

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
BOONE HOSPITAL
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**

**December 2014
A-07-13-05043**

Office of Inspector General

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

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EXECUTIVE SUMMARY

Boone Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$407,000 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 Boone Hospital (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 394-bed acute care hospital located in Columbia, Missouri. Medicare paid the Hospital approximately \$193 million for 17,565 inpatient and 93,826 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$5,415,786 in Medicare payments to the Hospital for 307 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 237 inpatient and 70 outpatient claims. Of the 307 claims, 285 claims had dates of service in CY 2010 or CY 2011, and 22 claims (involving inpatient and 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 202 of the 307 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 105 claims, resulting in net overpayments of \$407,495 for CYs 2010 and 2011 (90 claims) and CYs 2009 and 2012 (15 claims). Specifically, 67 inpatient claims had billing errors, resulting in overpayments of \$306,094, and 38 outpatient claims had

billing errors, resulting in net overpayments of \$101,401. (As of July 21, 2014, the amount of overpayment for one outpatient claim had not been determined because the claim had not been reprocessed and the correct payment amount had not been identified.) 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 \$407,495, consisting of \$306,094 in overpayments for 67 incorrectly billed inpatient claims and \$101,401 in overpayments for 37 incorrectly billed outpatient claims,
- determine the amount of overpayment for the one outpatient claim that had not been reprocessed and refund that amount to Medicare, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with our findings and recommendations. Specifically, the Hospital stated that it had fully reimbursed the overpayment amount and described corrective actions that it had taken or planned to take 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 Boone Hospital (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 manufacturer credits for replaced medical devices,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims paid in excess of charges,
- inpatient same-day discharges and readmissions,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient claims with payments greater than \$150,000,
- inpatient short stays,
- inpatient claims billed with kyphoplasty services,
- inpatient transfers,
- outpatient surgeries billed with units greater than one,
- outpatient claims billed with dental services,
- outpatient claims billed with modifiers,
- 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 malformed body member” (the Social Security Act (the Act), § 1862(a)(1)(A)). In addition, the

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

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).

Boone Hospital

The Hospital is a 394-bed acute care hospital located in Columbia, Missouri. Medicare paid the Hospital approximately \$193 million for 17,565 inpatient and 93,826 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 \$5,415,786 in Medicare payments to the Hospital for 307 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 237 inpatient and 70 outpatient claims. Of the 307 claims, 285 claims had dates of service in CY 2010 or CY 2011, and 22 claims 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 did not subject 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 22 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 202 of the 307 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 105 claims, resulting in net overpayments of \$407,495 for CYs 2010 and 2011 (90 claims) and CYs 2009 and 2012 (15 claims). Specifically, 67 inpatient claims had billing errors, resulting in overpayments of \$306,094, and 38 outpatient claims had billing errors, resulting in net overpayments of \$101,401.³ 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 67 of 237 selected inpatient claims that we reviewed. These errors resulted in net overpayments of \$306,094.

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 54 out of 237 selected claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate condition and value codes to reduce payments as required. (Of the 54 claims, 13 had dates of service in CY 2009, 23 had dates of service in CY 2010, and 18 had dates of service in CY 2011.) According to the Hospital, it was in the process of identifying Medicare claims with dates of service in CY 2011 through the current year and then refunding as appropriate. The Hospital added that after the review of CY 2011 through current year claims, it planned to review claims with dates of service before CY 2011. As a result of these errors, the Hospital received overpayments of \$244,173.

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 7 out of 237 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain procedure and diagnosis

³ As of July 21, 2014, the amount of overpayment for one outpatient claim had not been determined because the claim had not been reprocessed and the correct payment amount had not been identified.

codes were not supported in the medical records. The Hospital attributed the overpayments to human error. As a result of these errors, the Hospital received overpayments of \$66,455.

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 6 out of 237 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital attributed the overpayments to human error. As a result of these errors, the Hospital received a net underpayment of \$4,534.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 38 of 70 selected outpatient claims that we reviewed. These errors resulted in net overpayments of \$101,401.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations 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 (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 6 out of 70 selected claims, the Hospital received full credits for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims. (Of the six claims, two had dates of service in CY 2009 and four had dates of service in CY 2010.) According to the Hospital, it was in the process of identifying Medicare claims with dates of service in CY 2011 through the current year and then refunding as appropriate. The Hospital added that after the review of CY 2011 through current year claims, it planned to review claims with dates of service before CY 2011. As a result of these errors, the Hospital received overpayments of \$63,502.

