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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Saint Luke's Hospital of Kansas City did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately $581,000 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 Saint Luke's Hospital of Kansas City (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 410-bed acute care hospital located in Kansas City, Missouri. Medicare paid the Hospital approximately $234 million for 15,864 inpatient and 198,945 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered $8,626,510 in Medicare payments to the Hospital for 294 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 252 inpatient and 42 outpatient claims. Of the 294 claims, 274 claims had dates of service in CY 2011 or CY 2012, and 20 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010 or 2013.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 214 of the 294 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 80 claims, resulting in overpayments of $581,218 for CYs 2011 and 2012 (65 claims) and CY 2010 (15 claims). Specifically, 63 inpatient claims had

billing errors, resulting in overpayments of $366,584, and 17 outpatient claims had billing errors, resulting in overpayments of $214,634. 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 $581,218, consisting of $366,584 in overpayments for 63 incorrectly billed inpatient claims and $214,634 in overpayments for 17 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

Prompted by our review, the Hospital has initiated or completed claims adjustments or cancellation on certain claims.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital agreed with our findings regarding 71 of the 80 claims for which we had identified billing errors but strongly disagreed with our findings on the remaining 9 claims. The Hospital said that it had submitted corrected claims for the 71 claims and described corrective actions that it had taken or that were in progress.

The Hospital strongly disagreed with our finding regarding nine claims which, we found, had been incorrectly billed as inpatient claims. The Hospital said that it strongly believes that the physician determination for admission was justified and medically necessary and added that it intends to appeal these claims. The Hospital also said that the amount of overpayment conveyed in this finding appeared to be overstated, as it did not take into account the payment that the Hospital could receive under Medicare Part B if the finding is upheld on appeal.

After reviewing the Hospital's comments, we maintain that all of our findings and recommendations remain valid. We used Wisconsin Physicians Service Insurance Corporation (the Hospital's 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.

With respect to the Hospital's comment that the amount of overpayment for the inpatient claims in question appeared to be overstated, Medicare Part B claims that have not been billed are outside the scope of our review. As we note in the body of this report, 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, but we acknowledge that the Hospital may rebill

Medicare Part B for the incorrectly billed inpatient claims. Based on our own audit work as fully supported by the Medicare administrative contractor's review, we continue to believe that the Hospital should have billed these nine 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 Saint Luke's Hospital of Kansas City (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 short stays,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims billed with high severity level DRG codes,
- inpatient DRG verification,
- inpatient and outpatient claims paid in excess of charges,
- inpatient claims billed with same-day discharges and readmissions,
- inpatient claims billed with cancelled elective surgical procedures,
- inpatient claims with payments greater than $150,000,
- inpatient claims billed with kyphoplasty services,
- outpatient claims with payments greater than $25,000, and
- outpatient claims with surgeries billed with units greater than one.

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)).

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

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).

Saint Luke's Hospital of Kansas City

The Hospital is a 410-bed acute care hospital located in Kansas City, Missouri. Medicare paid the Hospital approximately $234 million for 15,864 inpatient and 198,945 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 $8,626,510 in Medicare payments to the Hospital for 294 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 252 inpatient and 42 outpatient claims. Of the 294 claims, 274 claims had dates of service in CY 2011 or CY 2012, and 20 claims had dates of service in CY 2010 or 2013.[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 28 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 214 of the 294 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 80 claims, resulting in overpayments of $581,218 for CYs 2011 and 2012 (65 claims) and CY 2010 (15 claims). Specifically, 63 inpatient claims had billing errors, resulting in overpayments of $366,584, and 17 outpatient claims had billing errors, resulting in overpayments of $214,634. These errors occurred primarily because the Hospital did

[2] We selected these 20 claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

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 63 of 252 selected inpatient claims that we reviewed. These errors resulted in overpayments of $366,584.

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 12 out of 252 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. For nine of these claims, the Hospital conducted its own review and said that it disagreed with our findings. However, the Medicare administrative contractor evaluated the medical necessity requirements associated with these nine claims and found that the Hospital had incorrectly billed them. For the three remaining claims, the Hospital attributed the overpayments to key controls that were in place but were not well-communicated to all of the case managers. As a result of these errors, the Hospital received estimated overpayments of $155,243.[3]

[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.

Insufficiently Documented Procedure or Diagnosis Codes

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 19 out of 252 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain procedure or diagnosis codes were not supported in the medical records. The Hospital attributed the overpayments to human errors or to certain controls that needed improvement. As a result of these errors, the Hospital received overpayments of $113,487.

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 28 out of 252 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 28 claims, 10 had dates of service in CY 2010, 7 had dates of service in CY 2011, and 11 had dates of service in CY 2012.) The Hospital said that these overpayments occurred because it relied on the manufacturer's representative to notify it that warranty credits would be applied, but for these claims the representative did not do so. As a result of these errors, the Hospital received overpayments of $82,961.

Same-Day Discharge and Readmission

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 4 out of 252 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital said that these overpayments occurred because of inadequate communication between the Health Information Management department and the Centralized Billing office. As a result of these errors, the Hospital received overpayments of $14,893.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 17 of 42 selected outpatient claims that we reviewed. These errors resulted in overpayments of $214,634.

