



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



May 1, 2012

TO: Peter Budetti
Deputy Administrator and Director
Center for Program Integrity
Centers for Medicare & Medicaid Services

Deborah Taylor
Director and Chief Financial Officer
Office of Financial Management
Centers for Medicare & Medicaid Services

FROM: /Brian P. Ritchie/
Assistant Inspector General for the
Centers for Medicare & Medicaid Audits

SUBJECT: Medicare Compliance Review of Barnes Jewish Hospital for Calendar Years 2009 and 2010 (A-07-11-05014) and Medicare Compliance Review of Indiana University Health for the Period October 2008 Through September 2010 (A-05-11-00069)

Attached, for your information are advance copies of two of our final reports for hospital compliance reviews. We will issue these reports to Barnes Jewish Hospital and Indiana University Health within 5 business days.

These reports are part of a series of the Office of Inspector General's hospital compliance initiative, designed to review multiple issues concurrently at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov, or your staff may contact the respective Regional Inspectors General for Audit Services:

Barnes Jewish Hospital

Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII
(816) 426-3591, email – Patrick.Cogley@oig.hhs.gov

Indiana University Health

Sheri L. Fulcher, Regional Inspector General for Audit Services, Region V
(312) 353-2618, email – Sheri.Fulcher@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 VII
601 EAST 12TH STREET, ROOM 0429
KANSAS CITY, MO 64106

May 7, 2012

Report Number: A-07-11-05014

Mr. Carlos Brown
Compliance Director
Barnes Jewish Hospital
4901 Forest Park Avenue
Mail Stop 90-75-571
St. Louis, MO 63110

Dear Mr. Brown:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Barnes Jewish 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 at (816) 426-3591, or contact Scott Englund, Audit Manager, at (573) 893-8338, extension 27, or through email at scott.englund@oig.hhs.gov. Please refer to report number A-07-11-05014 in all correspondence.

Sincerely,

/Patrick J. Cogley/
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
BARNES JEWISH HOSPITAL
FOR CALENDAR YEARS
2009 AND 2010**



Daniel R. Levinson
Inspector General

May 2012
A-07-11-05014

Office of Inspector General

<http://oig.hhs.gov>

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

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

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.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital 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 inpatient costs associated with the beneficiary's stay.

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 outpatient and inpatient services.

Barnes Jewish Hospital (the Hospital) has 1,259 beds and is located in St. Louis, Missouri. Medicare paid the Hospital approximately \$660 million for 43,084 inpatient and 293,869 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$5,598,277 in Medicare payments to the Hospital for 34 outpatient and 206 inpatient claims that we identified as potentially at risk for billing errors for CYs 2009 and 2010. (Of these 240 claims, 222 had dates of service in CYs 2009 and 2010 and the remaining 18 claims, involving replacement medical devices, had dates of service in CYs 2008 and 2011.)

OBJECTIVE

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

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 182 of the 240 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 58 claims, resulting in overpayments totaling \$725,185 for CYs 2008 through 2011. Specifically, 24 outpatient claims had billing errors, resulting in overpayments totaling \$392,829, and 34 inpatient claims had billing errors, resulting in overpayments totaling \$332,356. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$725,185, consisting of \$392,829 in overpayments for the 24 incorrectly billed outpatient claims and \$332,356 in overpayments for the 34 incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations and described corrective actions taken.

The Hospital's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Hospital Outpatient Prospective Payment System	1
Hospital Inpatient Prospective Payment System	1
Hospital Payments at Risk for Incorrect Billing	2
Medicare Requirements for Hospital Claims and Payments	2
Barnes Jewish Hospital	3
OBJECTIVE, SCOPE, AND METHODOLOGY	3
Objective	3
Scope	3
Methodology	3
FINDINGS AND RECOMMENDATIONS	4
BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS	4
Outpatient Claims With Payments Greater Than \$25,000.....	5
Outpatient Manufacturer Credits for Medical Devices.....	5
Outpatient Claims Paid in Excess of Charges.....	6
BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS	6
Inpatient Claims With Payments Greater Than \$150,000	6
Inpatient Short Stays	6
Inpatient Manufacturer Credits for Medical Devices	7
Inpatient Claims Paid in Excess of Charges	7
Inpatient Claims Billed With High Severity Level Diagnosis-Related Groups	7
RECOMMENDATIONS	8
AUDITEE COMMENTS	8
APPENDIX	
AUDITEE COMMENTS	

INTRODUCTION

BACKGROUND

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

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.¹

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.

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. For beneficiary stays incurring extraordinarily high costs,

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

² In 2009, SCHIP was formally redesignated as the Children's Health Insurance Program.

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

section 1886(d)(5)(A) of the Act provides for additional payments (called outlier payments) to Medicare-participating hospitals.

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. Examples of the types of claims at risk for noncompliance included the following:

- outpatient claims with payments greater than \$25,000,
- outpatient and inpatient manufacturer credits for medical devices,
- outpatient and inpatient claims paid in excess of charges,
- inpatient claims with payments greater than \$150,000,
- inpatient zero and 1 day stays (short stays), and
- inpatient claims billed with high severity level DRGs.

