

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
SAINT LOUIS UNIVERSITY HOSPITAL  
FOR 2011 AND 2012**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



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

**March 2016  
A-07-14-05066**

# *Office of Inspector General*

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## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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## EXECUTIVE SUMMARY

***Saint Louis University Hospital did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in net overpayments of approximately \$119,000 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 Saint Louis University Hospital (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

### BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification. 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.

The Hospital is a 356-bed academic teaching hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately \$156 million for 61,001 outpatient and 9,420 inpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered \$7,906,517 in Medicare payments to the Hospital for 261 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 4 outpatient and 257 inpatient claims and had dates of service in CY 2011 or CY 2012.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 243 of the 261 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 18 claims, resulting in net overpayments of \$118,576 for CYs 2011 and 2012. Specifically, 4 outpatient claims had billing errors, resulting in overpayments of \$65,099, and 14 inpatient claims had billing errors, resulting in net overpayments of \$53,477. (The \$118,576 in net overpayments consisted of inpatient claims totaling \$39,448 that were within the 3-year recovery period as well as outpatient and inpatient claims that were outside of

the 3-year recovery period and that, we estimate, totaled as much as \$79,128.) (The Patient Protection and Affordable Care Act established a 60-day repayment rule under which Medicare overpayments must be reported and returned within 60 days after being identified.) 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 \$39,448 in overpayments for 3 incorrectly billed inpatient claims;
- work with the Medicare contractor to return \$79,128 in net overpayments that were outside of the 3-year recovery period, consisting of 4 incorrectly billed outpatient claims that totaled \$65,099 in overpayments and 11 inpatient claims whose total of net overpayments we estimate to be as much as \$14,029, in accordance with the 60-day repayment rule; 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, Tenet Healthcare (which owned the Hospital during our audit period) agreed with all our findings and described corrective actions that it had taken or planned to take, including the processing of refunds, 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 Louis University Hospital (the Hospital) complied with Medicare requirements for billing outpatient and inpatient 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 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 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

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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.

(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 Claims at Risk for Incorrect Billing**

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

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

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)).

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 Louis University Hospital**

The Hospital is a 356-bed academic teaching hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately \$156 million for 61,001 outpatient and 9,420 inpatient 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 \$7,906,517 in Medicare payments to the Hospital for 261 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 4 outpatient and 257 inpatient claims. 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 10 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 243 of the 261 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 18 claims, resulting in net overpayments of \$118,576 for CYs 2011 and 2012. Specifically, 4 outpatient claims had billing errors, resulting in overpayments of \$65,099, and 14 inpatient claims had billing errors, resulting in net overpayments of \$53,477. (The \$118,576 in net overpayments consisted of inpatient claims totaling \$39,448 that were within the 3-year recovery period as well as outpatient and inpatient claims that were outside of the 3-year recovery period and that, we estimate, totaled as much as \$79,128.)<sup>2</sup> 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.

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<sup>2</sup> Our audit report represents the results for all claims within our audit period. Section 1870(b) of the Act governs the recovery of excess payments. This section provides that excess payments identified are barred from recovery 3 years after the year in which the original payment was made. In addition, the Hospital is responsible for reporting and returning overpayments it identified to its Medicare contractor. The Patient Protection and Affordable Care Act, P.L. No. 111-148 (Mar. 23, 2010), requires the reporting and return of Medicare overpayments along with written notice of the reason for the overpayment within 60 days after the overpayment was identified (60-day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

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

The Hospital incorrectly billed Medicare for all four of the selected outpatient claims that we reviewed. These errors resulted in overpayments of \$65,099, all of which were outside of 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 all four of the 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 said that these overpayments occurred because it did not fully implement its policy regarding the actions to be taken after it has received a scheduling request for a replacement of a recalled or defective implantable device. As a result of these errors, the Hospital received overpayments of \$65,099.

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 14 of 257 selected inpatient claims that we reviewed. These errors resulted in net overpayments of \$53,477, of which an estimated \$14,029 was outside of the 3-year recovery period.

### **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;

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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).

- 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 7 out of 257 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 four of the seven claims. However, the Medicare contractor evaluated the medical necessity requirements associated with these four claims and found that the Hospital had incorrectly billed them. For the remaining three claims, the Hospital attributed the overpayments to procedural errors in which the Hospital staff had inappropriately designated these beneficiary stays as having met inpatient medical necessity. As a result of these errors, the Hospital received estimated overpayments of \$84,591.<sup>4</sup> (The \$84,591 in overpayments included claims that were outside of the 3-year recovery period and that, we estimate, totaled as much as \$13,898.)

### **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 2 out of 257 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 incorrect coding. As a result of these errors, the Hospital received overpayments of \$5,856, all of which were outside of the 3-year recovery period.

### **Insufficiently Documented 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)).

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<sup>4</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.

