

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
COX MEDICAL CENTER
FOR 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
for Audit Services**

**September 2014
A-07-12-05038**

Office of Inspector General

<https://oig.hhs.gov/>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

Cox Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$302,000 over more than 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Cox Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient 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. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is a 635-bed acute care hospital located in Springfield, Missouri. Medicare paid the Hospital approximately \$245 million for 18,475 inpatient and 224,948 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$4,374,924 in Medicare payments to the Hospital for 210 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 108 inpatient and 102 outpatient claims. Of the 210 claims, 208 claims had dates of service in CY 2010 or CY 2011, and 2 claims (involving outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2012.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 177 of the 210 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 33 claims, resulting in overpayments of \$301,571 for CYs 2010 and 2011 (31 claims) and CYs 2009 and 2012 (2 claims). Specifically, 21 inpatient claims

had billing errors, resulting in overpayments of \$190,069, and 12 outpatient claims had billing errors, resulting in overpayments of \$111,502. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$301,571, consisting of \$190,069 in overpayments for 21 incorrectly billed inpatient claims and \$111,502 in overpayments for 12 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 all of our findings and described corrective actions that it had taken or planned to take, including the processing of refunds, to implement our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

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

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and 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 the Medicare program.

CMS contracts with Medicare contractors 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.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. 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.¹ All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- inpatient and outpatient claims paid in excess of charges,
- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level DRG codes,
- inpatient DRG verification,
- inpatient claims billed with kyphoplasty services,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims with payments greater than \$150,000,
- outpatient claims billed with inpatient only procedures,
- outpatient claims billed with modifiers,
- outpatient surgeries billed with units greater than one,
- outpatient claims billed during DRG payment window,
- outpatient claims with payments greater than \$25,000, and
- outpatient claims billed with doxorubicin hydrochloride.

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

Medicare Requirements for Hospital Claims and Payments

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

¹ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

malformed body member” (the Social Security Act (the Act), § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

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

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). In addition, the Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Cox Medical Center

The Hospital is a 635-bed acute care hospital located in Springfield, Missouri. Medicare paid the Hospital approximately \$245 million for 18,475 inpatient and 224,948 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS’s National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$4,374,924 in Medicare payments to the Hospital for 210 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 108 inpatient and 102 outpatient claims. Of the 210 claims, 208 claims had dates of service in CY 2010 or CY 2011, and 2 claims (involving outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2012.² We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected six claims to focused medical review to determine whether the services were medically necessary. 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 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.

See Appendix A for the details of our scope and methodology.

² We selected these two claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

FINDINGS

The Hospital complied with Medicare billing requirements for 177 of the 210 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 33 claims, resulting in overpayments of \$301,571 for CYs 2010 and 2011 (31 claims) and CYs 2009 and 2012 (2 claims). Specifically, 21 inpatient claims had billing errors, resulting in overpayments of \$190,069, and 12 outpatient claims had billing errors, resulting in overpayments of \$111,502. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 21 of 108 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$190,069.

Insufficiently Documented Procedures

Medicare payment 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" (the Act, § 1862(a)(1)(A)).

For 11 out of 108 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain procedure and diagnosis codes were not supported in the medical records. The Hospital attributed these errors to a misunderstanding of coding guidelines. As a result of these errors, the Hospital received overpayments of \$95,680.

Incorrectly Billed as Inpatient

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" (the Act, § 1862(a)(1)(A)).

According to chapter 1, section 10, of the *CMS Benefit Policy Manual* (Pub. No. 100-02), factors that determine whether an inpatient admission is medically necessary include:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;
- the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and

- the availability of diagnostic procedures at the time when and at the location where the patient presents.

For 3 out of 108 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital stated that the admitting physician makes the decision to admit the patient as an inpatient, and added that it has reorganized the Case Management Department to ensure better coverage for all cases. As a result of these errors, the Hospital received overpayments of \$56,920.³

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 5 out of 108 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital stated that these errors occurred due to a misunderstanding of what would be considered related and unrelated symptoms by the staff member making these decisions. As a result of these errors, the Hospital received overpayments of \$26,628.

Manufacturer Credit for Replaced Medical Devices Not Reported

Federal regulations 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 device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code "FD" (chapter 3, § 100.8).

For 1 out of 108 selected 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 to accurately reflect credits

³ 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 Medicare administrative contractor before the issuance of our report.

it had received from manufacturers. As a result of this error, the Hospital received an overpayment of \$7,500.

Unsupported Charge

The Act states: “[N]o such payments shall be made to any provider unless it has furnished such information ... in order to determine the amounts due such provider ... for the period with respect to which the amounts are being paid....” (§ 1815(a)).

For 1 out of 108 selected claims, the Hospital submitted the claim to Medicare with an unsupported charge, resulting in a higher outlier payment than was warranted. For this claim, the Hospital billed for a quantity of a medication that was not supported by the medical records. The Hospital attributed the overpayment to clerical error. As a result of this error, the Hospital received an overpayment of \$3,341.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 12 of 102 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$111,502.

Insufficiently Documented Procedures

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

For 6 out of 102 selected claims, the Hospital submitted the claims to Medicare with procedure codes that were not supported in the medical records. The Hospital attributed the overpayments to human and computer errors. As a result of these errors, the Hospital received overpayments of \$65,042.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations 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 (42 CFR § 419.45). For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.⁴

For 5 out of 102 selected claims, the Hospital received full credit for replaced medical devices but did not report the “FB” modifier and reduced charges on its claims. (Of the five claims, one

⁴ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

had a date of service in CY 2009, one had a date of service in CY 2010, two had dates of service in CY 2011, and one had a date of service in CY 2012.) These overpayments occurred because the Hospital did not have adequate controls to report the appropriate modifiers and charges to reflect credits received from manufacturers. As a result of these errors, the Hospital received overpayments of \$45,925.

