

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
SAINT MARY'S HEALTH CENTER  
FOR 2011 AND 2012**

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

July 2015  
A-07-14-05065

# *Office of Inspector General*

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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 Mary's Health Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$69,000 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 Mary's Health 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 525-bed acute care hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately \$153 million for 10,318 inpatient and 67,257 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered \$3,855,773 in Medicare payments to the Hospital for 193 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 159 inpatient and 34 outpatient claims. Of the 193 claims, 191 claims had dates of service in CY 2011 or CY 2012, and 2 claims (involving inpatient and 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 181 of the 193 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 12 claims, resulting in overpayments of \$69,171 for CYs 2011 and 2012 (10 claims) and CY 2010 (2 claims). Specifically, eight inpatient claims had

billing errors, resulting in overpayments of \$40,383, and four outpatient claims had billing errors, resulting in overpayments of \$28,788. 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 \$69,171, consisting of \$40,383 in overpayments for eight incorrectly billed inpatient claims and \$28,788 in overpayments for four 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 and stated that it had refunded the \$69,171 in overpayments. The Hospital also described corrective actions that it had taken or planned to take to implement our recommendations.

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## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

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

### **OBJECTIVE**

Our objective was to determine whether Saint Mary's Health 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.<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 claims billed with same-day discharges and readmissions,
- inpatient DRG verification,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims with payments greater than \$150,000,
- inpatient and outpatient claims paid in excess of charges,
- inpatient short stays,
- inpatient claims billed with cancelled elective surgical procedures,
- outpatient claims with payments greater than \$25,000,
- outpatient claims billed with modifiers,
- outpatient claims billed with Herceptin, 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)). Federal regulations state that the provider

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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.

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 Mary's Health Center**

The Hospital is a 525-bed acute care hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately \$153 million for 10,318 inpatient and 67,257 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 \$3,855,773 in Medicare payments to the Hospital for 193 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 159 inpatient and 34 outpatient claims. Of the 193 claims, 191 claims had dates of service in CY 2011 or CY 2012, and 2 claims had dates of service in CY 2010.<sup>2</sup> 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 two 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 181 of the 193 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 12 claims, resulting in overpayments of \$69,171 for CYs 2011 and 2012 (10 claims) and CY 2010 (2 claims). Specifically, eight inpatient claims had billing errors, resulting in overpayments of \$40,383, and four outpatient claims had billing errors, resulting in overpayments of \$28,788. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims

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

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 8 of 159 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$40,383.

### **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 159 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital said that it had processes in place to review records for such “overlaps in stay” and then to combine accounts and rebill Medicare. The Hospital added that in these cases, it combined the accounts and attempted to rebill, but the rebilled claims were denied because they did not meet Medicare requirements for timeliness. As a result of these errors, the Hospital received overpayments of \$18,503.

### **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 1 out of 159 selected claims, the Hospital incorrectly billed Medicare Part A for a beneficiary stay that should have been billed as outpatient or outpatient with observation services. The Hospital said that it had processes in place for case management review of encounters to comply with Medicare regulations regarding appropriate documentation to support inpatient billing and added that this case was a result of human error and key controls did not detect it. As a result of this error, the Hospital received an estimated overpayment of \$12,879.<sup>3</sup>

### **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 159 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. The Hospital said that it had protocols in place to ensure compliant billing in accordance with Medicare regulations but had a breakdown in the manual process related to certain controls, which resulted in the overpayments. As a result of these errors, the Hospital received overpayments of \$9,001.

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

The Hospital incorrectly billed Medicare for 4 of 34 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$28,788.

### **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.<sup>4</sup>

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<sup>3</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 administrative contractor before the issuance of our report.

<sup>4</sup> 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).

For 4 out of 34 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 four claims, two had dates of service in CY 2010 and two had dates of service in CY 2011.) The Hospital said that it had protocols in place to ensure compliant billing in accordance with Medicare regulations but had a breakdown in the manual process related to certain controls, which resulted in the overpayments. As a result of these errors, the Hospital received overpayments of \$28,788.

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$69,171, consisting of \$40,383 in overpayments for eight incorrectly billed inpatient claims and \$28,788 in overpayments for four 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 and stated that it had refunded the \$69,171 in overpayments. The Hospital also described corrective actions that it had taken or planned to take to implement our recommendations.

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

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

### **SCOPE**

Our audit covered \$3,855,773 in Medicare payments to the Hospital for 193 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 159 inpatient and 34 outpatient claims. Of the 193 claims, 191 claims had dates of service in CY 2011 or CY 2012, and 2 claims (involving inpatient and 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 two 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 May 2014 to April 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 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 193 claims (159 inpatient and 34 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 2 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 April 2, 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>				
Same-Day Discharges and Readmissions	4	\$46,157	4	\$18,503
Diagnosis-Related-Group Verification	69	1,318,369	1	12,879
Manufacturer Credits for Replaced Medical Devices	4	104,202	3	9,001
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	65	1,169,631	0	0
Claims With Payments Greater Than \$150,000	1	370,801	0	0
Claims Paid in Excess of Charges	8	232,563	0	0
Short Stays	6	90,820	0	0
Claims Billed With Cancelled Elective Surgical Procedures	2	6,418	0	0
<b>Inpatient Totals</b>	<b>159</b>	<b>\$3,338,961</b>	<b>8</b>	<b>\$40,383</b>
<b>Outpatient</b>				
Manufacturer Credits for Replaced Medical Devices	9	\$43,387	4	\$28,788
Claims With Payments Greater Than \$25,000	5	224,195	0	0
Claims Billed With Modifiers	13	201,091	0	0
Claims Billed With Herceptin	4	24,930	0	0
Claims Paid in Excess of Charges	1	14,220	0	0
Surgeries Billed With Units Greater Than One	2	8,989	0	0
<b>Outpatient Totals</b>	<b>34</b>	<b>\$516,812</b>	<b>4</b>	<b>\$28,788</b>
<b>Inpatient and Outpatient Totals</b>	<b>193</b>	<b>\$3,855,773</b>	<b>12</b>	<b>\$69,171</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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May 28, 2015

