

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
SANFORD USD MEDICAL
CENTER IN SIOUX FALLS
FOR CALENDAR YEARS
2010 AND 2011**

*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**

April 2013
A-07-12-05032

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

Sanford USD [University of South Dakota] Medical Center in Sioux Falls (the Hospital) has 545 beds and is located in Sioux Falls, South Dakota. Medicare paid the Hospital approximately \$214 million for 15,609 inpatient and 69,031 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$4,139,815 in Medicare payments to the Hospital for 140 inpatient and 76 outpatient claims that we identified as potentially at risk for billing errors for CYs 2010 and 2011.

OBJECTIVE

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

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 211 of the 216 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining five claims, resulting in overpayments totaling \$12,222 for CYs 2010 and 2011. Specifically, two inpatient claims had billing errors, resulting in overpayments totaling \$8,125, and three outpatient claims had billing errors, resulting in overpayments totaling \$4,097. Although the Hospital's controls were adequate to prevent incorrect billing of the vast majority of the Medicare claims that we reviewed, those controls did not prevent the errors we noted. Overpayments occurred due to human error and because the Hospital did not have adequate controls related to the reporting of manufacturers' credits for replaced medical devices.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$12,222, consisting of \$8,125 in overpayments for the two incorrectly billed inpatient claims and \$4,097 in overpayments for the three 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 described corrective actions that it had taken in accordance with our recommendations. Specifically, the Hospital stated that it refunded the \$12,222 in overpayments. In addition, the Hospital agreed to further enhance and strengthen its controls.

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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 permanent kidney disease. The Centers for Medicare and 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 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, 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 techniques. Examples of the types of claims at risk for noncompliance included the following:

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 manufacturer credits for replaced medical devices,
- inpatient claims with payments greater than \$150,000,
- inpatient claims billed with high severity level diagnosis-related group codes,
- inpatient hospital-acquired conditions and present on admission indicator reporting,
- inpatient and outpatient claims paid in excess of charges,
- inpatient same-day discharges and readmissions,
- inpatient transfers,
- outpatient claims billed with modifiers,
- outpatient claims with payments greater than \$25,000,
- outpatient claims billed with Doxorubicin Hydrochloride, and
- outpatient surgeries billed with units greater than one.

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 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.

Sanford USD Medical Center in Sioux Falls

Sanford USD [University of South Dakota] Medical Center in Sioux Falls (the Hospital) has 545 beds and is located in Sioux Falls, South Dakota. Medicare paid the Hospital approximately \$214 million for 15,609 inpatient and 69,031 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2010 and 2011 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 claims.

Scope

Our audit covered \$4,139,815 in Medicare payments to the Hospital for 140 inpatient and 76 outpatient claims that we identified as potentially at risk for billing errors for CYs 2010 and 2011.

We focused our review on the risk areas that we had identified during 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 October 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 2010 and 2011;

- obtained information on known credits for replaced medical devices from the device manufacturers for CY 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 216 claims (140 inpatient and 76 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- 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 on October 23, 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 211 of the 216 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining five claims, resulting in overpayments totaling \$12,222 for CYs 2010 and 2011. Specifically, two inpatient claims had billing errors, resulting in overpayments totaling \$8,125, and three outpatient claims had billing errors, resulting in overpayments totaling \$4,097. Although the Hospital's controls were adequate to prevent incorrect billing of the vast majority of the Medicare claims that we reviewed, those controls did not prevent the errors we noted. Overpayments occurred due to human error and because the Hospital did not have adequate controls related to the reporting of manufacturers' credits for replaced medical devices.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 2 of 140 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$8,125.

Lack of a Physician Order

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that "... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if, "with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment" Federal regulations (42 CFR § 424.13(a)) state that "Medicare Part A pays for inpatient hospital services ... only if a physician certifies and recertifies," among other things, the reasons for continued hospitalization.

For 1 out of 140 sampled claims, the Hospital incorrectly billed Medicare Part A for an inpatient short stay that did not have a valid physician order to admit the beneficiary for inpatient care. The Hospital attributed this error to an ordering error by the physician. As a result of this error, the Hospital received an overpayment of \$4,440.