Incorrectly Billed as Outpatient

Certain items and nonphysician services furnished to inpatients are covered under Medicare Part A and consequently are covered by the IPPS payment rate (the Manual, chapter 3, section 10.4).

For 1 out of 102 selected claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during an inpatient stay that should have been included on its inpatient (Part A) bills to Medicare. The Hospital attributed the overpayment to clerical error. As a result of this error, the Hospital received an overpayment of \$535.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$301,571, consisting of \$190,069 in overpayments for 21 incorrectly billed inpatient claims and \$111,502 in overpayments for 12 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 all of our findings and described corrective actions that it had taken or planned to take, including the processing of refunds, to implement our recommendations.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$4,374,924 in Medicare payments to the Hospital for 210 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 108 inpatient and 102 outpatient claims. Of the 210 claims, 208 claims had dates of service in CY 2010 or CY 2011, and 2 claims (involving outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2012 (footnote 2).

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected six claims to 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 October 2012 to June 2014.

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 replacement medical devices from the device manufacturers for CYs 2009 through 2012;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 210 claims (108 inpatient and 102 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected 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 selected claims;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- used an independent medical review contractor to determine whether six selected claims met medical necessity requirements;
- 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 9, 2014.

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: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Claims Paid in Excess of Charges	26	\$476,589	7	56,890
Short Stays	6	92,608	2	48,355
Same-Day Discharges and Readmissions	10	92,639	5	26,628
Claims Billed With High Severity Level Diagnosis-Related Group Codes	50	1,934,461	2	21,868
Diagnosis-Related Group Verification	11	271,015	2	16,922
Claims Billed With Kyphoplasty Services	1	8,565	1	8,565
Manufacturer Credits for Replaced Medical Devices	2	11,693	1	7,500
Claims With Payments Greater Than \$150,000	2	369,930	1	3,341
Inpatient Totals	108	\$3,257,500	21	\$190,069
Outpatient				
Claims Billed With Modifiers	20	\$274,769	1	\$52,597
Manufacturer Credits for Replaced Medical Devices	7	66,378	5	45,925
Claims Paid in Excess of Charges	2	17,587	2	8,972
Surgeries Billed With Units Greater Than One	8	35,374	3	3,473
Diagnosis-Related Group Payment Window	2	11,070	1	535
Claims With Payments Greater Than \$25,000	15	514,519	0	0
Claims Billed With Doxorubicin Hydrochloride	47	193,370	0	0
Claims Billed With Inpatient Only Procedures	1	4,357	0	0
Outpatient Totals	102	\$1,117,424	12	\$111,502
Inpatient and Outpatient Totals	210	\$4,374,924	33	\$301,571

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

APPENDIX C: AUDITEE COMMENTS



August 7, 2014

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

RE: Report Number: A-07-12-05038

Dear Mr. Cogley:

Thank you for forwarding a copy of the draft report of our Medicare Compliance Review. As I understand your letter, you are seeking a response from me on each "concurrence" that describes the nature of the corrective action taken or planned; as well as the reason for any "non-concurrence" and alternative corrective action taken or planned.

My comments are below:

Insufficiently Documented Procedures:

CoxHealth concurs with this finding. Our Health Information Management (HIM) coding department was notified of these coding errors and they have been re-educated. In addition CoxHealth has contracted with a new company to conduct periodic coding reviews of our inpatient and outpatient coding. All refunds have been processed.

Incorrectly Billed as Inpatient

CoxHealth concurs with this finding. We continue to provide education to our physicians regarding appropriate inpatient status vs. outpatient status. Annual Compliance Training this year focused on this topic and the CMS 2-midnight rule. All refunds have been processed.

Incorrectly Billed as Separate Inpatient Stays

CoxHealth concurs with this finding. We have re-worked this process and re-educated those involved regarding the definition of related and un-related visits.

Hulston Cancer Center Building • 3850 South National Avenue • Springfield, Missouri 65807

coxhealth.com

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Mr. Patrick J. Cogley
August 7, 2014
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Manufacturer Credit for Replaced Medical Devices Not Reported

CoxHealth concurs with this finding. CoxHealth has initiated a new process to catch device credits and ensure that the information is provided to CMS and the claim is billed correctly. All refunds have been processed.

Unsupported Charge

CoxHealth concurs with this finding. This was a clerical error during posting of charges for surgical services. Additional education was provided. All refunds have been processed.

Insufficiently Documented Procedures

CoxHealth concurs with this finding. This error resulted from a clerical posting mistake. Many of these minor errors were a result of launching a new IT program for our surgical services department. Although we worked diligently to audit and correct all errors, some were missed. All refunds have been processed.

Manufacturer Credits for Replaced Medical Devices Not Reported.

CoxHealth concurs with this finding. CoxHealth has initiated a new process to catch device credits and ensure that the information is provided to CMS and the claim is billed correctly. All but one of these claims has been refunded and reprocessed. The claim from 2009 has not been handled, as we are having difficulty with our Medicare Administrative Contract to re-open the claim so that we can re-process the credit. All other refunds have been processed.

Incorrectly Billed as Outpatient

CoxHealth concurs with this finding. Again, this was a clerical error within a very manual process of identifying patients who received services in one of 55 physician clinics and that were then admitted to the hospital within 3 days of those services. CoxHealth is working to bring the various billing systems to a single billing system, which would eliminate these types of errors. We will continue to monitor. All refunds have been processed.

CoxHealth appreciates the assistance provided by the Office of Inspector General during this audit process.

Sincerely,



Betty S. Breshears
Vice President / Corporate Integrity