

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
WESLEY MEDICAL CENTER
FOR 2012 AND 2013**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Office of Inspector General

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

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EXECUTIVE SUMMARY

Wesley Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$182,000 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 Wesley Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

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

The Hospital is a 760-bed acute care hospital located in Wichita, Kansas. Medicare paid the Hospital approximately \$209 million for 15,198 inpatient and 53,251 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

Our audit covered \$4,578,435 in Medicare payments to the Hospital for 246 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 232 inpatient and 14 outpatient claims and had dates of service in CY 2012 or CY 2013.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 208 of the 246 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 38 claims, resulting in overpayments of \$181,600. Specifically, 27 inpatient claims had billing errors, resulting in overpayments of \$92,308, and 11 outpatient claims had billing errors, resulting in overpayments of \$89,292. 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 \$181,600, consisting of \$92,308 in overpayments for 27 incorrectly billed inpatient claims and \$89,292 in overpayments for 11 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 did not directly address our recommendations, but described corrective actions that include processing refunds to the Medicare contractor and strengthening internal controls.

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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) 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 Wesley Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Medicare Program

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

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

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

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

within each APC group.¹ 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 DRG verification,
- inpatient claims paid in excess of charges,
- inpatient same-day discharges and readmissions,
- inpatient claims with payments greater than \$150,000,
- inpatient claims billed with high severity level DRG codes,
- outpatient claims billed with dental services, 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).

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

Wesley Medical Center

The Hospital is a 760-bed acute care hospital located in Wichita, Kansas. Medicare paid the Hospital approximately \$209 million for 15,198 inpatient and 53,251 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 \$4,578,435 in Medicare payments to the Hospital for 246 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 232 inpatient and 14 outpatient 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 objective.

See Appendix A for the details of our scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 208 of the 246 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 38 claims, resulting in overpayments of \$181,600. Specifically, 27 inpatient claims had billing errors, resulting in overpayments of \$92,308, and 11 outpatient claims had billing errors, resulting in overpayments of \$89,292. The errors that we identified occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 27 of 232 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$92,308.

Unsupported Codes

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

For 25 out of 232 selected claims, the Hospital billed Medicare with incorrectly coded claims. Specifically, certain diagnosis codes or procedure codes were not supported in the medical records. The Hospital stated that these errors were a result of inappropriate application of coding guidelines. As a result of these errors, the Hospital received overpayments of \$88,984.

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 2 out of 232 selected claims, the Hospital incorrectly billed Medicare separately for a patient's related discharge and readmission that occurred on the same day. The Hospital stated that the patient was moved from one of its off-site locations to its main campus and was inadvertently discharged then readmitted. This action created two separate inpatient stays, both of them incorrectly billed, rather than a single stay and a single claim. As a result of these errors, the Hospital received overpayments of \$3,324.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 11 of 14 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$89,292.

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 9 out of 14 selected claims, the Hospital incorrectly billed Medicare for services related to the removal of teeth. The Hospital stated that these errors were due to a lack of understanding of Medicare guidelines for dental services. As a result of these errors, the Hospital received overpayments of \$47,500.

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.²

For 2 out of 14 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 stated that the two claims in error were the result of a lack of communication between the facility's clinical department and the appropriate revenue cycle personnel. As a result of these errors, the Hospital received overpayments of \$41,792.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$181,600, consisting of \$92,308 in overpayments for 27 incorrectly billed inpatient claims and \$89,292 in overpayments for 11 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 did not directly address our recommendations, but described corrective actions that include processing refunds to the Medicare contractor and strengthening internal controls.

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

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).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$4,578,435 in Medicare payments to the Hospital for 246 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 232 inpatient and 14 outpatient 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 inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork from October 2014 to October 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 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 246 claims (232 inpatient and 14 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 January 12, 2016.

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
Inpatient				
Diagnosis-Related-Group Verification	139	\$2,092,001	23	\$59,883
Claims Paid in Excess of Charges	1	\$34,664	1	\$26,153
Same-Day Discharges and Readmissions	4	\$29,442	2	\$3,324
Claims With Payments Greater Than \$150,000	2	\$403,794	1	\$2,948
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	86	\$1,915,875	0	\$0
Inpatient Totals	232	\$4,475,776	27	\$92,308
Outpatient				
Claims Billed With Dental Services	9	\$47,500	9	\$47,500
Manufacturer Credits for Replaced Medical Devices	5	\$55,159	2	\$41,792
Outpatient Totals	14	\$102,659	11	\$89,292
Inpatient and Outpatient Totals	246	\$4,578,435	38	\$181,600