For 5 out of 257 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in either lower or higher DRG payments to the Hospital than should have been made. Specifically, certain diagnosis codes were not supported in the medical records. The Hospital attributed the overpayments and underpayments to coder errors. As a result of these errors, the Hospital received a net underpayment of \$36,970, of which an estimated \$5,725 was outside of the 3-year recovery period.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$39,448 in overpayments for 3 incorrectly billed inpatient claims;
- work with the Medicare contractor to return \$79,128 in net overpayments that were outside of the 3-year recovery period, consisting of 4 incorrectly billed outpatient claims that totaled \$65,099 in overpayments and 11 inpatient claims whose total of net overpayments we estimate to be as much as \$14,029, in accordance with the 60-day repayment rule; 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, Tenet Healthcare (which owned the Hospital during our audit period) agreed with all our findings and described corrective actions that it had taken or planned to take, including the processing of refunds, to implement our recommendations.<sup>5</sup>

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

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<sup>5</sup> Tenet Healthcare's written comments clarified that it sold the Hospital to Saint Louis University effective September 1, 2015, and that the Hospital is now owned by SSM [Sisters of Saint Mary] Healthcare.

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

### **SCOPE**

Our audit covered \$7,906,517 in Medicare payments to the Hospital for 261 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 4 outpatient and 257 inpatient claims.

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 10 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 outpatient and inpatient 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 August 2015.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient and inpatient 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 CY 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 261 claims (4 outpatient and 257 inpatient) 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 contractor) to determine whether 10 selected claims met medical necessity requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Hospital officials on August 26, 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 Overpayments/ Underpayments</b>	<b>Value of Overpayments/ (Underpayments)</b>
<b>Outpatient</b>				
Manufacturer Credits for Replaced Medical Devices	4	\$101,978	4	\$65,099
<b>Outpatient Totals</b>	<b>4</b>	<b>\$101,978</b>	<b>4</b>	<b>\$65,099</b>
<b>Inpatient</b>				
Short Stays	12	\$127,508	7	\$84,591
Same-Day Discharges and Readmissions	4	31,715	2	5,856
Diagnosis-Related-Group Verification	107	1,918,184	4	(4,962)
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	54	1,333,656	1	(32,008)
Claims With Payments Greater Than \$150,000	13	3,535,004	0	0
Claims Paid in Excess of Charges	23	442,103	0	0
Claims Billed With Cancelled Elective Surgical Procedures	44	416,369	0	0
<b>Inpatient Totals</b>	<b>257</b>	<b>\$7,804,539</b>	<b>14</b>	<b>\$53,477</b>
<b>Outpatient and Inpatient Totals</b>	<b>261</b>	<b>\$7,906,517</b>	<b>18</b>	<b>\$118,576</b>

**Notice:** The table above illustrates the results of our review by risk area. In it, we have organized outpatient and inpatient 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



February 5, 2016

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

Re: Report Number: A-07-14-05066

Dear Mr. Cogley:

Tenet Healthcare, the prior owner of Saint Louis University Hospital, submits the below response to the U.S. Department of Health and Human Services, Office of the Inspector General draft report entitled *Medicare Compliance Review of Saint Louis University Hospital for 2011 and 2012*. Tenet owned the hospital during the years covered by the OIG audit, however, sold the hospital to Saint Louis University effective September 1, 2015. The hospital is now owned by SSM Healthcare.

### **OUTPATIENT CLAIMS**

#### **Manufacturer Credits For Replaced Medical Devices Not Reported**

The draft report noted that for 4 of the selected claims, 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. The hospital concurs with the OIG that it did not place the appropriate “FB” modifier and reduced charges on these claims.

Prior to the audit, St Louis University Hospital had in place a policy, *Management of Medical Device Replacement Under Warranty*, requiring placement of the appropriate modifier on claims in circumstances when full or partial credit had been received in connection to medical device replacement. The hospital policy outlines the hospital process for identifying replacement procedures at the time of scheduling and further describes the actions to be taken after a scheduling request is received for a replacement of a recalled or defective implantable device. These actions include: notifying materials management of a recall or defect, securing any additional inventory that may be effected, notifying the Director of Revenue Cycle of a recalled product, verifying the rebate with the device manufacturer (including the amount of the rebate) in writing, and placing the claim on hold until all information has been received. Upon completion of the above steps, the policy requires that the information is to be forwarded to the hospital’s finance team and then to the coding teams for determination of the application of the appropriate FB or FC modifier on

the claim, prior to the release of the claim. For the cases identified in the audit, these processes were not fully followed.