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 outpatient and inpatient 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 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 3, section 10, of the Manual states that the hospital may bill only for services provided. In addition, chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

Barnes Jewish Hospital

Barnes Jewish Hospital (the Hospital) has 1,259 beds and is located in St. Louis, Missouri. Medicare paid the Hospital approximately \$660 million for 43,084 inpatient and 293,869 outpatient claims for services provided to Medicare 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 outpatient and inpatient services on selected claims.

Scope

Our audit covered \$5,598,277 in Medicare payments to the Hospital for 34 outpatient and 206 inpatient claims that we judgmentally selected as potentially at risk for billing errors. Of these 240 claims, 222 had dates of service in CYs 2009 and 2010. Eighteen of the 240 claims (involving replacement medical devices) had dates of service in CYs 2008 and 2011.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not use medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the outpatient and inpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

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

We conducted our fieldwork at the Hospital during July 2011 to January 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient and inpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;

- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2008, 2009, 2010, and 2011;
- 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 240 claims (34 outpatient and 206 inpatient) 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;
- discussed the incorrectly billed and/or coded claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- shared 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 182 of the 240 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 58 claims, resulting in overpayments totaling \$725,185 for CYs 2008 through 2011. Specifically, 24 outpatient claims had billing errors, resulting in overpayments totaling \$392,829, and 34 inpatient claims had billing errors, resulting in overpayments totaling \$332,356. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 24 of 34 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$392,829.

Outpatient Claims With Payments Greater Than \$25,000

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, section 20.4, states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For two out of five sampled claims, the Hospital billed Medicare for incorrect units of service. These two claims involved injections of Epoetin alfa, for which the service units involved specified dosages. Both claims were billed with 10,000 as the service units. However, because Epoetin alfa was administered in 1,000-unit billing increments and because the Hospital actually disbursed 10,000 units in each case, the number of billable service units should have been 10. The Hospital stated that these overpayments occurred due to a multiplier error between the pharmacy system and the charge description master. As a result of these errors, the Hospital received overpayments totaling \$185,722.

Outpatient Manufacturer Credits for Medical Devices

Federal regulations (42 CFR § 419.45) require a reduction in the OPSS 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 in the Manual explains how a provider should report no-cost and reduced-cost devices under the OPSS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and to reduce the 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.

Additionally, CMS guidance in Transmittal 1383, dated November 23, 2007, explains that for services furnished on or after January 1, 2008, CMS requires the provider to report the modifier “FC” on a claim that includes a procedure code for the insertion of a replacement device if the provider receives a credit from the manufacturer of 50 percent or more of the cost of the replacement device. Partial credits for less than 50 percent of the cost of a replacement device need not be reported with any modifier.

For 18 out of 21 sampled claims, the Hospital received either a full or a partial credit for a replaced medical device but did not report the “FB” or “FC” modifier or reduce charges on its claims. These overpayments occurred because the Hospital did not have adequate controls to report the appropriate modifiers and charges to reflect credits received from manufacturers. The Hospital stated that the issues contributing to the inadequacy of the controls were lack of specificity, distributed processes without central coordination, and limited stakeholder/participant knowledge of the full process. As a result of these errors, the Hospital received overpayments totaling \$150,639.

Outpatient Claims Paid in Excess of Charges

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, section 20.4, states: “The definition of service units ... is the number of times the service or procedure being reported was performed.” The Manual (chapter 4, sections 20.6 and 20.6.2) also instructs hospitals to use modifier 50 “... to report bilateral procedures that are performed at the same operative session as a single line item Do not submit two line items to report a bilateral procedure using modifier 50.”

For four out of eight sampled claims, the Hospital incorrectly billed Medicare with duplicate HCPCS codes (two claims) and incorrect units of service (two other claims). For two claims involving HCPCS code 61885, the Hospital used modifier 50 and in each case submitted two line items, rather than a single line item, for a bilateral procedure that was performed at the same operative session. For each of the other 2 claims, the Hospital billed 33 units of service when it should have billed 7 units of service. The Hospital stated that these overpayments occurred due to human error in coding these claims and because existing controls did not focus on the proper use of the multiplier for units of service. As a result of these errors, the Hospital received overpayments totaling \$56,468.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 34 of 206 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$332,356.

Inpatient Claims With Payments Greater Than \$150,000

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 3, section 10, states that a hospital may bill only for services provided.

Pursuant to 42 CFR § 412.80, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary.

For 6 out of 12 sampled claims, the Hospital submitted claims to Medicare with incorrect charges that resulted in incorrect outlier payments. The Hospital attributed these overpayments to a lack of controls. As a result of these errors, the Hospital received overpayments totaling \$132,036.