Manufacturer Credit for Replaced Medical Device Not Reported

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 1 out of 140 sampled claims, the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claim with the appropriate condition and value codes to reduce payment as required. This overpayment occurred because the Hospital did not have adequate controls to report the appropriate condition and value codes in order to accurately reflect the credit it had received from a manufacturer. As a result of this error, the Hospital received an overpayment of \$3,685.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 3 of 76 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$4,097.

Incorrect Healthcare Common Procedure Coding System Codes

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.”

For 2 out of 76 sampled claims, the Hospital incorrectly billed Medicare with incorrect HCPCS codes. Specifically, the Hospital submitted the claim with HCPCS code G0290 (stent placement), when HCPCS code 92982 (balloon angioplasty) was the correct code for the medical procedure in question (1 error). For another claim, the Hospital billed HCPCS code 33235 (removal of transvenous pacemaker electrode(s); dual lead system) when the correct HCPCS code, 33234 (removal of transvenous pacemaker electrode(s); single lead system), should have been billed. The Hospital stated that these errors occurred because of human error and because the coder misunderstood the documentation. As a result of these errors, the Hospital received overpayments totaling \$3,933.

Service Not Billable to Medicare

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.”

For 1 out of 76 sampled claims, the Hospital incorrectly billed Medicare by erroneously including an emergency department facility charge that was not supported in the medical records. The Hospital stated that the patient was processed through the emergency department but that no services were actually performed there. The Hospital attributed this error to human error. As a result of this error, the Hospital received an overpayment of \$164.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$12,222, consisting of \$8,125 in overpayments for the two incorrectly billed inpatient claims and \$4,097 in overpayments for the three 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 described corrective actions that it had taken in accordance with our recommendations. Specifically, the Hospital stated that it refunded the \$12,222 in overpayments. In addition, the Hospital agreed to further enhance and strengthen its controls.

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

OTHER MATTERS

Although our objective was to determine whether the Hospital complied with Medicare billing requirements for the selected inpatient and outpatient claims discussed above, we identified two other claims for which a payment error appeared to have taken place during processing by the Medicare contractor. In each instance, the Hospital billed for 1 unit of service for an APC, but the Medicare contractor paid the Hospital on the basis of 10 units of service. As a result of these errors, the Hospital received overpayments totaling \$11,513. Accordingly, we will forward detail data on these claims to the Medicare contractor for further adjudication.

APPENDIX

APPENDIX: AUDITEE COMMENTS



March 4, 2013

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

Report Number: A-07-12-05032

Dear Mr. Cogley,

On behalf of Sanford USD Medical Center (the Medical Center), I am providing comments to the report entitled *Medicare Compliance Review of Sanford USD Medical Center in Sioux Falls for Calendar Years 2010 and 2011*.

The Medical Center strives to create a culture that promotes understanding and adherence to applicable federal, state and local laws and regulations. It commits substantial resources to support an effective compliance program with the goal of preventing, detecting and correcting identified issues. This includes the implementation of operational procedures and controls to minimize the risk of billing errors.

The Medical Center has reviewed the recommendations in the report and has responded as follows:

- 1) The amount of \$12,222 which is identified as an overpayment in the report has been refunded through correction and resubmission of involved claims to our CMS contractor.
- 2) We appreciate the recognition of the strength of the Medical Center's controls to prevent incorrect billing which assured accurate billing in 211 out of 216 Medicare claims reviewed, however, note that errors did occur in 5 of the claims. To further enhance and strengthen the Medical Center's controls, we have taken the following steps:

Education

Human error accounted for 4 of the 5 billing errors noted. We have reviewed those errors with the individuals and departments involved with the purpose of avoiding recurrence.

Medical Device Credit Process Enhancement

The process for assuring medical device credits are properly reflected on Medicare claims is complex. The Medical Center has strengthened their controls by identifying and assigning proper communication between departments to assure credits are accurately reflected and coded on claims.

Sanford USD Medical Center takes its obligation to produce accurate bills for its services very seriously. As such we will continue to monitor and improve our documentation and billing processes. Thank you for the opportunity to review and comment on this report.

Sincerely,

A handwritten signature in black ink that reads "Charles P. O'Brien MD". The signature is written in a cursive style with a prominent loop at the end of the name.

Charles P. O'Brien, MD
President
Sanford USD Medical Center