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 16 out of 42 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 16 claims, 5 had dates of service in CY 2010, 9 had dates of service in CY 2011, and 2 had dates of service in CY 2012.) The Hospital said that these overpayments occurred because it relied on the manufacturer's representative to notify it that warranty credits would be applied, but for these claims the representative did not do so. As a result of these errors, the Hospital received overpayments of $214,286.

Incorrect 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 1 out of 42 selected claims, the Hospital billed Medicare for an incorrect number of service units. The Hospital said that this overpayment occurred because its pharmacy had submitted the charge for a medication based on the dosage it had dispensed rather than the lower dosage (made necessary by a change in the patient's weight) actually administered. As a result of this error, the Hospital received an overpayment of $348.

[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).

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $581,218, consisting of $366,584 in overpayments for 63 incorrectly billed inpatient claims and $214,634 in overpayments for 17 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

Prompted by our review, the Hospital has initiated or completed claims adjustments or cancellation on certain claims.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with our findings regarding 71 of the 80 claims for which we had identified billing errors (54 of the 63 inpatient claims and all 17 outpatient claims) but strongly disagreed with our findings on the remaining 9 claims. The Hospital said that it had submitted corrected claims for the 71 claims and described corrective actions that it had taken or that were in progress.

The Hospital strongly disagreed with our finding regarding nine claims which, we found, had been incorrectly billed as inpatient claims. The Hospital said that it strongly believes that the physician determination for admission was justified and medically necessary and added that it intends to appeal these claims. The Hospital also said that the amount of overpayment conveyed in this finding appeared to be overstated, as it did not take into account the payment that the Hospital could receive under Medicare Part B if the finding is upheld on appeal.

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 all of our findings and recommendations remain valid. We used Wisconsin Physicians Service Insurance Corporation (the Hospital's 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.

With respect to the Hospital's comment that the amount of overpayment for the inpatient claims in question appeared to be overstated, Medicare Part B claims that have not been billed are outside the scope of our review. As we note in the body of this report (footnote 3), 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, but we acknowledge that the Hospital

may rebill Medicare Part B for the incorrectly billed inpatient claims. Based on our own audit work as fully supported by the Medicare administrative contractor's review, we continue to believe that the Hospital should have billed these nine inpatient claims as outpatient or outpatient with observation services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $8,626,510 in Medicare payments to the Hospital for 294 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 252 inpatient and 42 outpatient claims. Of the 294 claims, 274 claims had dates of service in CY 2011 or CY 2012, and 20 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010 or 2013 (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 28 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 April 2014 to January 2015.

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 2013;
- 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 294 claims (252 inpatient and 42 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;

- asked Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether 28 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 January 30, 2015.

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				
Short Stays	27	$383,875	10	$149,440
Manufacturer Credits for Replaced Medical Devices	38	822,697	28	82,961
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	54	1,767,057	7	76,175
Diagnosis-Related-Group Verification	94	2,142,244	9	21,149
Claims Paid in Excess of Charges	11	150,231	3	16,163
Same-Day Discharges and Readmissions	6	59,442	4	14,893
Claims Billed With Cancelled Elective Surgical Procedures	10	56,389	2	5,803
Claims With Payments Greater Than $150,000	10	2,322,663	0	0
Claims Billed With Kyphoplasty Services	2	20,107	0	0
Inpatient Totals	**252**	**$7,724,705**	**63**	**$366,584**
Outpatient				
Manufacturer Credits for Replaced Medical Devices	27	$276,144	16	$214,286
Claims With Payments Greater Than $25,000	14	621,160	1	348
Surgeries Billed With Units Greater Than One	1	4,501	0	0
Outpatient Totals	**42**	**$901,805**	**17**	**$214,634**
Inpatient and outpatient Totals	**294**	**$8,626,510**	**80**	**$581,218**

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

Saint Luke's
HOSPITAL OF KANSAS CITY

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April 8, 2015

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

Dear Mr. Cogley,

Saint Luke's Hospital of Kansas City (SLH) appreciates the opportunity to respond to the OIG draft report titled *Medicare Compliance Review of Saint Luke's Hospital of Kansas City for 2011 and 2012*. SLH would like to acknowledge the professionalism and openness of communication shown by the OIG auditors. SLH has an active compliance program and strives to strictly adhere to Medicare regulations. The OIG report identifies certain areas where SLH has opportunity to improve internal processes to ensure full compliance with Medicare regulations. None of the errors reported are attributable to any wrongful intent. SLH agrees with the OIG on 71 of the errors identified but respectfully disagrees with 9 of the short stay claims that the OIG has identified as incorrect. In all instances cited in the draft report as billing errors, the patients received reasonable, high quality care that contributed to their quality of life.

