

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
NEBRASKA METHODIST HOSPITAL  
FOR 2012 AND 2013**

*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**

**December 2015  
A-07-15-05073**

# *Office of Inspector General*

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

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <http://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## **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

***Nebraska Methodist Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$111,000 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) 2013, Medicare paid hospitals \$156 billion, which represents 45 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 Nebraska Methodist Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is a 423-bed acute-care hospital located in Omaha, Nebraska. Medicare paid the Hospital approximately \$147 million for 11,137 inpatient and 140,742 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

Our audit covered \$3,165,984 in Medicare payments to the Hospital for 138 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 136 inpatient and 2 outpatient claims.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 119 of the 138 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 19 claims, resulting in net overpayments of \$111,116. Specifically, 17 inpatient claims had billing errors, resulting in net overpayments of \$86,494, and 2 outpatient claims had billing errors, resulting in overpayments of \$24,622. 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 \$111,116, consisting of \$86,494 in overpayments for 17 incorrectly billed inpatient claims and \$24,622 in overpayments for 2 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital concurred with our findings and our first recommendation and stated that it had refunded the \$111,116 in overpayments to the Medicare contractor. Although the Hospital did not directly address our second recommendation, it described corrective actions that it had taken or planned to take to implement both of our recommendations.

## TABLE OF CONTENTS

INTRODUCTION .....	1
Why We Did This Review .....	1
Objective .....	1
Background .....	1
The Medicare Program .....	1
Hospital Inpatient Prospective Payment System .....	1
Hospital Outpatient Prospective Payment System .....	1
Hospital Claims at Risk for Incorrect Billing .....	2
Medicare Requirements for Hospital Claims and Payments .....	2
Nebraska Methodist Hospital .....	3
How We Conducted This Review .....	3
FINDINGS .....	3
Billing Errors Associated With Inpatient Claims .....	3
Insufficiently Documented Diagnosis Codes .....	3
Incorrectly Billed as Inpatient .....	4
Same-Day Discharge and Readmission .....	4
Billing Errors Associated With Outpatient Claims .....	5
Manufacturer Credits for Replaced Medical Devices Not Reported .....	5
RECOMMENDATIONS .....	5
AUDITEE COMMENTS .....	6
APPENDIXES	
A: Audit Scope and Methodology .....	7
B: Results of Review by Risk Area .....	9
C: Auditee Comments .....	10

## **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) 2013, Medicare paid hospitals \$156 billion, which represents 45 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 Nebraska Methodist Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### **BACKGROUND**

#### **The Medicare Program**

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

#### **Hospital Inpatient Prospective Payment System**

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

#### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services

within each APC group.<sup>1</sup> All services and items within an APC group are comparable clinically and require comparable resources.

### **Hospital Claims at Risk for Incorrect Billing**

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

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

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).

---

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

## **Nebraska Methodist Hospital**

The Hospital is a 423-bed acute-care hospital located in Omaha, Nebraska. Medicare paid the Hospital approximately \$147 million for 11,137 inpatient and 140,742 outpatient 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 \$3,165,984 in Medicare payments to the Hospital for 138 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 136 inpatient and 2 outpatient 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 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 119 of the 138 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 19 claims, resulting in net overpayments of \$111,116. Specifically, 17 inpatient claims had billing errors, resulting in net overpayments of \$86,494, and 2 outpatient claims had billing errors, resulting in overpayments of \$24,622. 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 INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 17 of 136 selected inpatient claims that we reviewed. These errors resulted in net overpayments of \$86,494.

##### **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)).

For 12 out of 136 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in either higher or lower 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 error. As a result of these errors, the Hospital received net overpayments of \$64,557.

### **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 3 out of 136 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 said that at the time it provided the services, it had controls in place to bill them correctly, based on the guidance and tools it had available. As a result of these errors, the Hospital received estimated overpayments of \$18,026.<sup>2</sup>

### **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

---

<sup>2</sup> The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor before the issuance of our report.

by the original stay by combining the original and subsequent stay onto a single claim.

For 2 out of 136 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital said that based on its reviews of the two encounters at the times of their initial billing, it decided that the readmissions were not related to the first admissions. As a result of these errors, the Hospital received overpayments of \$3,911.

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

The Hospital incorrectly billed Medicare for both of the two selected outpatient claims that we reviewed. These errors resulted in overpayments of \$24,622.

