

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW
OF ALTRU HOSPITAL
FOR 2012 AND 2013**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



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

**October 2015
A-07-15-05070**

Office of Inspector General

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

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EXECUTIVE SUMMARY

Altru Hospital did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately \$66,000 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 Altru 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 265-bed acute care hospital located in Grand Forks, North Dakota. Medicare paid the Hospital approximately \$167 million for 249,362 outpatient and 9,106 inpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

Our audit covered \$4,659,419 in Medicare payments to the Hospital for 253 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 36 outpatient and 217 inpatient claims and had dates of service in CY 2012 or CY 2013.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 241 of the 253 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 12 claims, resulting in overpayments of \$66,436. Specifically, nine outpatient claims had billing errors, resulting in overpayments of \$38,957, and three inpatient claims had billing errors, resulting in overpayments of \$27,479. 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 \$66,436, consisting of \$38,957 in overpayments for nine incorrectly billed outpatient claims and \$27,479 in overpayments for three incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with both of our recommendations. Specifically, the Hospital stated that overpayments totaling \$66,436 had been refunded to its Medicare contractor. In addition, the Hospital said that it had worked to strengthen controls to ensure that these types of errors do not occur in the future.

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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 Altru 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.¹ All services and items within an APC group are comparable clinically and require comparable resources.

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

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 Claims at Risk for Incorrect Billing

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

- outpatient claims billed with dental services,
- outpatient claims with payments greater than \$25,000,
- outpatient manufacturer credits for replaced medical devices,
- outpatient claims with surgeries billed with units greater than one,
- outpatient claims billed for Herceptin,
- inpatient claims paid in excess of charges,
- inpatient DRG verification,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims billed with elective admissions,
- inpatient claims billed with cancelled elective surgical procedures,
- inpatient short stays, and
- inpatient claims billed with kyphoplasty services.

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

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).

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)).

Altru Hospital

The Hospital is a 265-bed acute care hospital located in Grand Forks, North Dakota. Medicare paid the Hospital approximately \$167 million for 249,362 outpatient and 9,106 inpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$4,659,419 in Medicare payments to the Hospital for 253 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 36 outpatient and 217 inpatient claims and had dates of service in CY 2012 or CY 2013. 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 did not use 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 241 of the 253 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 12 claims, resulting in overpayments of \$66,436. Specifically, nine outpatient claims had billing errors, resulting in overpayments of \$38,957, and three inpatient claims had billing errors, resulting in overpayments of \$27,479. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of

Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 9 of 36 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$38,957.

Services Not Billable to Medicare

Medicare payments may not be made for items or services "... where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth..." (the Act, § 1862(a)(12)).

For 2 out of 36 selected claims, the Hospital incorrectly billed Medicare for services related to the removal of teeth. The Hospital said that it believed the overpayments were most likely the result of oral surgeons who were not aware of the Medicare guidelines that do not allow for payment on behalf of Medicare beneficiaries for this type of case. As a result of these errors, the Hospital received overpayments of \$18,214.

Incorrect Number of Units

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 6 out of 36 selected claims, the Hospital billed Medicare for an incorrect number of service units. The Hospital said that pharmacy or provider office staff manually documented these claim types, which allowed for inconsistencies in documentation to occur. As a result of these errors, the Hospital received overpayments of \$15,879.

Manufacturer Credit for Replaced Medical Device 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.²

² 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).

For 1 out of 36 selected claims, the Hospital received full credit for a replaced medical device but did not report the “FB” modifier and reduced charge on its claim. The Hospital said that the staff involved was not aware that the FB modifier was applicable to this claim. As a result of this error, the Hospital received an overpayment of \$4,864.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 3 of 217 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$27,479.

Insufficiently Documented Procedure or Diagnosis Codes

Medicare payments may not be made for items or services that “... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, § 1862(a)(1)(A)).

For 3 out of 217 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain diagnosis codes were not supported in the medical records. The Hospital said that human error when coding the claims caused the overpayments. As a result of these errors, the Hospital received overpayments of \$27,479.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$66,436, consisting of \$38,957 in overpayments for nine incorrectly billed outpatient claims and \$27,479 in overpayments for three incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with both of our recommendations. Specifically, the Hospital stated that overpayments totaling \$66,436 had been refunded to its Medicare contractor. In addition, the Hospital said that it had worked to strengthen controls to ensure that these types of errors do not occur in the future.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$4,659,419 in Medicare payments to the Hospital for 253 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 36 outpatient and 217 inpatient claims and had dates of service in CY 2012 or CY 2013.

