

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
MISSOURI BAPTIST
MEDICAL CENTER
FOR 2011 AND 2012**

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**Patrick J. Cogley
Regional Inspector General
for Audit Services**

**January 2015
A-07-14-05058**

Office of Inspector General

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

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EXECUTIVE SUMMARY

Missouri Baptist Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$414,000 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 Missouri Baptist 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 489-bed acute care hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately \$235 million for 19,550 inpatient and 141,189 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered \$6,945,192 in Medicare payments to the Hospital for 253 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 206 inpatient and 47 outpatient claims. Of the 253 claims, 249 claims had dates of service in CY 2011 or CY 2012, and 4 claims (involving outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 207 of the 253 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 46 claims, resulting in overpayments of \$413,757 for CYs 2011 and 2012 (45 claims) and CY 2010 (1 claim). Specifically, 40 inpatient claims had billing

errors, resulting in overpayments of \$328,323, and 6 outpatient claims had billing errors, resulting in overpayments of \$85,434. 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 \$413,757, consisting of \$328,323 in overpayments for 40 incorrectly billed inpatient claims and \$85,434 in overpayments for 6 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital agreed with our findings associated with 39 claims, but disagreed with our findings on the remaining 7 claims. The Hospital said that it had fully reimbursed the overpayment amounts on all claims that we had identified as having been incorrectly billed, except for four claims that are pending further action in the Medicare claims processing system. The Hospital also described corrective actions that it had taken or that were in progress.

The Hospital disagreed with our finding on seven inpatient claims in which we found that the Hospital should have billed the claim as outpatient or outpatient with observation services. The Hospital stated that processes are in place to ensure that case management reviews take place and that it complies with all Medicare regulations regarding appropriate documentation to support inpatient billing. The Hospital added that it would appeal these seven claims through the Medicare appeal process.

After reviewing the Hospital's comments, we maintain that this finding and the associated recommendation are valid. We used Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether the inpatient claims with which the Hospital disagreed met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractor's conclusion, we determined, and continue to believe, that the Hospital should have billed the inpatient claims as outpatient or outpatient with observation services.

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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 Missouri Baptist 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 claims billed with high severity level DRG codes,
- inpatient short stays,
- inpatient DRG verification,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims with payments greater than \$150,000,
- inpatient claims paid in excess of charges,
- inpatient same-day discharges and readmissions,
- outpatient claims billed with modifiers,
- outpatient claims with payments greater than \$25,000, and
- outpatient claims billed with Herceptin.

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 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)).

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

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).

Missouri Baptist Medical Center

The Hospital is a 489-bed acute care hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately \$235 million for 19,550 inpatient and 141,189 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$6,945,192 in Medicare payments to the Hospital for 253 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 206 inpatient and 47 outpatient claims. Of the 253 claims, 249 claims had dates of service in CY 2011 or CY 2012, and 4 claims had dates of service in CY 2010.² 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 17 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.

FINDINGS

The Hospital complied with Medicare billing requirements for 207 of the 253 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 46 claims, resulting in overpayments of \$413,757 for CYs 2011 and 2012 (45 claims) and CY 2010 (1 claim). Specifically, 40 inpatient claims had billing errors, resulting in overpayments of \$328,323, and 6 outpatient claims had billing errors, resulting in overpayments of \$85,434. 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.

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

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 40 of 206 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$328,323.

Insufficiently Documented Procedures

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)).

For 29 out of 206 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain diagnosis and procedure codes were not supported in the medical records. The Hospital attributed the overpayments to several factors: physician documentation that did not contain enough detail for the coders, human error, and incorrect billing of procedures. As a result of these errors, the Hospital received overpayments of \$223,719.