### **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 two out of two 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 it returned devices appropriately to the vendors when warranty issues existed but encountered instances when it was unable to tie the credits back to the appropriate patients. As a result of these errors, the Hospital received overpayments of \$24,622.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$111,116, consisting of \$86,494 in overpayments for 17 incorrectly billed inpatient claims and \$24,622 in overpayments for 2 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

---

<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).

## **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital concurred with our findings and our first recommendation and stated that it had refunded the \$111,116 in overpayments to the Medicare contractor. Although the Hospital did not directly address our second recommendation, it described corrective actions that it had taken or planned to take to implement both of our recommendations.

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

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

### **SCOPE**

Our audit covered \$3,165,984 in Medicare payments to the Hospital for 138 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 136 inpatient and 2 outpatient 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 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 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 December 2014 to September 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 2012 and 2013;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2012 through 2013;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 138 claims (136 inpatient and 2 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;
- 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 September 3, 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>				
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	50	\$1,287,335	4	\$33,722
Diagnosis-Related-Group Verification	73	1,249,689	7	27,564
Claims Billed With Cancelled Elective Surgical Procedures	3	21,746	2	11,998
Claims Billed With Elective Admissions	2	23,217	1	6,028
Same-Day Discharges and Readmissions	2	14,357	2	3,911
Claims Paid in Excess of Charges	5	136,251	1	3,271
Claims With Payments Greater Than \$150,000	1	405,175	0	0
<b>Inpatient Totals</b>	<b>136</b>	<b>\$3,137,770</b>	<b>17</b>	<b>\$86,494</b>
<b>Outpatient</b>				
Manufacturer Credits for Replaced Medical Devices	2	\$28,214	2	\$24,622
<b>Outpatient Totals</b>	<b>2</b>	<b>\$28,214</b>	<b>2</b>	<b>\$24,622</b>
<b>Inpatient and outpatient Totals</b>	<b>138</b>	<b>\$3,165,984</b>	<b>19</b>	<b>\$111,116</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

Report Number: A-07-15-05073

November 19, 2015



8511 W. Dodge Road  
Omaha, NE 68114-3403  
(402) 354-4800

November 19, 2015

Patrick J. Cogley  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Inspector General  
Office of Audit Services, Region VII  
Kansas City, MO 64106

RE: Draft Report entitled *Medicare Compliance Review of Nebraska Methodist Hospital for 2012 and 2013*

Report Number: A-07-15-05073

Dear Mr. Cogley:

Methodist Hospital (MH) appreciates the opportunity to review and comment on the OIG’s Draft Report entitled *Medicare Compliance Review of Nebraska Methodist Hospital for 2012 and 2013, Report Number: A-07-15-05073 (Report)*. MH is highly committed to ensuring that it complies with all federal healthcare program rules and directives. As part of that commitment, MH has had in place a compliance program covering MH’s clinical and billing activities for over twenty years. MH continues to improve its internal controls and to perform proactive reviews to prevent billing errors.

MH’s responses to the OIG’s findings and recommendations detailed in the Report are provided in this letter. MH concurs with the findings of the Report and the recommendation to refund WPS Medicare the estimated overpayments described in the Report, and has already refunded those amounts.

**Methodist Hospital Responses:**

**Inpatient Claims Paid Greater Than Charges, DRG Validation, Inpatient Claims Billed with High Severity of Level Diagnosis Related Groups (CC/MCC)**

The Report found that MH incorrectly billed 11 out of 127 inpatient claims to Medicare Part A that were billed with Incorrect Diagnosis Related Group Codes. 129 inpatients records were requested for the initial review. Two of these records had been previously reviewed by either WPS Medicare or HDI and therefore were excluded from the review.

With respect to this finding, MH has taken the following actions:

1. The Clinical Coding Department has designated a full time ICD-9/ICD-10 trainer that is responsible to train newly employed inpatient coders, audit current inpatient coders' code assignments and provide education when issues are identified.
2. Inpatient coders work closely with the clinical documentation specialists who are registered nurses to assist in the interpretation of clinical documentation, query physicians for additional documentation when necessary and conduct ongoing physician education.
3. Clinical Coding has scheduled continued ICD-10 diagnosis and procedure training.
4. MH has contracted with an external auditor to perform DRG validation audits semi-annually.
5. MH has shared the results of this audit with the inpatient Clinical Coders and Clinical Documentation Specialists, and provided specific training on sepsis and septic syndrome.
6. MH has submitted corrected claims to Medicare for payment adjustment.