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 did not use 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 November 2014 to June 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 2012 and 2013;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2012 and 2013;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 253 claims (36 outpatient and 217 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;
- 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 June 23, 2015.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Outpatient				
Claims Billed With Dental Services	2	\$18,214	2	\$18,214
Claims With Payments Greater Than \$25,000	18	693,989	6	15,879
Manufacturer Credits for Replaced Medical Devices	3	15,214	1	4,864
Surgeries Billed With Units Greater Than One	7	51,161	0	0
Claims Billed for Herceptin	6	19,571	0	0
Outpatient Totals	36	\$798,149	9	\$38,957
Inpatient				
Claims Paid in Excess of Charges	36	\$764,280	3	\$27,479
Diagnosis-Related-Group Verification	119	1,896,505	0	0
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	50	1,052,250	0	0
Claims Billed With Elective Admissions	5	52,914	0	0
Claims Billed With Cancelled Elective Surgical Procedures	2	41,641	0	0
Short Stays	4	41,078	0	0
Claims Billed With Kyphoplasty Services	1	12,602	0	0
Inpatient Totals	217	\$3,861,270	3	\$27,479
Outpatient and Inpatient Totals	253	\$4,659,419	12	\$66,436

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.



August 13, 2015

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
Office of the Inspector General
U.S. Department of Health and Human Services
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: Response to OIG Final Draft for Audit A-07-15-05070
Altru Health System, Grand Forks, ND

Dear Mr. Cogley,

We have received the draft version of the report *Medicare Compliance Review of Altru Hospital for 2012 and 2013* and we would like to thank you for the opportunity to review the draft prior to the final report and also for the opportunity to provide comments to become part of the final report.

This compliance audit included the review of 253 total claims, 36 outpatient and 217 inpatient, totaling \$4,659,419 in Medicare payments. The audit results showed that Altru Hospital complied with Medicare billing requirements for 241 of the 253 outpatient and inpatient claims reviewed. The OIG findings show that we did not comply on the remaining claims, resulting in overpayments of \$66,436. These overpayments have been refunded to our MAC and we have also worked to strengthen our controls to ensure these types of errors do not occur in the future. The information below reflects the OIG findings for this audit as well as our corresponding response and any actions we have taken to further improve our internal controls.

Billing Errors Associated with Outpatient Claims

Services Not Billable to Medicare

OIG Findings: For 2 out of 36 selected claims, the Hospital incorrectly billed Medicare for services related to the removal of teeth. As a result of these errors, the Hospital received overpayments of \$18,214.

Hospital Response: Concerning the outpatient dental claims which were paid in error, Altru Health System does not employ any oral surgeons; therefore, cases which had been scheduled were performed by external oral surgeons practicing in the Grand Forks community. The circumstances were likely that the external oral surgeon(s) were not aware of the Medicare guidelines that do not allow for payment of these types of cases for Medicare beneficiaries, as was likely with the employee who worked with the external provider to schedule the operating

room for these patients. Near the time of these particular cases, this type of error was discovered and an initiative formed to educate external providers and their staff on the Medicare guidelines. Continuous outreach is done with our external providers in order to provide education in an effort to eliminate noncompliance with Medicare regulations. Internal technical provisions are being implemented to prevent this type of visit from being scheduled within our electronic health record system without the pre-authorized eligibility, to further prevent any errors.

Payments totaling \$18,214 have been refunded to our Medicare Administrative Contractor, Noridian, to correct the overpayments on these two claims.

Incorrect Number of Units

OIG Findings: For 6 of 36 selected claims, the Hospital billed Medicare for an incorrect number of service units. As a result of these errors, the Hospital received overpayments of \$15,879.

