

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF CALIFORNIA
PACIFIC MEDICAL CENTER,
PACIFIC CAMPUS,
FOR CALENDAR YEARS
2009 AND 2010**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Brian P. Ritchie
Assistant Inspector General

January 2013
A-09-12-02027

Office of Inspector General

<https://oig.hhs.gov>

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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

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays 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, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these payments to hospitals using computer matching, data mining, and analysis of claims. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

California Pacific Medical Center, Pacific Campus (the Hospital), is an acute-care hospital located in San Francisco, California. Medicare paid the Hospital approximately \$254 million for 15,035 inpatient and 164,765 outpatient claims for services provided to beneficiaries during calendar years 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$3,118,585 in Medicare payments to the Hospital for 224 claims that we judgmentally selected as potentially at risk for billing errors. These 224 claims consisted of 181 inpatient and 43 outpatient claims.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 63 of the 224 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 161 claims, resulting in overpayments totaling \$1,220,636. Specifically, 123 inpatient claims had billing errors, resulting in overpayments totaling \$1,138,758, and 38 outpatient claims had billing errors, resulting in overpayments totaling \$81,878. These overpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$1,220,636, consisting of \$1,138,758 in overpayments for the incorrectly billed inpatient claims and \$81,878 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations and provided information on actions taken to address our recommendations.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System.....	1
Hospital Payments at Risk for Incorrect Billing.....	1
Medicare Requirements for Hospital Claims and Payments	2
California Pacific Medical Center, Pacific Campus	3
OBJECTIVE, SCOPE, AND METHODOLOGY	3
Objective.....	3
Scope.....	3
Methodology.....	3
FINDINGS AND RECOMMENDATIONS	4
BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS	5
Incorrectly Billed as Inpatient.....	5
Incorrect Discharge Status	5
Incorrect Diagnosis-Related Groups.....	6
Manufacturer Credits for Replaced Medical Devices Not Reported	6
BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS	6
Incorrect Healthcare Common Procedure Coding System Codes or Number of Units	6
Services Not Billable to Medicare	7
RECOMMENDATIONS	7
HOSPITAL COMMENTS	7
APPENDIX	
HOSPITAL COMMENTS	

INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

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

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays 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, 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) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.¹ The OPPS is effective for services furnished on or after August 1, 2000. 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.² All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Payments at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these payments to hospitals using computer matching, data mining, and analysis of claims.

¹ In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Examples of the types of claims at risk for noncompliance included the following:

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient transfer claims,
- inpatient claims with high severity level DRG codes,
- inpatient claims involving manufacturer credits for replaced medical devices,
- inpatient and outpatient claims paid in excess of charges,
- outpatient surgeries billed with units greater than one,
- outpatient claims with payments for drug injections,
- outpatient intensity-modulated radiation therapy planning services, and
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day).

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.”

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that 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.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment.

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

California Pacific Medical Center, Pacific Campus

California Pacific Medical Center, Pacific Campus (the Hospital), is an acute-care hospital located in San Francisco, California. Medicare paid the Hospital approximately \$254 million for 15,035 inpatient and 164,765 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

Scope

Our audit covered \$3,118,585 in Medicare payments to the Hospital for 224 claims that we judgmentally selected as potentially at risk for billing errors. These 224 claims consisted of 181 inpatient and 43 outpatient claims. Of the 224 claims, 214 claims had dates of service in CYs 2009 and 2010, 9 claims (involving transfers) had dates of service in 2008, and 1 claim (involving a replaced medical device) had a date of service in January 2011.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but 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 claims selected for review because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review enabled us to establish 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 inpatient and outpatient claims and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital from January to September 2012.

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 2008 through 2010;

- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2009 through 2011;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 224 claims (181 inpatient and 43 outpatient claims) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- 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.

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.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 63 of the 224 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 161 claims, resulting in overpayments totaling \$1,220,636. Specifically, 123 inpatient claims had billing errors, resulting in overpayments totaling \$1,138,758, and 38 outpatient claims had billing errors, resulting in overpayments totaling \$81,878. These overpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 123 of 181 selected inpatient claims, which resulted in overpayments totaling \$1,138,758.

Incorrectly Billed as Inpatient

Section 1862(a)(1)(A) of the Act states that 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.”

For 62 of 181 selected inpatient claims, the Hospital incorrectly billed Medicare Part A. The Hospital subsequently reviewed each of the claims and determined that the patient did not meet the severity of illness or level of care required to be admitted as an inpatient. The Hospital stated that these errors occurred because during the period of our review Hospital staff had not used the assistance of an evidence-based clinical decision support tool.³ In addition, the Hospital stated that admitting physician staff were not well informed or educated regarding inpatient admission determinations. As a result of these errors, the Hospital received overpayments totaling \$680,071.⁴

Incorrect Discharge Status

Federal regulations (42 CFR § 412.4(b)) state that a discharge of a hospital inpatient is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge. A discharge of a hospital inpatient is also considered to be a transfer when the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to a home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient’s stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 43 of 181 selected inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to other facilities. For a majority of these claims, the Hospital should have coded the discharge status as a transfer to another facility instead of as a discharge to a home; thus, the Hospital should have received the per diem payment instead of the full DRG payment. The Hospital stated that these errors primarily occurred because case management and nursing staff inconsistently documented the patient’s

³ The Hospital now uses McKesson Corp.’s InterQual evidence-based clinical decision support criteria to answer critical questions about the appropriateness of levels of care and resource use.

