

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW  
OF FREEMAN HOSPITAL  
FOR 2011 AND 2012**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
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**Patrick J. Cogley  
Regional Inspector General  
for Audit Services**

**March 2016  
A-07-14-05064**

# *Office of Inspector General*

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## EXECUTIVE SUMMARY

***Freeman Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$311,000 over 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 Freeman 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 346-bed teaching hospital located in Joplin, Missouri. Medicare paid the Hospital approximately \$182 million for 14,061 inpatient and 141,475 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered \$4,215,166 in Medicare payments to the Hospital for 225 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 208 inpatient and 17 outpatient claims and had dates of service in CY 2011 or CY 2012.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 180 of the 225 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 45 claims, resulting in overpayments of \$311,447. Specifically, 42 inpatient claims had billing errors, resulting in overpayments of \$304,311, and 3 outpatient claims had billing errors, resulting in overpayments of \$7,136. The errors that we identified 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 \$311,447, consisting of \$304,311 in overpayments for 42 incorrectly billed inpatient claims and \$7,136 in overpayments for 3 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS AND OUR RESPONSE**

The draft report that we issued to the Hospital conveyed three recommendations. This final report combines the numbers of claims and the dollar amounts from the first two of those three recommendations into a single recommendation.

In written comments on our draft report, the Hospital agreed with our findings regarding 35 of the 45 claims for which we had identified billing errors but disagreed with our findings on the remaining 10 claims (9 inpatient claims and 1 outpatient claim). The Hospital said that it would appeal our determinations for these 10 claims. The Hospital also described corrective actions that it had taken or planned to take.

For the nine inpatient claims, in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services, the Hospital stated that the physician determinations for admission were justified and medically necessary. The Hospital also said that it believed that we overstated the amount of overpayments for these claims, because that amount did not take into account the payment that the Hospital could receive under Medicare Part B.

The Hospital also disagreed with our finding regarding one outpatient claim that involved a replaced medical device for which the Hospital received full credit but did not report a necessary modifier on its claim. The Hospital said that based on its review of a Medicare criterion, the use of a different modifier is appropriate when a hospital receives a credit of 50 percent or more of the estimated cost of the replacement device. Because the total cost for the new replacement device was \$500 more than the credit the Hospital received, the Hospital said that it believed that the use of the different modifier was appropriate.

After reviewing the Hospital's comments, we maintain that all our findings and recommendations remain valid. We used Wisconsin Physicians Service Insurance Corporation (the Hospital's Medicare administrative contractor) to determine whether the nine inpatient claims with which the Hospital disagreed met medical necessity requirements. The contractor examined all 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 assertion that we may have overstated the amount of overpayments for the nine inpatient claims in question, Medicare Part B claims that the Hospital

has not 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 Part B would have on the overpayment amount, because the Hospital had not billed for these services and the Medicare contractor had not adjudicated the claims before we issued this report. We acknowledge, though, that the Hospital can rebill Part B for the incorrectly billed inpatient claims. Based on our own audit work as fully supported by the Medicare contractor's review, we continue to believe that the Hospital should have billed these inpatient claims as outpatient or outpatient with observation services.

Regarding the Hospital's comment that it correctly used the different modifier for the outpatient claim in question, Medicare payment policy regarding the reporting of manufacturer credits for replaced medical devices is clear and specific as to the modifier that must be used in claims for these devices.

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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 Freeman 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.<sup>1</sup> 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 claims billed with high severity level DRG codes,
- inpatient and outpatient claims paid in excess of charges,
- inpatient DRG verification,
- inpatient claims billed with kyphoplasty services,
- inpatient claims billed with cancelled elective surgical procedures,
- inpatient same-day discharges and readmissions,
- outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed with modifiers, and
- outpatient claims with payments greater than \$25,000.

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)).

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<sup>1</sup> 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).

## **Freeman Hospital**

The Hospital is a 346-bed teaching hospital located in Joplin, Missouri. Medicare paid the Hospital approximately \$182 million for 14,061 inpatient and 141,475 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 \$4,215,166 in Medicare payments to the Hospital for 225 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 208 inpatient and 17 outpatient claims and had dates of service in CY 2011 or CY 2012. 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 16 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 180 of the 225 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 45 claims, resulting in overpayments of \$311,447. Specifically, 42 inpatient claims had billing errors, resulting in overpayments of \$304,311, and 3 outpatient claims had billing errors, resulting in overpayments of \$7,136. The errors that we identified 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 42 of 208 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$304,311.

