identified a pattern of inconsistency in the application of the Medicare billing standards. Specifically, the Hospital's expert reviewers identified claims with similar patient histories which had inconsistent findings--*i.e.*, some claims were found to be properly payable while others were not. Further, there may have been instances where the government's reviewers substituted their judgment for the real time judgment of the physician caring for the patient, even though the medical documentation did not support it. Finally, there appear to be instances where the government's reviewers stated that the record lacked proper orders when in fact the orders did exist.

As noted in earlier correspondence with the audit team, CSRH welcomes the opportunity to meet and discuss each of the issues listed above. To the extent that is not possible, and the OIG draft findings become final, CSRH intends to dispute the claims through the Medicare Administrative Contractor (MAC) appeal process.

Finally, CSRH requests that the OIG reconsider its damages calculation based on extrapolation. As acknowledged in the draft report, some portion of the alleged overpayment may be properly billable under Medicare Part B. Further, as noted above, some of the denied claims are, in fact, properly payable. As such, the amount of the actual overpayment based on the sample claims

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reviewed is yet to be determined. Extrapolating from a sample with such uncertainty is not appropriate.

To the extent that the OIG determines to include the extrapolated damages amount in its final report, CSRH requests that the extrapolated damages calculations not be referred to the MAC for collection. A MAC may only base a notice of overpayment on extrapolated damages where there has been a prior determination of sustained or high level of payment error or documentation that educational intervention has failed to correct the payment error.² In this case, there has been no such finding.

CSRH Controls to Ensure Medicare Compliance:

CSRH is committed to taking the steps necessary to ensure that its inpatient short stay billings are consistent with the existing regulations. To that end, CSRH has put in place the procedures discussed below.

All patients are screened by Case Management or the House Supervisor for level of care appropriateness upon admission and prior to bed assignment. After discharge, any Medicare short- stays are re-screened prior to billing by Case Managers to ensure that they meet either Milliman or InterQual inpatient criteria. Additionally, a hospital billing check is in place to stop any Medicare short-stays from being billed without first having been subjected to a review for medical necessity. If upon screening, the case meets inpatient criteria, Case Management will approve it for billing. If it does not, CSRH will exclude the inpatient charges from the bill.

The hospital has also contracted with a nationally known consultant to assist Case Management and our physicians with appropriate level of care determinations. The consultant is available to CSRH at any point in the process (pre, during and post hospitalization) and provides physician-level medical necessity guidance.

Thank you for allowing us to respond to the draft report. CSRH recognizes its obligations to ensure that proper billing safeguards are in place and appreciates the opportunity to learn from the issues highlighted by this review.

Sincerely,



John Finley, Esq., MPH
VP, Corporate Compliance and Privacy
CHRISTUS Health

² See 42 U.S.C. §1395ddd (f)(3); Program Integrity Manual Chapter 8 §8.4.1.2 – The Purpose of Statistical Sampling.

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