⁴ The Hospital may be able to bill Medicare Part B for some services related to some of these incorrect Medicare Part A claims. 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 or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

discharge disposition in the medical records. As a result of these errors, the Hospital received overpayments totaling \$234,554.

Incorrect Diagnosis-Related Groups

Section 1862(a)(1)(A) of the Act states that 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.” Chapter 1, section 80.3.2.2, of the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For 16 of 181 selected inpatient claims, the Hospital submitted claims to Medicare with incorrect DRGs. For example, for one claim, the Hospital used a DRG for a heart transplant or the implantation of a heart assistance system even though the patient did not receive such a service or system. The Hospital stated that these errors occurred because of a lack of internal quality auditing, a lack of education policies and procedures, and inadequate quality monitoring of coding vendors that resulted in incorrect coding of these claims. As a result of these errors, the Hospital received overpayments totaling \$212,733.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations (42 CFR § 412.89(a)) require a reduction in the IPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of the device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device. The Manual, chapter 3, section 100.8, states that to correctly bill for a replacement device that was provided with a credit, hospitals must use the combination of condition code 49 or 50 (which identifies the replacement device) and value code FD (which identifies the amount of the credit or cost reduction received by the hospital for the replaced device).

For 2 of 181 selected inpatient claims, the Hospital received a reportable medical device credit for a replaced medical device from a manufacturer. However, the Hospital did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required. The Hospital stated that these errors occurred because credit memos received by the Hospital finance department were not forwarded to patient financial services for review and claims adjustment. As a result of these errors, the Hospital received overpayments totaling \$11,400.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 38 of 43 selected outpatient claims, which resulted in overpayments totaling \$81,878.

Incorrect Healthcare Common Procedure Coding System Codes or Number of Units

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, section 20.4, of the

Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For 35 of 43 selected outpatient claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes and/or an incorrect number of units. The Hospital stated that these errors occurred because of a lack of internal quality auditing, a lack of education policies and procedures, inadequate ongoing education of coding staff, and inadequate quality monitoring. As a result of these errors, the Hospital received overpayments totaling \$76,393.

Services Not Billable to Medicare

Section 1862(a) of the Act states that “... no payment may be made under part A or part B for any expenses incurred 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 Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, section 20.6.4.A, of the Manual states that modifier -73 is used to indicate that a procedure requiring anesthesia was terminated after the patient had been prepared for the procedure.

For 3 of 43 selected outpatient claims, the Hospital incorrectly billed Medicare for services provided that were not allowable for Medicare reimbursement. For two of the claims, the Hospital billed Medicare for noncovered dental services (i.e., routine care, treatment, and removal of teeth). For the other claim, the Hospital incorrectly billed Medicare for a procedure (with modifier -73) that was canceled before the patient was prepared for surgery. The Hospital stated that these errors occurred because of a lack of internal claim edits to prevent billing for dental services and a lack of education on the use of modifier -73. As a result of these errors, the Hospital received overpayments totaling \$5,485.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$1,220,636, consisting of \$1,138,758 in overpayments for the incorrectly billed inpatient claims and \$81,878 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations and provided information on actions taken to address our recommendations. The Hospital’s comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: HOSPITAL COMMENTS



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November 27, 2012

Lori A. Ahlstrand
Regional Inspector General
For Audit Services
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RE: Report Number: A-09-12-02027

Dear Ms. Ahlstrand:

This letter is in response to the U.S. Department of Health and Human Services Office of Inspector General (OIG), draft report entitled *Medicare Compliance Review of California Pacific Medical Center, Pacific Campus for Calendar Years 2009 and 2010*, dated November 1, 2012.

The OIG audit covered \$3,118,585 in Medicare payments for the 224 claims (181 inpatient and 43 outpatient claims). We understand that these claims were judgmentally selected by the OIG as potentially at risk for billing errors. As a result of the detailed review, the OIG identified 161 claims with billing errors, totaling \$1,220,636 in overpayments for CYs 2009 and 2010.

California Pacific Medical Center (the "Hospital") has reviewed the findings and, except as otherwise stated, concurs with the recommendations noted in the draft report.

1. The OIG recommends the Hospital *refund the Medicare contractor \$1,220,636, consisting of \$1,138,758 in overpayments for incorrectly billed inpatient claims and \$81,878 in overpayments for the incorrectly billed outpatient claims.*

The Hospital has refunded \$1,220,636 while awaiting adjudication of the Part B claims, and we are researching our ability to re-bill for certain Part B services in relation to those stays.

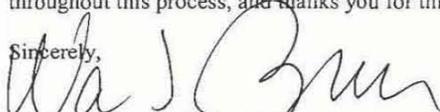
2. The OIG recommends the Hospital *strengthen control to ensure full compliance with Medicare requirements.*

The Hospital is taking the OIG audit findings and recommendations seriously, as we further enhance our internal controls. These include providing additional education to coding and billing staff, creating additional edits, providing education to case management staff, and building processes to ensure that manufacturer credits are appropriately refunded.

Additionally, the Hospital audits and monitors high risk areas as part of our ongoing efforts to ensure that our inpatient and outpatient claims are submitted in compliance with Medicare regulations and guidance.

California Pacific Medical Center appreciates the professionalism of the OIG audit team throughout this process, and thanks you for this opportunity to respond to the draft report.

Sincerely,

A handwritten signature in black ink, appearing to read "Warren Browner". The signature is written in a cursive, flowing style.

Warren Browner, M.D., M.P.H.
Chief Executive Officer