Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF CEDARS-SINAI MEDICAL CENTER FOR THE PERIOD JANUARY 1, 2008, THROUGH JUNE 30, 2011

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EXECUTIVE SUMMARY

Cedars-Sinai Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of $2.2 million over 3½ 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 are at risk for noncompliance with Medicare billing requirements. For calendar year 2011, Medicare paid hospitals $151 billion, which represented 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.

Our objective was to determine whether Cedars-Sinai 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. 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 an acute-care hospital located in Los Angeles, California. Medicare paid the Hospital approximately $1.37 billion for 66,467 inpatient and 574,807 outpatient claims for services provided to beneficiaries during the period January 1, 2008, through June 30, 2011.

Our audit covered $5,590,434 in Medicare payments to the Hospital for 490 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 240 inpatient and 250 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 81 of the 490 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 409 claims, resulting in overpayments of $2,244,649 for the period January 1, 2008, through June 30, 2011. Specifically, 176 inpatient claims had billing errors, resulting in overpayments of $1,869,455, and 233 outpatient claims had billing errors, resulting in overpayments of $375,194. 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 $2,244,649, consisting of $1,869,455 in overpayments for the incorrectly billed inpatient claims and $375,194 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 generally agreed with our findings and provided information on actions that it had taken or planned to take to address 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 are at risk for noncompliance with Medicare billing requirements. For calendar year 2011, Medicare paid hospitals $151 billion, which represented 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 Cedars-Sinai 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 identified these types of hospital claims at risk for noncompliance:

- inpatient short stays,
- inpatient transfers,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient and outpatient claims paid in excess of charges,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed for Lupron injections,
- outpatient surgeries billed with units greater than one, 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." 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, payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 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). 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.

Cedars-Sinai Medical Center

The Hospital is an acute-care hospital located in Los Angeles, California. Medicare paid the Hospital approximately $1.37 billion for 66,467 inpatient and 574,807 outpatient claims for services provided to beneficiaries during the period January 1, 2008, through June 30, 2011.[2]

HOW WE CONDUCTED THIS REVIEW

Our audit covered $5,590,434 in Medicare payments to the Hospital for 490 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service during the period January 1, 2008, through June 30, 2011, and consisted of 240 inpatient and 250 outpatient claims. We focused our review on the risk areas that we had identified 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. 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 81 of the 490 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 409 claims, resulting in overpayments of $2,244,649 for the period January 1, 2008, through June 30, 2011. Specifically, 176 inpatient claims had billing errors, resulting in overpayments of $1,869,455, and 233 outpatient claims had billing errors, resulting in overpayments of $375,194. 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 a detailed list of the risk areas that we reviewed and associated billing errors, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 176 of 240 selected inpatient claims, which resulted in overpayments of $1,869,455. Two claims contained more than one type of error.

[2] These data came from CMS's National Claims History file.

Incorrect Billing of Part A for Beneficiary Stays That Should Have Been Billed as Outpatient Services

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 100 of 240 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient-with-observation services. The Hospital attributed the patient admission errors primarily to late night and weekend admissions through the emergency department and insufficient case management staffing, which resulted in a failure to review all accounts before billing Medicare. As a result of these errors, the Hospital received overpayments of $1,116,401.[3]

Incorrect Billing for Patient Discharges That Should Have Been Billed as Transfers

Hospitals must bill inpatient discharges as transfers when (1) the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge or (2) the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to home under a home health agency's written plan of care for home health services that begin within 3 days after the date of discharge (42 CFR §§ 412.4(b) and (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 56 of 240 selected claims, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers to other facilities.[4] For these claims, the Hospital should have coded the discharge status as a transfer to home under a written plan of care for the provision of home health services or to an acute-care hospital. However, for a majority of these claims, the Hospital incorrectly coded the discharge status as "discharged to home" or "left against medical advice"; therefore, the Hospital should have received the per diem payment instead of the full DRG payment. The Hospital stated that these errors occurred because (1) patients sought alternative health care services at other facilities without the Hospital's knowledge, (2) the coding staff did not identify the disposition status information in the plan of care and the physician's final orders indicated the patient was to be sent home, or (3) the coding staff incorrectly assigned the patient discharge status. As a result of these errors, the Hospital received overpayments of $522,074.

[3] 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.

[4] For one of these claims, the Hospital also billed Medicare with an incorrect DRG.

Incorrect Diagnosis-Related Groups

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)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 19 of 240 selected claims, the Hospital billed Medicare with incorrect DRGs.[5] For example, for one claim, the Hospital billed a DRG for a ventricular shunt procedure with major complication or comorbidities rather than billing the DRG for other disorders of the nervous system with major complication or comorbidities. The Hospital stated that code assignment is dependent on clear physician documentation. For a majority of the errors, physician documentation in the medical records was not clear, and the coding staff made code assignment decisions on the basis of the documentation at hand. As a result of these errors, the Hospital received overpayments of $206,185.