Inpatient Short Stays

Section 1862(a)(1)(A) of the Act states that no Medicare payment may 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 an individual may be made only to providers of services that are eligible and only if "... with respect to inpatient hospital services, which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment"

For 10 out of 111 sampled claims, the Hospital incorrectly billed Medicare for inpatient short stays that did not have valid physician orders for inpatient admission. The Hospital stated that these overpayments occurred due to insufficient general controls related to documentation quality, physician signatures, dates, and times that were primarily focused on areas other than admission orders. As a result of these errors, the Hospital received overpayments totaling \$80,437.

Inpatient Manufacturer Credits for Medical Devices

Federal regulations (42 CFR § 412.89) require reductions in the IPPS payments 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 must code its Medicare claims with a combination of condition code 49 or 50 along with value code "FD."

For 15 out of 42 sampled claims, the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claim with the appropriate value and condition codes to reduce payment as required. These overpayments occurred because the Hospital did not have adequate controls to report the appropriate value and condition codes in order to accurately reflect credits it had received from manufacturers. The Hospital stated that the issues contributing to the inadequacy of the controls were lack of specificity, distributed processes without central coordination, and limited stakeholder/participant knowledge of the full process. As a result of these errors, the Hospital received overpayments totaling \$72,965.

Inpatient Claims Paid in Excess of Charges

Section 1862(a)(1)(A) of the Act states that no Medicare payment may 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." The Manual, chapter 3, section 10, states: "The hospital may bill only for services provided." Finally, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For two out of eight sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that these overpayments occurred due to human error. As a result of these errors, the Hospital received overpayments totaling \$44,686.

Inpatient Claims Billed With High Severity Level Diagnosis-Related Groups

Section 1862(a)(1)(A) of the Act states that no Medicare payment may 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." The Manual, chapter 3, section 10, states: "The hospital may bill only for services provided." Finally, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For 1 out of 26 sampled claims billed with high severity level DRGs, the Hospital billed Medicare with an incorrectly coded DRG. The Hospital stated that this overpayment occurred due to human error. As a result of this error, the Hospital received an overpayment of \$2,232.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$725,185, consisting of \$392,829 in overpayments for the 24 incorrectly billed outpatient claims and \$332,356 in overpayments for the 34 incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations and described corrective actions taken.

The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: AUDITEE COMMENTS



Richard J. Liekweg
President

March 30, 2012

DHHS, Office of Inspector General
Office of Audit Services
Region VII
601 East 12th Street
Room 0429
Kansas City, MO 64106

Attn: Mr. Patrick J. Cogley
Regional Inspector General for Audit Services

This letter is in response to the draft *Medicare Compliance Review* of Barnes-Jewish Hospital ("BJH") for calendar years 2008-2011, dated February 17, 2012. Barnes-Jewish Hospital appreciates the opportunity to respond to the draft report and share our process control, technology, and training and education improvements. As noted in the draft report, the Office of Inspector General reviewed 240 claims. 222 had dates of service in CYs 2009 and 2010 and the remaining claims, all involving replacement medical devices, had dates of service in CYs 2008 and 2011. We understand the claims were selected as a judgmental (non-statistically significant) sample because such claims were potentially at risk for billing errors. BJH concurs with the OIG's findings and recommendations noted in the draft report and has taken the following action:

- BJH has processed refunds to the Medicare contractor, Wisconsin Physician Services ("WPS") in the amount of \$725,185, consisting of \$392,829 in overpayments for the 24 incorrectly billed outpatient claims and \$332,356 in overpayments for the 34 incorrectly billed inpatient claims, and
- BJH has strengthened internal controls to meet our goal of full compliance with Medicare requirements.

To strengthen its processes relating to the issues identified by the OIG and to support its commitment to full compliance with Medicare billing requirements, BJH has:

- Modified existing information systems to address issues related to physician signature requirements for admission orders. We have acquired new software programs to support coding and charge capture as well as to assist in the identification of claims paid in excess of charges;
- Developed and delivered individual and departmental focused education related to the areas identified in the report such as coding and the use of modifiers, charge entry and charge reconciliation;

One Barnes-Jewish Hospital Plaza • St. Louis, Missouri 63110 • 314-362-5400 • www.BarnesJewish.org

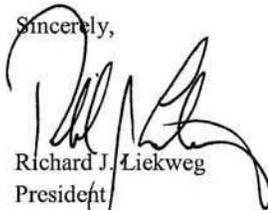
Barnes-Jewish Hospital at Washington University Medical Center

Engaged in process review and re-engineering to implement additional reconciliation steps and enhanced controls at the unit, department and hospital levels which will address concerns related to manufacturer device credits and inpatient short stays; and

- Worked with the service delivery departments to increase the frequency of auditing and monitoring activities by Corporate Compliance and Internal Audit and to strengthen existing controls.

We appreciate the opportunity to respond to your findings. BJH takes these findings very seriously. Please let me know if you have any questions or comments related to the responses provided above. We look forward to the final report.

Sincerely,



Richard J. Liekweg
President
Barnes-Jewish Hospital