

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
CHRISTIAN HOSPITAL
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

Christian Hospital did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately \$341,000 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 Christian 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 485-bed acute care hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately \$145 million for 127,343 outpatient and 11,160 inpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

Our audit covered \$2,782,865 in Medicare payments to the Hospital for 199 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 93 outpatient and 106 inpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 95 of the 199 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 104 claims, resulting in overpayments of \$341,221 for CYs 2012 and 2013. Specifically, 89 outpatient claims had billing errors, resulting in overpayments of \$279,663, and 15 inpatient claims had billing errors, resulting in overpayments of \$61,558. 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 \$341,221, consisting of \$279,663 in overpayments for 89 incorrectly billed outpatient claims and \$61,558 in overpayments for 15 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 our findings and recommendations. Specifically, the Hospital stated that it had fully reimbursed the overpayment amounts that we identified and described corrective actions that it had taken or planned to take to implement our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 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 Christian 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.

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

¹ 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 surgeries billed with units greater than one,
- outpatient claims with payments greater than \$25,000,
- outpatient and inpatient manufacturer credits for replaced medical devices,
- inpatient same-day discharges and readmissions,
- inpatient short stays,
- inpatient claims billed with cancelled elective surgical procedures,
- inpatient DRG verification,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims with payments greater than \$150,000, and
- inpatient claims paid in excess of charges.

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).

Christian Hospital

The Hospital is a 485-bed acute care hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately \$145 million for 127,343 outpatient and 11,160 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 \$2,782,865 in Medicare payments to the Hospital for 199 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 93 outpatient and 106 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 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 95 of the 199 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 104 claims, resulting in overpayments of \$341,221 for CYs 2012 and 2013. Specifically, 89 outpatient claims had billing errors, resulting in overpayments of \$279,663, and 15 inpatient claims had billing errors, resulting in overpayments of \$61,558. 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 89 of 93 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$279,663.

Unsupported Number of Service 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 89 out of 93 selected claims, the Hospital billed Medicare for unsupported numbers of service units. On most of these claims billed in error, the Hospital charged Medicare for unsupported units of service for venous angioplasty. The Hospital attributed the overpayments to complex coding requirements. As a result of these errors, the Hospital received overpayments of \$279,663.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 15 of 106 selected inpatient claims that we reviewed. This error resulted in overpayments of \$61,558.

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 8 out of 106 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital attributed these errors to human error: that is, due to the complexity of the evaluations of the beneficiaries’ medical conditions, Hospital staff overlooked the need to combine the original and subsequent stays for these cases into single claims. As a result of these errors, the Hospital received overpayments of \$26,241.

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 106 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 key controls identified the errors; however, human error in the case management area resulted in staff not correcting the claims prior to billing. As a result of these errors, the Hospital received estimated overpayments of \$21,377.²

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 4 out of 106 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 the coding errors were the result of human error. As a result of these errors, the Hospital received overpayments of \$13,940.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$341,221, consisting of \$279,663 in overpayments for 89 incorrectly billed outpatient claims and \$61,558 in overpayments for 15 incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

² 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.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with our findings and recommendations. Specifically, the Hospital stated that it had fully reimbursed the overpayment amounts that we identified and described corrective actions that it had taken or planned to take to implement our recommendations.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$2,782,865 in Medicare payments to the Hospital for 199 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 93 outpatient and 106 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 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 October 2014 to December 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 CY 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 199 claims (93 outpatient and 106 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 February 3, 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
Outpatient				
Surgeries Billed With Units Greater Than One	89	\$749,175	89	\$279,663
Claims With Payments Greater Than \$25,000	3	136,858	0	0
Manufacturer Credits for Replaced Medical Devices	1	8,353	0	0
Outpatient Totals	93	\$894,386	89	\$279,663
Inpatient				
Same-Day Discharges and Readmissions	8	\$72,992	8	\$26,241
Short Stays	1	11,495	1	11,495
Claims Billed With Cancelled Elective Surgical Procedures	3	14,586	2	9,882
Diagnosis-Related-Group Verification	79	1,210,658	2	7,700
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	11	320,967	1	7,452
Claims With Payments Greater Than \$150,000	1	209,899	0	\$0
Manufacturer Credits for Replaced Medical Devices	1	27,279	0	\$0
Claims Paid in Excess of Charges	2	20,603	1	(1,212)
Inpatient Totals	106	\$1,888,479	15	\$61,558
Outpatient and Inpatient Totals	199	\$2,782,865	104	\$341,221

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



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May 6, 2016

Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
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Attention: Patrick J. Cogley
Regional Inspector General for Audit Services

Subject: Report Number A-07-15-05075
Medicare Compliance Review of Christian Hospital for 2012 and 2013

Christian Hospital received the draft report dated April 14, 2016 requesting written comments and a statement describing the corrective action taken or actions planned by Christian Hospital in response to the recommendations identified in the report.

The OIG concluded that Christian Hospital complied with CMS requirements for 95 of the 199 inpatient and outpatient claims reviewed. However, the OIG auditors determined Christian Hospital did not fully comply with Medicare billing requirements for the remaining 104 claims, resulting in net overpayments of \$341,221 for calendar years 2012-2013. Specifically, 15 inpatient claims had billing errors, resulting in overpayments of \$61,558, and 89 outpatient claims had billing errors, resulting in overpayments of \$279,663.

In response to the audit we want to assure you that Christian Hospital is committed to ensuring appropriate operational procedures and controls are in place to minimize the risk of billing errors. The following describes Christian Hospital's response to the recommendations identified, the corrective actions that are completed, and the efforts currently in progress.

After review of the audit findings and recommendations Christian Hospital agrees with the 104 claims identified with billing errors. We have fully reimbursed the overpayment amounts as determined by your audit.

Christian Hospital responds to the remaining findings as follows:

Outpatient Claims

Unsupported Number of Service Units

For 89 of the 93 selected claims, the hospital billed Medicare for an unsupported number of service units which resulted in overpayment of \$279,663.

- Misinterpretation of the CPT coding rules resulted in billing errors. Education was provided to the radiology department staff and coding staff, and an edit was created in the system for pre-bill review of all claims.

Inpatient Claims

Incorrectly Billed as Separate Inpatient Stays

For 8 of the 106 selected claims, the hospital billed Medicare separately for related discharges and readmissions that occurred within the same day, which resulted in an overpayment of \$26,241.

- Due to the complexity of the evaluations of the beneficiaries' medical conditions, Christian Hospital staff overlooked the need to combine the original and subsequent stays for these cases into single claims. Continued feedback and education was provided to the coding staff and case management staff.

Incorrectly Billed as Inpatient

For 3 of the 106 selected claims, the hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services which resulted in overpayment of \$21,377.

- Appropriate patient status remains a focus of our compliance program. Processes are in place to ensure Case Management reviews and complies with all Medicare regulations regarding appropriate documentation to support inpatient billing.

Unsupported Codes

For 4 of the 106 selected claims, the hospital billed Medicare with incorrectly coded claims which resulted in an overpayment of \$13,940.

- Due to human error; certain diagnosis codes or procedure codes were not supported by the documentation in the medical records. Continued feedback and education was provided to the coding staff.

Christian Hospital is committed to ensuring compliance with Medicare billing requirements and ongoing review of our internal control processes. We would also like to thank the OIG audit team for their professionalism, communication, time and effort, and cooperation during this process.

If you have any questions, or need additional information please contact me at 314-286-0647.

Sincerely,



Kathy Boschert
Director, BJC Corporate Compliance

cc: Sally Terrace, Vice President, BJC Corporate Compliance