## Unsupported 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 25 out of 208 selected claims, the Hospital billed Medicare with incorrectly coded claims. Specifically, certain diagnosis codes or procedure codes were not supported in the medical records. The Hospital stated that these overpayments happened due to human error. As a result of these errors, the Hospital received overpayments of \$157,096.

## 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 15 out of 208 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 disagreed with our findings for 9 of the 15 claims and stated that it believed the patients met utilization review criteria and that the Hospital followed its utilization review plan process. However, the Medicare contractor found that the Hospital had incorrectly billed based on medical necessity. For the other six claims, the Hospital said that these errors were either because of human error or because Hospital staff were not able to review the claims prior to discharge. As a result of these errors, the Hospital received estimated overpayments of \$143,682.<sup>2</sup>

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<sup>2</sup> 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 contractor before the issuance of our report.

## **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 2 out of 208 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital stated that these errors could have happened if the Hospital discharged the patients prior to staff reviewing the claims with the utilization review plan. As a result of these errors, the Hospital received overpayments of \$3,533.

## **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 3 of 17 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$7,136, all of which were within the 3-year recovery period.

## **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.<sup>3</sup>

For 2 out of 17 selected claims, the Hospital received full credits for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims. The Hospital disagreed with our findings for one of the two claims, stating that it had submitted a corrected claim prior to our review and had received reduced payment. However, for this claim we determined that the Hospital had incorrectly coded it with an "FC" modifier, which had the effect of partially reducing the claim payment. The Hospital should have coded the claim with the "FB" modifier, the effect of which would have reduced the claim payment further to reflect the correct modifier. For the other claim, the Hospital stated that it was not always provided timely reports or

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<sup>3</sup> 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).

warranty determinations from the device manufacturers. As a result of these two errors, the Hospital received overpayments of \$6,198.

### **Incorrect Number of Service 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 17 selected claims, the Hospital billed Medicare for an incorrect number of service units. The Hospital stated that this overpayment happened due to human error. As a result of this error, the Hospital received an overpayment of \$938.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$311,447, consisting of \$304,311 in overpayments for 42 incorrectly billed inpatient claims and \$7,136 in overpayments for 3 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS<sup>4</sup>**

In written comments on our draft report, the Hospital agreed with our findings regarding 35 of the 45 claims for which we had identified billing errors but disagreed with our findings on the remaining 10 claims (9 inpatient claims and 1 outpatient claim). The Hospital said that it would appeal our determinations for these 10 claims. The Hospital also described corrective actions that it had taken or planned to take.

The Hospital disagreed with our findings regarding the nine inpatient claims in which we found that it should have billed the claims as outpatient or outpatient with observation services. The Hospital stated that it believed that the physician determinations for admission in these cases were justified and medically necessary. The Hospital also said that it believed that we overstated the amount of overpayments for these claims, because that amount did not take into account the payment that the Hospital could receive under Medicare Part B if Wisconsin Physicians Service Insurance Corporation (WPS), the Hospital’s Medicare administrative contractor, upholds our determinations.

The Hospital also disagreed with our finding regarding one outpatient claim, in which we found that the Hospital received full credit for a replaced medical device but did not report the FB

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<sup>4</sup> The draft report that we issued to the Hospital conveyed three recommendations. This final report combines the numbers of claims and the dollar amounts from the first two of those three recommendations into a single recommendation.

modifier on its claim. The Hospital said that based on its review of a Medicare criterion, the use of the FC modifier is appropriate when a hospital receives a credit of 50 percent or more of the estimated cost of the replacement device. Because the total cost for the new replacement device was \$500 more than the credit the Hospital received, the Hospital said that it believed that the use of the FC code was appropriate.

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

### **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the Hospital's comments, we maintain that all our findings and recommendations remain valid. We used WPS to determine whether the nine inpatient claims with which the Hospital disagreed met medical necessity requirements. The contractor examined all 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 assertion that we may have overstated the amount of overpayments for the nine inpatient claims in question, Medicare Part B claims that the Hospital has not billed are outside the scope of our review. As we note earlier in this report (footnote 2), we were unable to determine the effect that billing Part B would have on the overpayment amount, because the Hospital had not billed for these services and the Medicare contractor had not adjudicated the claims before we issued this report. We acknowledge, though, that the Hospital can rebill Part B for the incorrectly billed inpatient claims. Based on our own audit work as fully supported by WPS's review, we continue to believe that the Hospital should have billed these inpatient claims as outpatient or outpatient with observation services.