The opportunities for improvement regarding the above process specifically focused on the Hospital's Invasive Cardiology areas by re-designing the actions taken in the Cardiac Catheterization and Electrophysiology labs. Specifically, a department policy was created and implemented that outlines improved process for identifying these types of procedures at the time of scheduling including:

- 1) A process to facilitate the identification of an inpatient undergoing device replacement that is not required to go through the department scheduler.
- 2) The addition of a check point where staff fills out an implant record and is asked to indicate if any part of the procedure was a result of a recall or warranty.
- 3) Ensuring that the explanted device is returned to the manufacturer for evaluation post operatively allowing for determination of the rebates on a case by case basis.
- 4) The Department Management is responsible for ensuring that the account is placed on hold at the conclusion of the procedure and once rebate information is received in writing the device, supply, and procedure charges are reviewed and adjusted by the Department, Finance and Coding as necessary before the account is then released.

All of the management team in the Cardiology areas participated in the development of the department specific policy and ensured that the policy elements were implemented. For the 4 claims identified in the audit as having been billed incorrectly, corrected claims have been submitted to the Hospital's MAC (Novitas), although to date no payment adjustment has been made by Novitas.

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

### **Incorrectly Billed as Inpatient**

The draft report noted that for 7 of the 257 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient with observation services. The Hospital agrees that these 7 accounts were billed incorrectly, and efforts to complete the claims adjustment are in process.

As part of our efforts to facilitate compliance with billing and coding requirements, Saint Louis University Hospital periodically monitors accuracy of patient placement. As part of this routine monitoring, an internal assessment had been conducted on staff competencies related to InterQual® utilization by Patient Acceptance and Case Management prior to the OIG audit, and actions had been taken to enhance our processes. Specifically, the hospital converted to utilization of a centralized call center (the "Call Center") for management of all patient status reviews in April 2014. The Call Center team is a highly specialized team of nurses whose sole responsibility is to perform InterQual® reviews and facilitate the identification of appropriate patient status. The Call Center Team monitors all patient admissions and physician orders electronically. The team ensures that InterQual® reviews for patient status appropriateness are completed within 24 hours of admission and

facilitates appropriate status placement. Moreover, each nurse of the Call Center Team is highly trained in the performance of admission review. The staff is routinely monitored for performance and achievement of an error rate below 5% in Interqual accuracy.

### **Same-Day Discharge and Readmissions**

The draft report noted that for 2 of the 257 selected claims, the Hospital separately billed Medicare for a related discharge and readmission. The hospital has a specific control measure to facilitate accuracy in Same Day Discharge/Readmission accounts through the implementation of an edit that places a hold on any inpatient accounts discharged and readmitted on the same day. The hold remains in place until a full review is completed by a coder. The Hospital agrees that these accounts were incorrectly coded and determined during its review that the coder performing the original review made an error when evaluating/confirming the reasons for admission, and accordingly incorrectly applied the B4 modifier. The claims adjustment has already been completed for these accounts.

To minimize coding errors, the Hospital relies on a coding compliance program which establishes key controls to ensure that each account is coded correctly. This coding compliance program is based on the “seven elements of an effective compliance program” which was published in the OIG’s Compliance Program Guidance for hospitals on February 23, 1998. The Hospital’s policies, procedures and processes address each of the seven elements, with specific focus on “Education and Training” and “Auditing and Monitoring.” Policies, procedures and processes are reviewed annually and revised as needed.

New coders receive six hours of coding compliance orientation training; part of this includes a review of the official coding guidelines involving the correct selection of principal and secondary diagnoses. Additionally each new coder receives an initial coding review to determine the coder’s accuracy. If the variance rate does not meet internally established thresholds, the coder receives corrective action which may include additional education, a change in job assignments and other disciplinary action up to and including termination of employment. Once a coder satisfies all orientation requirements, he/she is then monitored for coding quality on a daily and quarterly basis. Coders not meeting established quality indicators are placed on a corrective action plan.

Additionally, all inpatient accounts coded each day are reviewed by a quality monitoring tool that randomly selects accounts for review. Once an account is chosen for review all principal diagnoses, principal procedures, and discharge dispositions are reviewed. Finally, processes are in place to daily identify accounts where the actual length of stay is less than the Medicare 25<sup>th</sup> percentile length of stay for the DRG assigned, accounts where a solitary MCC/CC has been assigned, and many other rules to identify potential overpayments. Cases flagged for a possible variance must be re-reviewed prior to billing.

## **Insufficient Documented Diagnosis Codes**

The draft report noted that for 5 of the 257 selected claims, the Hospital incorrectly coded claims that resulted in either lower or higher DRG payments to the Hospital than should have been made. The Hospital agrees that these accounts were incorrectly coded resulting in an overpayment. The claims adjustment has already been completed for these accounts.

The Hospital's audit analysis of the coding for these 5 admissions revealed errors made by two coders. A description of the Hospital's coding compliance program is provided above.

In the event you have any additional questions or comments, please do not hesitate to contact me.

Sincerely,

Kate Dunn  
Hospital Compliance Officer  
Tenet Healthcare