Incorrectly Billed as Inpatient

SLH agrees with the OIG's findings on three of the twelve (12) claims and has already submitted corrected claims. However, SLH strongly disagrees with the OIG findings with regard to nine of the short stay claims. In addition to internal review by SLH staff, the hospital had these claims reviewed by Executive Health Resources (EHR), an independent third party reviewer which agrees with SLH's position. SLH strongly believes that the physician determination for admission was justified and medically necessary and intends to appeal these claims. Given the success SLH has had in having these denials overturned in appeals for RAC claims, we are confident in our determination that these are appropriate inpatient admissions and that the denials will be overturned on appeal. Additionally, the overpayment figure cited by the OIG appears to be overstated as it does not take into account the payment that SLH could receive under Part B if the OIG determination is upheld upon appeal.

Insufficiently Documented Procedure or Diagnosis Codes

SLH agrees with the OIG's findings that nineteen (19) of the 252 claims selected were billed incorrectly and has already submitted corrected claims. These errors can be attributed to individual human errors. Generally, coding staff is audited monthly. Any coder whose accuracy falls below 95% on the monthly audit is subject to review of 100% of their work. The Health Information Management Department also works to identify trends in coding errors and once identified, performs

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focused reviews and education for staff. Additionally, the coding staff has received focused education to ensure that supporting clinical documentation follows the "MEET" criteria. Coding staff has also received additional education about querying providers when documentation does not support a selected diagnosis. The Health Information Management Department will continue to regularly monitor all coders and provide education to prevent these errors in the future.

Manufacturer Credits for Replaced Medical Devices Not Reported

SLH agrees with the OIG findings that the twenty eight (28) claims were billed incorrectly and has already submitted corrected claims. As a result of this audit, SLH has identified a gap in the process for preparing and submitting the medical device credit claims. In addition to a failure in the notification process from the device manufacturer, SLH has recognized there are opportunities for improvement in the process for holding these claims and affixing the appropriate modifiers and value codes. SLH has created a new process that incorporates all of the departments involved in the submission of these medical device claims. The new process developed includes internal review of device replacement cases to identify potential credit situations as well as a process for stopping the claims for manual review prior to submission to ensure accuracy. The SLH compliance team will also perform additional audits to ensure the submission of correct claims where the hospital has received full or partial credit for devices.

Same Day Discharge and Readmission

SLH agrees with the OIG's findings that the four (4) claims were billed incorrectly and has already submitted corrected claims. In 2013, SLH indentified there was inadequate communication between the two departments responsible for processing and submitting these types of claims. Therefore, a process change was initiated and responsibilities were clarified. SLH believes that the process change implemented in 2013 has prevented and will prevent these errors from occurring again in the future.

Billing Errors Associated with Outpatient Claims

Manufacturer Credits for Replaced Medical Devices Not Reported

SLH agrees with the OIG's findings that the sixteen (16) claims identified in this area were billed incorrectly and has already submitted corrected claims. As explained for medical device credits on the inpatient side, SLH identified gaps in the existing process as a result of this audit. In addition to a failure in the notification process from the device manufacturer, SLH has recognized that there are opportunities for improvement in the process for holding these claims and affixing the appropriate modifiers and value codes. SLH has created a new process that incorporates all of the departments involved in the submission of these medical device claims. The new process developed includes internal review of device replacement cases to identify potential credit situations as well as a process for stopping the claims for manual review prior to submission to ensure accuracy. The SLH

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compliance team will also perform additional audits to ensure the submission of correct claims where the hospital has received full or partial credit for devices.

Incorrect Number of Units (Claims Paid Greater Than $25,000)

SLH agrees with the OIG's findings that the one (1) claim identified in this area was billed incorrectly and has already submitted a corrected claim. The dosage on this claim changed due to a change in patient weight. The change occurred after the pharmacy had dispensed the medication but prior to administration. At the time of the claim, the pharmacy charged for medication at the time of dispensing the medication. The change should have been communicated to the pharmacy to change the charge but was not done adequately. In 2013, the pharmacy changed to a billing system that charges upon administration rather than dispense. Therefore, SLH believes that the process in place since 2013has prevented similar errors and will continue to do so in the future.

OIG Recommendations

The OIG has made the following two recommendations:

- That the Hospital refund to the Medicare contractor $581,218, consisting of $366,584 in overpayments for 63 incorrectly billed inpatient claims and $214,634 in overpayments for 17 incorrectly billed outpatient claims, and
- Strengthen controls to ensure full compliance with Medicare requirements.

With respect to the first recommendation, SLH partially concurs and has already refunded the Medicare contractor for 54 of the inpatient claims and 17 of the outpatient claims through the submission of corrected claims. For the nine remaining inpatient claims, SLH respectfully disagrees with the OIG's findings and intends to appeal the overpayment determination made by the OIG. SLH believes that the amount of the overpayment for the nine disputed short stay claims is overstated and respectfully requests that that the OIG take into account the amount SLH could bill for those claims under Part B and reduce the amount of the stated overpayment accordingly.

With respect to the second recommendation to strengthen controls to ensure compliance with Medicare requirements, SLH works continuously at strengthening internal controls and compliance activities related to Medicare compliance. SLH considers this audit to be a learning opportunity and will continue to monitor and audit claims as well as provide education for our staff.

Sincerely,

Sally Thieman
Chief Ethics and Compliance Officer
Saint Luke's Health System