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

Incorrectly Billed Number of Units

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 19 out of 70 selected claims, the Hospital billed Medicare with the incorrect number of units of service. The Hospital explained that, for certain outpatient revenue codes, it reviewed all claims with units of service greater than one and subsequently reduced the units of service to one, unless an appropriate modifier was present. The Hospital added that although this control process was in place, claims that had certain anatomic modifiers present were released (that is, without the appropriate reduction in the units of service) in error. As a result of these errors, the Hospital received overpayments of \$27,534.

Incorrect Billing for Noncovered Dental Services

Section 1862(a)(12) of the Act states: “No payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.”

For 9 out of 70 selected claims, the Hospital incorrectly billed Medicare for services related to the removal of teeth. The Hospital attributed the overpayments to a lack of controls. As a result of these errors, the Hospital received overpayments of \$5,226.

Insufficiently Documented Procedures and Modifiers

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 4 out of 70 selected claims, the Hospital submitted the claims to Medicare with incorrect procedure codes and unnecessary modifiers. The Hospital attributed the inappropriate application of modifiers to the fact that some of its staff members were not entirely able to identify and understand the edits in its claim processing software. As a result of these errors, the Hospital received overpayments of \$5,139.⁵

⁵ As of July 21, 2014, the amount of overpayment for one of these claims had not been determined because the claim had not been reprocessed and the correct payment amount had not been identified.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$407,495, consisting of \$306,094 in overpayments for 67 incorrectly billed inpatient claims and \$101,401 in overpayments for 37 incorrectly billed outpatient claims,
- determine the amount of overpayment for the one outpatient claim that had not been reprocessed and refund that amount to Medicare, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with our findings and recommendations. Specifically, the Hospital stated that it had fully reimbursed the overpayment amount and described corrective actions that it had taken or planned to take 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 \$5,415,786 in Medicare payments to the Hospital for 307 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 237 inpatient and 70 outpatient claims. Of the 307 claims, 285 claims had dates of service in CYs 2010 or CY 2011, and 22 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2012 (footnote 3).

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 did not subject 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 March 2013 to July 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 307 claims (237 inpatient and 70 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;
- 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 July 21, 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/(Underpayments)
Inpatient				
Manufacturer Credits for Replaced Medical Devices	74	\$1,472,904	54	\$244,173
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	89	1,554,501	5	37,225
Claims Paid in Excess of Charges	10	179,425	2	29,230
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	44	1,418,522	0	0
Claims With Payments Greater Than \$150,000	1	152,556	0	0
Short Stays	11	53,800	0	0
Claims Billed With Kyphoplasty Services	1	5,378	0	0
Post-Acute Transfer to Skilled Nursing Facilities	1	5,167	0	0
Same-Day Discharges and Readmissions	6	104,966	6	(4,534)
Inpatient Totals	237	\$4,947,219	67	\$306,094
Outpatient				
Manufacturer Credits for Replaced Medical Devices	16	\$120,169	6	\$63,502
Surgeries Billed With Units Greater Than One	20	59,681	19	27,534
Dental Services	9	7,947	9	5,226
Claims Billed With Modifiers	20	193,585	4	5,139
Claims With Payments Greater Than \$25,000	3	79,994	0	0
Claims Paid With Doxorubicin Hydrochloride	2	7,191	0	0
Outpatient Totals	70	\$468,567	38	\$101,401
Inpatient and Outpatient Totals	307	\$5,415,786	105	\$407,495

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



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October 3, 2014

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Office of Audit Services, Region VII
601 East 12th Street, Room 0429
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Attention: Patrick J. Cogley
Regional Inspector General for Audit Services

Subject: Report Number A-07-13-05043
Medicare Compliance Review of Boone Hospital Center for 2010 and 2011

Boone Hospital Center received the draft report dated September 22, 2014 requesting written comments and a statement describing the corrective action taken or actions planned by Boone Hospital Center to your recommendations identified in the report.