Regarding the Hospital's comment that it correctly used the FC modifier for the outpatient claim in question, Medicare payment policy regarding the reporting of manufacturer credits for replaced medical devices is clear and specific as to the modifier that must be used in claims for these devices. The Manual, chapter 4, section 61.3.2, states: "When a hospital replaces a device with a more expensive device and receives a credit in the amount that the device being replaced would otherwise cost, the Hospital must append modifier FB to the procedure code...."

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered \$4,215,166 in Medicare payments to the Hospital for 225 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 208 inpatient and 17 outpatient claims and had dates of service in CY 2011 or CY 2012.

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 16 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 from February 2014 to October 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 2011;
- 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 225 claims (208 inpatient and 17 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 WPS (the Medicare contractor) to determine whether 16 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 October 6, 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**

| <b>Risk Area</b>   | <b>Selected Claims</b> | <b>Value of Selected Claims</b> | <b>Claims With Over-payments</b> | <b>Value of Over-payments</b> |
|--|------------------------|---------------------------------|----------------------------------|-------------------------------|
| <b>Inpatient</b>   |                        |                                 |                                  |                               |
| Short Stays  | 14                     | \$137,246                       | 12                               | \$123,112                     |
| Claims Billed With High Severity Level Diagnosis-Related-Group Codes | 92                     | 1,868,625                       | 14                               | 94,747                        |
| Claims Paid in Excess of Charges                                     | 13                     | 238,416                         | 2                                | 34,972                        |
| Diagnosis-Related-Group Verification                                 | 75                     | 1,323,665                       | 9                                | 27,377                        |
| Claims Billed With Kyphoplasty Services                              | 2                      | 16,623                          | 2                                | 16,623                        |
| Claims Billed With Cancelled Elective Surgical Procedures            | 4                      | 28,250                          | 1                                | 3,947                         |
| Same-Day Discharges and Readmissions                                 | 8                      | 135,070                         | 2                                | 3,533                         |
| <b>Inpatient Totals</b>  | <b>208</b>             | <b>\$3,747,895</b>              | <b>42</b>                        | <b>\$304,311</b>              |
|  |                        |                                 |                                  |                               |
| <b>Outpatient</b>  |                        |                                 |                                  |                               |
| Manufacturer Credits for Replaced Medical Devices                    | 2                      | \$10,239                        | 2                                | \$6,198                       |
| Claims Billed With Modifiers   | 1                      | 12,418                          | 1                                | 938                           |
| Claims With Payments Greater Than \$25,000                           | 13                     | 435,099                         | 0                                | 0                             |
| Claims Paid in Excess of Charges                                     | 1                      | 9,515                           | 0                                | 0                             |
| <b>Outpatient Totals</b>   | <b>17</b>              | <b>\$467,271</b>                | <b>3</b>                         | <b>\$7,136</b>                |
|  |                        |                                 |                                  |                               |
| <b>Inpatient and Outpatient Totals</b>                               | <b>225</b>             | <b>\$4,215,166</b>              | <b>45</b>                        | <b>\$311,447</b>              |

**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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January 5, 2016

Mr. Patrick Cogley  
Regional Inspector General for Audit Services  
OIG - Office of Audit Services, Region VII  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

RE: Report Number A-07-14-05064

Dear Mr. Cogley:

Freeman Health System (Freeman) appreciates the opportunity to respond to the OIG's report titled Medicare Compliance Review of Freeman Hospital for 2011 and 2012. Freeman has an active compliance program and strives to strictly adhere to Medicare regulations. The OIG report identifies certain areas where we have opportunity to improve our internal processes to ensure full compliance with Medicare regulations. None of the errors reported are attributable to any wrongful or malicious intent.

The OIG's report identified 45 payment errors. Freeman agrees with the OIG on 35 of the payment errors identified, but respectfully disagrees with 10 of them. Freeman plans to appeal the OIG's denial determination for these 10 cases. Freeman's comments for each audit recommendation in the report is as follows:

### **Billing Errors Associated with Inpatient Claims**<sup>5</sup>

**Unsupported Codes:** The OIG audited 211 claims to validate the appropriate assignment of DRG coding, claims for appropriate coding of claims with MCCs or CCs, which impacted the determination of DRG coding. Of these 211 claims, the OIG reported 25 had errors. We agree with these findings which resulted in an overpayment of \$157,096 and corrected claims have already been submitted. To address these errors, Freeman has taken the following actions: (1) coders are required to have all accounts with only one CC or MCC reviewed by a second more experienced coder before finalizing the record for billing; and (2) coders will be provided additional and refresher training on appropriate diagnosis code sequencing.