Unreported Manufacturer Credits for Replaced Medical Devices

Federal regulations 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 device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89(a)). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a 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) (chapter 3, § 100.8).

For 1 of 240 selected claims, the Hospital received a reportable medical device credit for a replaced device from a manufacturer but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required. The Hospital stated that this error occurred because of lack of coordination between various departments. As a result, the Hospital received an overpayment of $24,795.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 233 of 250 selected outpatient claims, which resulted in overpayments of $375,194.

Incorrect Billing of Healthcare Common Procedure Coding System Code or Number of Units

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed

[5] For one of these claims, the Hospital also billed Medicare for a patient discharge that it should have billed as a transfer to another facility.

accurately" (chapter 1, § 80.3.2.2). In addition, the Manual states: "The definition of service units … is the number of times the service or procedure being reported was performed" (chapter 4, § 20.4).

For 224 of 250 selected claims, the Hospital submitted claims to Medicare with the incorrect HCPCS code or an incorrect number of units:

- For 219 claims, the Hospital billed Medicare with the incorrect HCPCS code. Specifically, the Hospital billed the incorrect HCPCS code for a drug available in two separate dosages, each assigned its own HCPCS code and separately packaged.

- For five claims, the Hospital billed Medicare with an incorrect number of units. For example, for one claim, rather than billing 1 unit for a procedure performed on the nose, the Hospital billed 76 units.

The Hospital stated that these errors occurred because the Hospital's cancer center did not have the charge code for the correct HCPCS code and the Hospital's billing system failed to convert charges for operating-room time to billable units. As a result of these errors, the Hospital received overpayments of $346,380.

Unreported Manufacturer Credits for Replaced Medical Devices

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(a)). 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.[6]

For 3 of 250 selected claims, the Hospital incurred no cost or received full credit for the replaced device but did not properly report the -FB modifier or reduced charges on its claims. The Hospital stated that these errors occurred because of lack of coordination between various departments. As a result of these errors, the Hospital received overpayments of $24,478.

Incorrect Billing for Unlabeled Use of a Drug or Noncovered Dental Services

CMS's *Medicare Benefit Policy Manual* defines an unlabeled use of a drug as a use that is not included as an indication on the drug's label as approved by the Food and Drug Administration (FDA) (Pub. 100-02, chapter 15, § 50.4.2). This section states that FDA-approved drugs used for indications other than what is indicated on the official label may be covered under Medicare

[6] CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS. 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 (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

if the contractor determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature, and/or accepted standards of medical practice.

The Act states that no payment may be made under Medicare 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 ..." (§ 1862(a)(12)).

For 6 of 250 selected claims, the Hospital billed Medicare for services that were not allowable for Medicare reimbursement. For five claims, the Hospital billed Medicare for the unlabeled use of a chemotherapy drug without confirming with the Medicare contractor that the unlabeled use was medically accepted. For one claim, the Hospital billed Medicare for noncovered dental services (i.e., routine care, treatment, and removal of teeth). The Hospital stated that these errors occurred because the billing system did not prevent billing for the unlabeled use of a drug (five claims) and a billing system edit to prevent billing for dental services was overridden (one claim). As a result of these errors, the Hospital received overpayments of $4,336.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $2,244,649, consisting of $1,869,455 in overpayments for the incorrectly billed inpatient claims and $375,194 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 generally agreed with our findings and provided information on actions that it had taken or planned to take to address our recommendations. The Hospital's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $5,590,434 in Medicare payments to the Hospital for 490 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service during the period January 1, 2008, through June 30, 2011 (audit period), and consisted of 240 inpatient and 250 outpatient claims.

We focused our review on the risk areas that we had identified 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 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 CMS's 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 at the Hospital from February 2012 to January 2013.

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 the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 490 claims (240 inpatient and 250 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 objectives.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Billing Errors	Value of Overpayments
Inpatient				
Short Stays	171	$3,163,836	108	$1,120,404
Transfers	61	1,472,884	61	548,442
Claims Paid in Excess of Charges	6	174,284	5	141,366
Claims Billed With High-Severity-Level DRG Codes	1	43,405	1	34,448
Manufacturer Credits for Replaced Medical Devices	1	32,364	1	24,795
Inpatient Totals	**240**	**$4,886,773**	**176**	**$1,869,455**
Outpatient				
Claims Billed for Lupron Injections	224	$508,013	224	$292,979
Surgeries Billed With Units Greater than One	5	45,546	5	30,930
Claims Paid in Excess of Charges	3	34,359	1	26,807
Manufacturer Credits for Replaced Medical Devices	3	38,732	3	24,478
Claims Billed With Modifier -59	15	77,011	0	0
Outpatient Totals	**250**	**$703,661**	**233**	**$375,194**
Inpatient and Outpatient Totals	**490**	**$5,590,434**	**409**	**$2,244,649**

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 this report's findings.