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 8 out of 206 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 did not agree with our findings with respect to seven of the eight claims and said that its case management staff works to comply with all Medicare regulations regarding appropriate documentation to support inpatient billing. However, the Medicare administrative contractor

found that the Hospital had incorrectly billed based on medical necessity. As a result of these errors, the Hospital received overpayments of \$94,157.³

Manufacturer Credits 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 3 out of 206 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 three claims, one had a date of service in CY 2011 and two had dates of service in CY 2012.) The Hospital stated that at the time of our audit work it was in the process of reviewing Medicare claims with dates of service in CY 2011 through the current year for potential overpayments and refunding as appropriate. As a result of these errors, the Hospital received overpayments of \$10,447.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 6 of 47 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$85,434.

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 5 out of 47 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 five claims, one

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.

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).

had a date of service in CY 2010, one had a date of service in CY 2011, and three had dates of service in CY 2012.) The Hospital stated that at the time of our audit work it was in the process of reviewing Medicare claims with dates of service in CY 2011 through the current year for potential overpayments and refunding as appropriate. As a result of these errors, the Hospital received overpayments of \$84,992.

Insufficiently Documented Procedure

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 1 out of 47 selected claims, the Hospital billed Medicare with an incorrect procedure code. The Hospital stated that this was a random error. As a result of this error, the Hospital received an overpayment of \$442.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$413,757, consisting of \$328,323 in overpayments for 40 incorrectly billed inpatient claims and \$85,434 in overpayments for 6 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 agreed with our findings associated with 39 claims, but disagreed with our findings on the remaining 7 claims. The Hospital said that it had fully reimbursed the overpayment amounts on all claims that we had identified as having been incorrectly billed, except for four claims that are pending further action in the Medicare claims processing system. The Hospital also described corrective actions that it had taken or that were in progress.

The Hospital disagreed with our finding on seven inpatient claims, with \$81,339 in associated questioned costs, in which we found that the Hospital should have billed the claim as outpatient or outpatient with observation services. The Hospital stated that processes are in place to ensure that case management reviews take place and that it complies with all Medicare regulations regarding appropriate documentation to support inpatient billing. The Hospital added that it would appeal these seven claims through the Medicare appeal process.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, we maintain that our finding regarding the seven inpatient claims, and the associated recommendation, are valid. We used Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether the inpatient claims with which the Hospital disagreed met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractor's conclusion, we determined, and continue to believe, that the Hospital should have billed the inpatient claims as outpatient or outpatient with observation services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$6,945,192 in Medicare payments to the Hospital for 253 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 206 inpatient and 47 outpatient claims. Of the 253 claims, 249 claims had dates of service in CY 2011 or CY 2012, and 4 claims (involving outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010 (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 17 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 audit work from January 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 2011 and 2012;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2010 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 253 claims (206 inpatient and 47 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 Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether 17 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 August 27, 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 Billed With High Severity Level Diagnosis-Related-Group Codes	77	\$2,281,223	23	\$170,271
Short Stays	18	205,720	8	94,157
Diagnosis-Related-Group Verification	78	1,405,001	6	53,448
Manufacturer Credits for Replaced Medical Devices	7	148,501	3	10,447
Claims With Payments Greater Than \$150,000	8	1,434,642	0	0
Claims Paid in Excess of Charges	16	350,485	0	0
Same-Day Discharges and Readmissions	2	26,165	0	0
Inpatient Totals	206	\$5,851,737	40	\$328,323
Outpatient				
Manufacturer Credits for Replaced Medical Devices	12	\$149,755	5	\$84,992
Claims Billed With Modifiers	3	44,994	1	442
Claims With Payments Greater Than \$25,000	22	851,416	0	0
Claims Billed With Herceptin	10	47,290	0	0
Outpatient Totals	47	\$1,093,455	6	\$85,434
Inpatient and Outpatient Totals	253	\$6,945,192	46	\$413,757

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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November 18, 2014

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Office of Inspector General
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-07-14-05058
Medicare Compliance Review of Missouri Baptist Medical Center for 2011 and 2012

Missouri Baptist Medical Center received the draft report dated November 7, 2014 requesting written comments and a statement describing the corrective action taken or actions planned by Missouri Baptist Medical Center to your recommendations identified in the report.