Department of Health and Human Services  
Office of Inspector General  
Office of Audit Services, Region VII  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

Attention: Patrick Cogley  
Regional Inspector General for Audit Services

Subject: Report Number A-07-14-05065  
Medicare Compliance Review of SSM St. Mary's Health Center for 2011 and 2012

SSM St. Mary's Health Center received the draft report dated May 20, 2015 with a request to provide written comments and corrective actions taken or planned by SSM St. Mary's Health Center based on the recommendations provided in the report.

As a result of this review, the OIG determined that SSM St. Mary's Health Center complied with 181 of the 193 inpatient and outpatient claims reviewed. The review did identify 12 claims that the hospital did not fully comply with Medicare billing requirements resulting in overpayments of \$69,171 for claim years 2011 and 2012. Specifically, eight inpatient claims resulting in overpayments of \$40,383 and four outpatient claims resulting in overpayments of \$28,788.

In response to the audit SSM St. Mary's Health Center would like to assure you of its commitment to create and maintain robust procedures and controls to minimize risk of billing errors. After review of the audit findings SSM St. Mary's Health Center agrees with the 12 claims identified with billing errors. We have fully reimbursed the overpayment amount of \$69,171 for the claims determined by your audit to be billed in error.

SSM St. Mary's Health Center has reviewed the recommendations in the report and responds as follows:

### Inpatient Claims

#### ***Same-Day Discharge and Readmission***

For 4 out of 159 selected claims, the hospital incorrectly billed Medicare separately for related discharges and readmissions that occurred within the same day resulting in an overpayment of \$18,503.

Processes are in place within the Billing Office for account combination to comply with Medicare regulations. For the encounters in question for this audit the billing office had manual processes in place to capture overlaps in stay using reports and then combining the accounts when they met the criteria. Through this manual process, these accounts were identified and were attempted to rebill, but the accounts were denied as timely filing. With the implementation of a new revenue cycle management system the process for identifying overlaps in stay has become automated based on required criteria. After review of the 4 cases the hospital does agree with the findings of this audit and will repay \$18,503.

#### ***Incorrectly Billed as Inpatient***

For 1 out of 159 selected claims, the hospital incorrectly billed Medicare Part A for beneficiary stays that did not qualify for inpatient status which resulted in an overpayment of \$12,879.

Processes are in place for case management review of encounters that comply with Medicare regulations regarding appropriate documentation to support inpatient billing. This case is a result of human error and was not detected by controls. The claim was incorrectly assigned inpatient status. Due to changes in the regulations for patient status, processes have been updated to meet the requirements which included education for case management staff. After review of the case the hospital does agree with the findings of this audit and will repay \$12,879.

Through our exceptional health care services, we reveal the healing presence of God.



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***Manufacturer Credits for Replaced Medical Devices Not Reported***

For 3 out of 159 selected claims, the audit alleges the hospital received reportable medical device credits from manufacturers but did not adjust inpatient claims with appropriate value and condition codes to reduce payments as required resulting in an overpayment of \$9,001.

SSM Revenue Integrity Management have protocols in place to ensure compliant billing in accordance with Medicare Regulations. Based on the results of this review SSM Revenue Integrity identified the breakdown in the process and are currently working with the vendors on a new process for receiving the vendor credit reports and the application of the data elements required to ensure we comply with billing requirements for these services. After review of the 3 cases the hospital does agree with the findings of this audit and will repay \$9,001.

**Outpatient Claims**

***Manufacturer Credits for Replaced Medical Devices Not Reported***

For 4 out of 159 selected claims, the audit alleges the hospital received a full or partial credit for a replaced medical device but did not report the "FB" modifier on the bill to Medicare resulting in an overpayment of \$28,788.

SSM Revenue Integrity Management have protocols in place to ensure compliant billing in accordance with Medicare Regulations. Based on the results of this review SSM Revenue Integrity identified the breakdown in the process and are working with the vendors on a new process for receiving the vendor credit reports and the application of the modifier required to ensure we comply with billing requirements for these services. After review of the 4 cases the hospital does agree with the findings of this audit and will repay \$28,788.

SSM St. Mary's Health Center is committed to its Corporate Responsibility Process, which is consistent with our Mission and Values. If you have any questions or require further information, please contact me at 314-989-6838.

Respectfully Submitted,

A handwritten signature in cursive script that reads "Melissa Shine".

Melissa Shine  
Manager Corporate Responsibility

Through our exceptional health care services, we reveal the healing presence of God.