Hospital Response: Concerning the claims with the incorrect number of units billed, the error in each case was that Altru Health System billed both the amount administered to the patient as well as the amount that was wasted due to single use vials of the medication. The waste was not properly documented in the patient chart and as a result, the units on the claim included both the amount of administered medication as well as that which was wasted. At the time of these claims, staff understanding of proper documentation for wasted drugs was not consistent; therefore the proper documentation for drug waste was also inconsistent, dependent upon the provider and place of service. Furthermore, within Altru's electronic record system, these specific case types do not automatically generate appropriate documentation. Thus, unlike other administration documentation, the documentation for this waste is a manual process relying on pharmacy or provider office staff. These factors together allowed for inconsistencies in documentation to occur. As Altru became aware of the error, staff education has prevented these cases from being documented inappropriately in the patients' charts, while ensuring compliance and appropriate billing reflective of the documentation.

Payments totaling \$15,879 have been refunded to our Medicare Administrative Contractor, Noridian, to correct the overpayments for these six claims.

Manufacturer Credit for Replaced Medical Device Not Reported

OIG Findings: For 1 out of 36 selected claims, the Hospital received full credit for a replaced medical device but did not report the "FB" modifier and reduced charge on its claim. As a result of this error, the Hospital received an overpayment of \$4,864.

Hospital Response: During initial review of this claim, following notice of the OIG audit request, we identified that HCPCS device code C1898 was present on the claim with a \$1.00 charge, which was appropriate; however, the FB modifier was not appended to the appropriate procedure code. Staff involved in this case at the time was not aware that the FB modifier was applicable to this claim. Further, our electronic record system is unable to automatically flag these cases or prevent the claim from processing incorrectly, requiring it to be manually processed through communications of multiple departments. Altru has since implemented controls to further prevent outpatient medical device credit reporting errors. Outpatient device

credits are currently being reviewed within Altru Health System. Included within the review team is our Supply Coordinator, Reimbursement Analyst, coding staff, and business office staff, each of whom has a role in the review process to ensure claim requirements are met and the appropriate payment is received.

Payment of \$4,864 is being refunded to our Medicare Administrative Contractor, Noridian, to correct the overpayment on this claim.

Billing Errors Associated with Inpatient Claims

Insufficiently Documented Procedure or Diagnosis Codes

OIG Findings: For 3 out of 217 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain diagnosis codes were not supported in the medical records. As a result of these errors, the Hospital received overpayments of \$27,479.

Hospital Response: Each of these three cases were reviewed and coded by certified coding staff, and not all were reviewed by the same coder, showing no pattern in possible staffing issues. In regard to case B21, the encephalitis was coded in place of encephalopathy, which is what was documented in the patient's chart. Therefore, this case appears to have been pure human error of incorrectly determining the correct ICD-9-CM code. For the other two cases, B23 and B32, sepsis was documented within the patient's charts; however, the diagnosis was not consistently documented throughout the patients' stay on each day by medical staff. As a result, it appears the sepsis code would not have been applicable due to incomplete documentation. Since the time of these cases, significantly more guidance has been provided regarding the appropriate use of the sepsis diagnosis code in regards to correct documentation and extensive education has been done with our coding staff, our clinical documentation team and our clinicians in order to ensure the proper documentation and coding in these types of cases. Altru Health System performs self-audits as well as utilization of outside consulting services while continually monitoring best practices and guideline changes to ensure compliance within our documentation and coding practices.

Payments of \$27,479 have been refunded to our Medicare Administrative Contractor, Noridian, to correct the overpayments on these claims.

* * * * *

Altru Health System maintains that we continuously seek out best practices, maintaining compliance in all areas of our practice and at the same time, always keeping the best interest of our patients at the forefront. We continually provide education to staff in order to ensure compliance with Medicare guidelines. We also conduct internal and external audits and monitoring to remain proactive in our efforts to remain compliant. Altru staff is committed to a culture which upholds a behavioral and ethical model of the highest standards.

Should you need any additional information, please do not hesitate to contact myself, Teresa Moe, Supervisor of Reimbursement and Audit, at (701)780-5221, Tom Tweten, Compliance Manager, at (701)-780-6158, or Dwight Thompson, CFO, at (701)780-5203. Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Teresa Moe". The signature is fluid and cursive, with the first name being more prominent than the last.

Teresa Moe, MBA, RHIT
Supervisor of Reimbursement
Altru Health System