Through this review, the OIG concluded the hospital complied with Medicare for 207 of the 253 inpatient and outpatient claims reviewed. However, the auditors determined the hospital did not fully comply with Medicare billing requirements for the remaining 46 claims, resulting in net overpayments of \$413,757 for calendar years 2011-2012. Specifically, 40 inpatient claims had billing errors, resulting in overpayment of \$328,323, and 6 outpatient claims had billing errors, resulting in overpayment of \$85,434.

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

After review of the audit findings and recommendations Missouri Baptist Medical Center agrees with the 39 claims identified with billing errors, and disagree with 7 claims. We have fully reimbursed the overpayment amounts as determined by your audit with the exception of 4 claims as further explained:

- 3 claims pending in the Medicare system due to suspense errors, and
- 1 claim pending due to patient updates in Common Working File.

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

Inpatient Claims

Insufficiently Documented Procedures

For 29 of the 206 selected claims, the hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the hospital which resulted in overpayment of \$223,719.

- In 16 cases the errors were the result of human error and were not detected by key controls. 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 monitoring, feedback and education is provided to the coding staff to help to reduce the possibility of human error in the coding process.
- In 12 cases the errors were due to insufficient physician documentation that lacked enough detail for the coder to determine if an ICD-9-CM diagnosis code should be assigned for post-operative conditions. Codes are not to be assigned when the condition is an expected outcome of the surgery performed. The Hospital had identified this issue prior to this audit and had provided education to the physicians and coding staff regarding the documentation necessary for accurate code assignment. An additional audit was initiated to determine if additional cases outside the timeframe of this audit should be refunded.
- One case was the result of incorrect billing of outpatient procedures within 3 calendar days of an inpatient admission. The Hospital currently has processes in place to prevent errors in billing compliance with the 3-day window.

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Incorrectly Billed as Inpatient Stays

For 8 of the 206 selected claims, the audit alleges the hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services, which resulted in an overpayment of \$94,157.

- Processes are in place to ensure Case Management reviews and complies with all Medicare regulations regarding appropriate documentation to support inpatient billing.
- The hospital does not agree with the findings with respect to seven of the eight claims and will appeal these cases through the Medicare appeal process.

Manufacturer Credit for Replaced Medical Devices Not Reported

For 3 of the 206 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 \$10,447.

- BJC Corporate Compliance and Missouri Baptist Medical Center were currently in the process of identifying Medicare claims with dates of service 2011 through current year, and refunding as appropriate. After review of 2011 through current claims, it was planned to review claims with dates of service prior to 2011.
- BJC Corporate Compliance, along with Missouri Baptist Medical Center, receives monthly device credit reports which are internally updated to indicate Medicare credits > 50%. We are in the process of developing a front end process to hold claims in order 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%.

Outpatient

Manufacturer Credits for Replaced Medical Devices Not Reported

For 5 of the 47 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 \$84,992.

- BJC Corporate Compliance and Missouri Baptist Medical Center were currently in the process of identifying Medicare claims with dates of service 2011 through current year, and refunding as appropriate. After review of 2011 through current claims, it was planned to review claims with dates of service prior to 2011.
- BJC Corporate Compliance, along with Missouri Baptist Medical Center, receives monthly device credit reports which are internally updated to indicate Medicare credits > 50%. We are in the process of developing a front end process to hold claims to in order 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 1 of the 47 selected claims, the hospital submitted the claims to Medicare with incorrect procedures codes which resulted in an overpayment of \$442.

- While Missouri Baptist Hospital Center (MBMC) concurs with the error, this was a random procedure coding error which caused a modifier edit. The chart was re-reviewed and corrected. MBMC re-educated the coder along with providing education to all coding staff. MBMC also implemented a monthly modifier internal audit.

Missouri Baptist Medical 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
John Antes
Tony Noronha