### **Cancelled Surgeries**

The Report found that MH incorrectly billed Medicare Part A for two beneficiary stays that the OIG determined should have been billed as outpatient when a planned inpatient surgical procedure was cancelled. Methodist Hospital recognizes that, in some instances, an emergent medical condition may cause surgery to be cancelled, but submits that the patient may still need to be admitted under an inpatient level of care.

While Methodist Hospital believes that these two inpatient admissions were not inappropriately admitted under an inpatient level of care based on these patients' severity of illness and intensity of services, Methodist Hospital has taken the following actions:

1. Methodist Hospital has defined a process to identify patients admitted for planned surgical procedures that are subsequently cancelled.
2. UR staff reviews the clinical indication for the cancelled procedure, and if appropriate based upon InterQual criteria and Medicare inpatient admission guidelines, converts the admission to an outpatient status prior to the patient's discharge or, in the event the patient is not notified of the change in patient status, bills only ancillary services, if inpatient admission criteria are not met.
3. Corrected claims have been submitted to Medicare for payment adjustments.

### **Elective Readmissions**

For two of the selected claims, the OIG determined that MH incorrectly billed claims to Medicare Part A that should have been billed as outpatient.

Methodist Hospital has taken the following actions:

1. Utilization Review (UR) staff use InterQual Criteria to review and assess appropriate patient status. In addition, Methodist Hospital increased UR staff to provide for Emergency Department and weekend coverage.

2. Methodist Hospital has engaged Executive Health Resources to perform secondary reviews of admissions and provide peer to peer documentation education to providers.
3. UR staff are trained in collaboration with physician advisors to ensure accurate documentation of patient status is gathered at the time of admission.
4. Methodist Hospital has implemented the FY 2014 IPPS Rule "2 Midnight Presumption" as an inpatient admission criterion with documentation supporting medical necessity.
5. UR staff review all one and two day stays that are billed to Medicare as an inpatient to ensure they meet inpatient criteria.
6. Corrected claims have been submitted to Medicare for payment adjustments.

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

For two of the selected claims, the OIG determined that MH incorrectly billed Medicare separately for a related discharge and readmission for a beneficiary that occurred within the same day. While MH believed the two episodes may not have been clinically related, based on its review the OIG believed that they were.

Methodist Hospital has taken the following actions:

1. MH has developed a mechanism to identify any patient that is discharged and subsequently readmitted to the hospital on the same day.
2. Upon completion of the coding process, the two admissions are reviewed to determine if the second admission is related to, or for evaluation and management of, the prior stay's medical condition.
3. In situations where it is difficult to determine a clinically related readmission, the two admissions are reviewed by a physician advisor.
4. When the conditions are determined to be related, the original claim is adjusted to reflect a single claim by combining the original and subsequent stay into a single claim.
5. Corrected claims have been submitted to Medicare for payment adjustments.

#### **Outpatient Medical Device Credits**

For two of the selected claims, the OIG determined that Methodist Hospital received full credit for replaced medical devices but did not report the "FB" modifier on the bills to Medicare.

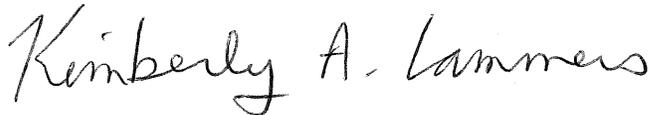
MH has taken the following actions:

1. Methodist Hospital has developed a process to identify device credits from a manufacturer. An interdisciplinary team has been created and includes representatives from Surgery Scheduling, Surgery, Purchasing, Pathology, Clinical Coding, Billing, Accounts Payable and Compliance.
2. Each member of the committee is responsible to perform their assigned task in the process to ensure devices are returned to the vendor for the credit.

3. The process also defines points of communication to ensure the information on credit adjustments is forwarded to the Clinical Coding Department for the addition of the appropriate modifier on the claim.
4. The Business Office is notified by the Clinical Coding Department when the modifier has been added to the claim so that the Business Office can submit a corrected claim.
5. Corrected claims have been submitted to Medicare for payment adjustment.

Methodist Hospital would like to thank the OIG audit staff who conducted the compliance review of MH for their openness, collegiality and willingness to work with the MH Compliance staff. We appreciate the opportunity to respond to the draft audit report and take these findings seriously. We are committed to improving our processes and remain committed to having an active and strong compliance program to help ensure our billing is accurate and in compliance with Medicare billing rules.

Sincerely,



Kimberly A. Lammers, JD, CPC  
Vice President of Compliance  
Methodist Health System