Through this review, the OIG concluded the hospital complied with Medicare for 202 of the 307 inpatient and outpatient claims reviewed. However, the auditors determined the hospital did not fully comply with Medicare billing requirements for the remaining 105 claims, resulting in net overpayments of \$407,495 for calendar years 2009-2012. Specifically, 67 inpatient claims had billing errors, resulting in overpayment of \$306,094, and 38 outpatient claims had billing errors, resulting in overpayment of \$101,401.

In response to the audit we want to assure you that Boone Hospital Center is committed to ensuring appropriate operational procedures and controls are in place to minimize the risk of billing errors. The following identifies Boone's response to the recommendations identified, and the corrective action that is completed, and the efforts currently in progress.

After review of the audit findings and recommendations Boone Hospital Center agrees with the 105 claims identified with billing errors and we have fully reimbursed the overpayment amount as determined by your audit.

The hospital has reviewed the recommendations in the report and responds as follows:

Inpatient Claims

Manufacturer Credit for Replaced Medical Devices Not Reported

For 54 of the 237 selected claims, the hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with appropriate condition and value codes to reduce payment which resulted in overpayment of \$244,173.

- BJC Corporate Compliance, along with Boone Hospital Center, receives monthly device credit reports which are internally reviewed for Medicare credits > 50%.
- We are in the process of developing a front end process to hold claims to ensure credits have been appropriately reported.
- Quarterly monitoring is performed by BJC Corporate Compliance to ensure correct identification and refund of accounts with device credits greater than 50%.

Insufficiently Documented Procedures

For 7 of the 237 selected claims, the hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the hospital which resulted in overpayment of \$66,455.

- The coding process involves the individual coder's ability to interpret complex medical record documentation and to assign a code using complex coding rules that can change on a quarterly basis.
- Continuing feedback and education is provided to the coding staff to help to reduce the possibility of human error in the coding process.

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Incorrectly Billed as Separate Inpatient Stays

For 6 of the 237 selected claims, the hospital billed Medicare separately for related discharges and readmissions that occurred within the same day which resulted in an underpayment of \$4,534.

- Processes are in place to ensure Case Management reviews same date re-admits; however, in part because of the complexity of the evaluation of the medical condition these cases were missed due to human error and were not detected by key controls.

Outpatient

Manufacturer Credits for Replaced Medical Devices Not Reported

For 6 of the 70 selected claims, the hospital received full credits for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims which resulted in an overpayment of \$63,502.

- Quarterly monitoring is performed by BJC Corporate Compliance to ensure credits have been appropriately reported with the modifier.

Incorrectly Billed Number of Units

For 19 of the 70 selected claims, the hospital billed Medicare with the incorrect number of units of service which resulted in an overpayment of \$27,534.

- System programming changed our charging system to only drop one unit of CPT-4 codes in surgical revenue codes 360 and 361.
- Key control is in the electronic clearing house programming, which holds claims with surgical revenue codes 360 and 361 with more than one unit of service, for manual review. All claims identified will be reviewed and corrected as appropriate.

Incorrect Billing for Non Covered Dental Services

For 9 of the 70 selected claims, the hospital incorrectly billed Medicare for services related to the removal of teeth which resulted in an overpayment of \$5,226.

- Edits are now in place to assure that all dental claims are reviewed prior to claim submission.

Insufficiently Documented Procedures and Modifiers

For 4 of the 70 selected claims, the hospital submitted the claims to Medicare with incorrect procedures codes and unnecessary modifiers which resulted in an overpayment of \$5,139.

- New software was put in place that now stops the claim from processing when an NCCI edit is identified. The claim is moved to a work-list to be reviewed by staff that is now appropriately trained to review and process these claims.

Boone Hospital Center is committed to ensuring compliance with Medicare billing requirements and ongoing review of our internal control processes. We would also like to thank the OIG audit team for their professionalism, communication, time and effort, and cooperation during this process.

If you have any questions, please contact me at 314-286-0647.

Sincerely,



Kathy Boschert
Director, BJC Corporate Compliance

KMB/baj

cc: Sally Terrace
Jim Sinek
Kate Pitzer
Brian Winn