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



March 31, 2016

Via Certified Mail

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

RE: Response to the Draft Report of the Medicare Compliance Review of Wesley Medical Center, Report Number A-07-15-05074

Dear Mr. Cogley,

Wesley Medical Center ("Wesley" or "Hospital") is in receipt of the draft report from the U.S. Department of Health and Human Services, Office of Inspector General ("OIG")(A-07-15-05074) dated March 8, 2016, entitled *Medicare Compliance Review of Wesley Medical Center for 2012 and 2013* (referred herein as "Draft Report"). As requested in the Draft Report, this letter sets forth the Hospital's response to the OIG's findings with respect to the review of selected inpatient and outpatient claims; and the OIG's recommendations that the Hospital refund to the Medicare Contractor the total of \$181,600.00.

I. Background

The OIG did not audit Wesley due to any perceived improper billing or compliance practices. Rather, the OIG selected Wesley as part of a series of hospital compliance reviews focused on certain risk areas for hospitals across the country.

In the Wesley review, the OIG considered seven risk areas: 1) Diagnosis-Related-Group Verification, 2) Claims Paid in Excess of Charges, 3) Same-Day Discharges and Readmissions, 4) Claims With Payment Greater than \$150,000, 5) Claims Billed With High Severity Level Diagnosis-Related-Group Codes, 6) Claims Billed With Dental Services and 7) Manufacturer Credits for Replaced Medical Devices.

The audit covered 246 claims for \$4,578,435 with dates of service in calendar years 2012 - 2013 ("Audit Period") judgmentally selected by the OIG as potentially at risk for billing errors. Of the 246 claims, there were 232 inpatient claims: 139 DRG verification, 1 claim paid in excess of charges, 4 same-

day discharges and readmission, 2 claims payments greater than \$150,000 and 86 claims billed with high severity level DRG codes. The remaining fourteen (14) were outpatient claims: 9 claims billed with dental services and 5 manufacturer credits for replaced medical devices.

The OIG requested that the Hospital self-evaluate the selected claims to determine whether the services were billed correctly. The Hospital conducted the requested review and provided the results of the internal review to the OIG. The OIG also reviewed the itemized bills and medical record documentation provided by the Hospital.

II. Draft Report Findings

At the conclusion of the OIG review, it found that Wesley complied with 208 of the 246 selected claims. The OIG concluded that 38 claims of the 246 were allegedly billed in error for the total alleged overpayment of \$181,600 out of the total value of \$4,578,435 for the selected claims, resulting in a 4 percent financial error rate.

The OIG recommends that Wesley (1) refund to the Medicare contractor \$181,600, consisting of \$92,308 in overpayments for 27 incorrectly billed inpatient claims and \$89,292 in overpayments for 11 incorrectly billed outpatient claims, and (2) strengthen controls to ensure full compliance with Medicare requirements. Consistent with the OIG's direction on May 12, 2015, the Hospital already has processed the appropriate refunds to the Medicare contractor.

III. Wesley's Internal Controls

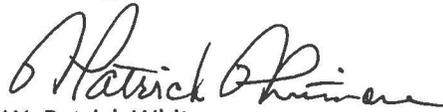
Wesley is a responsible provider of healthcare items and services with a deep commitment to operating in compliance with applicable rules and regulations. As part of this commitment, the Hospital routinely examines its coding and billing practices and procedures with the objective of achieving ever-improved accuracy and completeness.

Indeed, the low financial error rate in this review strongly suggests that the Hospital's internal controls are fully operational and highly efficient. That said, the Hospital takes any finding of potential errors seriously. Wesley will intensify its efforts to address identified opportunities for improvement, including continuing its efforts related to appropriately billing for same day discharge and readmissions. With regard to DRG coding issues, Wesley reviewed the findings from the Draft Report with the coding personnel and additional education was provided. The Hospital continues to have a process in place to provide ongoing monitoring in order to minimize inaccurate DRG assignment.

With regard to outpatient billing errors, Wesley provided additional education to the hospital staff regarding the Medicare guidelines for dental services and will continue to provide ongoing monitoring to address this risk area. For the instances that the manufacturer provides a credit for a replaced medical device, the Hospital has strengthened controls to improve communication between the Hospital's clinical department and the appropriate revenue cycle personnel to ensure that manufacturer credits are handled appropriately and billed accordingly.

We trust that this response provides you with the information you requested. We will make ourselves available to you in the event you have any questions or require further information.

Sincerely,



W. Patrick Whitmore

CFO