These errors can be attributed to individual human error. 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 Coding Department also works to identify trends in coding errors and once identified, performs focused reviews and education for staff. The coding staff has also received additional education about querying providers when documentation does not support a selected diagnosis. The Coding Department will continue to regularly monitor all coders and provide education to prevent these errors in the future.

<sup>5</sup> Office of Inspector General Note: The 211 inpatient claims that the Hospital mentions just below reflect a typographical error in an early communication from us to the Hospital. We actually reviewed 208 inpatient claims, as stated in our report.

**Incorrectly Billed as Inpatient:** In all instances cited in the report as incorrectly billed as inpatient billing errors, the patients received reasonable high quality care. As stated above, Freeman agrees with the OIG's findings on six (6) of the fifteen (15) claims and has already submitted corrected claims. However, Freeman strongly disagrees with the OIG findings with regard to nine (9) of the inpatient denials. Upon a thorough internal review, Freeman strongly believes that the physician determination for admission was justified and medically necessary and intends to appeal these claims. Given the success Freeman has in having these type of denials overturned on appeal for RAC and MAC reviews, we are confident in our determination that these are appropriate inpatient admissions. Additionally, Freeman feels the overpayment figure cited by the OIG appears to be overstated as it does not take into account the payment that Freeman could receive under Part B, if the OIG determination is upheld upon appeal.

**Incorrectly Billed as Separate Inpatient Stays:** Freeman agrees with the OIG's findings that the two (2) claims were billed incorrectly and has already submitted corrected claims. In 2013, Freeman identified 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. Freeman 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:** Freeman agrees with the OIG's findings on one (1) of the two (2) claims and has already submitted corrected claims. However, Freeman strongly disagrees with the OIG's finding with regard to the other denial. Upon a thorough internal review, Freeman strongly believes that K01 was billed correctly in 2011 with the FC modifier based upon our review of MLN Matters Number SE0732 – Change Request 5668. This MLN Matters publication states, “the hospital or ASC received a credit of 50 percent or more of the estimated cost of the new replacement device” is when the FC modifier should be used. We have the credit memo for the device removed and the invoice for the replacement device. The total cost for the new replacement device was \$500 more than the credit we received, hence Freeman feels the use of modifier FC was appropriate.

To address the one agreed upon error, we have implemented a new process requiring device manufacturers to provide us a monthly statement regarding any credits applied on a monthly basis to ensure claims are submitted correctly.

**Incorrect Number of Service Units:** The OIG audited 1 claim to validate the appropriate assignment of modifier-59 and determined the claim was paid in error. This error can be attributed to individual human error. The coding staff has received additional education about the appropriate use of modifiers, especially modifier-59. The Coding Department will continue to regularly monitor all coders and provide education to prevent this error in the future.

## OIG Recommendations

The OIG has made the following three recommendations:

- That the Hospital refund to the Medicare contractor \$260,973, consisting of \$253,837 in overpayments for 37 incorrectly billed inpatient claims and \$7,136 in overpayments for 3 incorrectly billed outpatient claims;
- Work with the Medicare contractor to return up to \$50,474 in overpayments for 5 incorrectly billed inpatient claims that were outside the 3-year recovery period, in the accordance with the 60-day repayment rule; and
- Strengthen controls to ensure full compliance with Medicare requirements.

With respect to the first recommendation, Freeman partially concurs and has already refunded the Medicare contractor for these 40 claims via the submission of corrected claims. However, there are 5 claims, Freeman respectfully disagrees with the OIG's findings and intends to appeal the overpayment determination made by the OIG.

In the second recommendation, the OIG denied 5 inpatient short stays and have identified that they are outside the 3-year recovery period. Freeman again respectfully disagrees that these claims were paid in error and plan to appeal the OIG's findings. Due to the OIG's indication of the 60-day repayment rule for these 5 claims, we plan to appeal these denials immediately with WPS' to ensure our appeal is filed within a timely manner.

With respect to the third recommendation to strengthen controls to ensure compliance with Medicare requirements, Freeman works continuously at strengthening internal controls and compliance activities related to Medicare compliance. Freeman considers this audit as an opportunity to further enhance our compliance efforts and to provide education for our staff.

Freeman appreciates the opportunity to respond to the OIG's report findings. We understand our compliance obligations and continually strive to adhere to all Medicare requirements.

Sincerely,

/Carlos Haley/

Carlos Haley, MBA  
Vice President of Compliance

cc: Paula Baker, Freeman Health System President and CEO