

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
NORTH KANSAS CITY HOSPITAL
FOR CALENDAR YEARS
2009 AND 2010**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Patrick J. Cogley
Regional Inspector General

October 2012
A-07-12-01115

Office of Inspector General

<https://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 <https://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 permanent kidney 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 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.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

The North Kansas City Hospital (the Hospital) has 451 licensed beds and is located in North Kansas City, Missouri. Medicare paid the Hospital approximately \$199 million for 21,195 inpatient and 84,180 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 \$1,268,260 in Medicare payments to the Hospital for 53 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 15 inpatient transfers, and 38 inpatient and outpatient claims with manufacturer credits for replaced medical devices, with dates of service in CYs 2009 and 2010.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient transfers and inpatient and outpatient claims with manufacturer credits for replaced medical devices.

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for each of the 15 inpatient transfers claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 35 of the 38 inpatient and outpatient claims with manufacturer credits for replaced medical devices, resulting in overpayments totaling \$250,851 for CYs 2009 and 2010. Specifically, 31 inpatient claims had billing errors that resulted in overpayments totaling \$174,535, and 4 outpatient claims had billing errors that resulted in overpayments totaling \$76,316. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims with manufacturer credits for replaced medical devices.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$250,851, consisting of \$174,535 in overpayments for the 31 incorrectly billed inpatient claims and \$76,316 in overpayments for the 4 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital concurred with both of our recommendations. The Hospital stated that it has refunded the overpayments and described corrective actions that it has taken to ensure compliance with Medicare requirements.

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

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System.....	1
Hospital Payments at Risk for Incorrect Billing.....	2
Medicare Requirements for Hospital Claims and Payments	2
North Kansas City Hospital	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective.....	2
Scope.....	3
Methodology.....	3
FINDINGS AND RECOMMENDATIONS	4
MANUFACTURER CREDITS FOR REPLACED MEDICAL DEVICES	4
Inpatient Manufacturer Credits for Replaced Medical Devices	4
Outpatient Manufacturer Credits for Replaced Medical Devices.....	5
INADEQUATE INTERNAL CONTROLS	5
MEDICARE OVERPAYMENTS RECEIVED BY THE HOSPITAL	5
RECOMMENDATIONS	5
AUDITEE COMMENTS	6
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 permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

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

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, P.L. No. 106-113.² The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.³ All services and items within an APC group are comparable clinically and require comparable resources.

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

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

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

Hospital Payments at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis of claims. Examples of the types of claims at risk for noncompliance included inpatient transfers and inpatient and outpatient manufacturer credits for replaced medical devices.

For purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.”

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of 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.

North Kansas City Hospital

The North Kansas City Hospital (the Hospital) has 451 licensed beds and is located in North Kansas City, Missouri. Medicare paid the Hospital approximately \$199 million for 21,195 inpatient and 84,180 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 inpatient transfers and inpatient and outpatient claims with manufacturer credits for replaced medical devices.

Scope

Our audit covered \$1,268,260 in Medicare payments to the Hospital for 53 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 15 inpatient transfers, and 38 inpatient and outpatient claims with manufacturer credits for replaced medical devices, with dates of service in CYs 2009 and 2010.

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 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. 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 during April and May 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient 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 selected device manufacturers for CYs 2009 and 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 53 claims (15 inpatient transfers and 38 inpatient and outpatient claims with manufacturer credits for replaced medical devices) 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 claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Hospital officials on June 12, 2012.

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 each of the 15 inpatient transfers claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 35 of the 38 inpatient and outpatient claims with manufacturer credits for replaced medical devices, resulting in overpayments totaling \$250,851 for CYs 2009 and 2010. Specifically, 31 inpatient claims had billing errors that resulted in overpayments totaling \$174,535, and 4 outpatient claims had billing errors that resulted in overpayments totaling \$76,316. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims with manufacturer credits for replaced medical devices.

MANUFACTURER CREDITS FOR REPLACED MEDICAL DEVICES

The Hospital incorrectly billed Medicare for 35 of the 38 sampled inpatient and outpatient manufacturer credits for replaced medical devices claims that we reviewed. These errors resulted in overpayments totaling \$250,851.

Inpatient Manufacturer Credits for Replaced 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 bill correctly 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 31 out of 32 sampled claims, the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claim with the proper value and condition codes to reduce payment as required. As a result of these errors, the Hospital received overpayments totaling \$174,535.

Outpatient Manufacturer Credits for Replaced Medical Devices

Federal regulations (42 CFR § 419.45) require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device.

CMS guidance in Transmittal 1103, dated November 3, 2006, and in the Manual explains 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 to reduce charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device.

For four out of six sampled claims, the Hospital received full credit for a replaced device but did not report the “FB” modifier or reduced charges on its claim. As a result of these errors, the Hospital received overpayments totaling \$76,316.

INADEQUATE INTERNAL CONTROLS

These errors occurred because the Hospital did not have adequate controls to report the appropriate billing codes and charges to reflect credits due from manufacturers. The Hospital stated that it had internal controls in place to report medical device credits from manufacturers but added that it did not follow these internal controls. The Hospital attributed these errors to a lack of communication between the catheter lab department and the patients’ accounts department.

MEDICARE OVERPAYMENTS RECEIVED BY HOSPITAL

As a result of these errors, the Hospital received overpayments totaling \$250,851 for inpatient and outpatient manufacturer credits for replaced medical devices for CYs 2009 and 2010.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$250,851, consisting of \$174,535 in overpayments for the 31 incorrectly billed inpatient claims and \$76,316 in overpayments for the 4 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital concurred with both of our recommendations. The Hospital stated that it has refunded the overpayments and described corrective actions that it has taken to ensure compliance with Medicare requirements. The Hospital's comments appear in their entirety as the Appendix.

APPENDIX

APPENDIX: AUDITEE COMMENTS



2800 Clay Edwards Drive
North Kansas City, MO
64116-3220

(816) 691-2000
www.nkch.org

August 2, 2012

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Re: Draft Report Number A-07-12-01115

Dear Mr. Cogley:

Thank you for the opportunity to review the Office of Inspector General's draft report entitled *Medicare Compliance Review of North Kansas City Hospital for Calendar Years 2009 and 2010*. North Kansas City Hospital concurs with both of the OIG's recommendations. We have refunded the identified overpayments to our Medicare Administrative Contractor. We also have strengthened internal controls by developing a billing policy for claims that involve device credits, by requesting assistance from our vendors to identify and track device credits, and by forming an interdisciplinary work group that meets monthly to review claims and ensure appropriate communication between procedural areas and our billing department.

North Kansas City Hospital expresses its tremendous regret that this error occurred. We are committed to Medicare billing compliance and believe that we have taken appropriate corrective action.

Sincerely,

A handwritten signature in black ink, appearing to read "Peggy F. Schmitt".

Peggy F. Schmitt
President & CEO