

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
COMMUNITY REGIONAL  
MEDICAL CENTER**

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**Brian P. Ritchie**  
Assistant Inspector General

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A-09-12-02071

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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

***Community Regional Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of \$1.1 million over 4 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 (CY) 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 Community Regional 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 Fresno, California. Medicare paid the Hospital approximately \$541 million for 31,884 inpatient and 185,755 outpatient claims for services provided to beneficiaries during CYs 2008 through 2011.

Our audit covered \$3,283,707 in Medicare payments to the Hospital for 301 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 210 inpatient and 91 outpatient claims. Of the 301 claims, 280 claims had dates of service in CYs 2008 through 2011, and 21 claims (in areas with a higher risk of billing errors) had dates of service in CY 2012.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 71 of the 301 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 230 claims, resulting in overpayments of \$1,075,310. Specifically, 143 inpatient claims had billing errors, resulting in overpayments of \$919,033, and 87 outpatient claims had billing errors, resulting in overpayments of \$156,277. 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 \$1,075,310, consisting of \$919,033 in overpayments for the incorrectly billed inpatient claims and \$156,277 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 (CY) 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 Community Regional 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. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System

(HCPCS) codes and descriptors to identify and group the services within each APC group.<sup>1</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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

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

- inpatient transfers,
- inpatient short stays,
- inpatient mechanical ventilation,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims related to hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed for Lupron injections,
- outpatient claims for injectable drugs,
- outpatient claims billed before and during inpatient stays, and
- outpatient claims billed for doxorubicin hydrochloride.

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)).

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

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).

## **Community Regional Medical Center**

The Hospital is an acute-care hospital located in Fresno, California. Medicare paid the Hospital approximately \$541 million for 31,884 inpatient and 185,755 outpatient claims for services provided to beneficiaries during CYs 2008 through 2011.<sup>2</sup>

## **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$3,283,707 in Medicare payments to the Hospital for 301 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 210 inpatient and 91 outpatient claims. Of the 301 claims, 280 claims had dates of service in CYs 2008 through 2011, and 21 claims (in areas with a higher risk of billing errors, i.e., inpatient transfers, Lupron injections, and other injectable drugs) had dates of service in CY 2012. 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 71 of the 301 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 230 claims, resulting in overpayments of \$1,075,310. Specifically, 143 inpatient claims had billing errors, resulting in overpayments of \$919,033, and 87 outpatient claims had billing errors, resulting in overpayments of \$156,277. 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.

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<sup>2</sup> These data came from CMS's National Claims History file.

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 143 of 210 selected inpatient claims, which resulted in overpayments of \$919,033.

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

Federal regulations 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 (42 CFR § 412.4(b)). 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 home under a written plan of care for the provision of home health services or to a skilled nursing facility (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 86 of 210 selected inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers. For these claims, the Hospital should have coded the discharge status as a transfer to (1) home under a written plan of care for the provision of home health services (83 claims), (2) an acute-care hospital (1 claim), (3) a skilled nursing facility (1 claim), or (4) a non-acute-care facility (1 claim). However, 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 a more robust monitoring and auditing process was needed to review the discharge status for patients discharged to home according to discharge orders. As a result of these errors, the Hospital received overpayments of \$406,649.

### **Incorrect Billing of Medicare 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 48 of 210 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient-with-observation services. The majority of these claims involved canceled surgical procedures. The Hospital attributed the patient admission errors primarily to insufficient case management staffing, which resulted in a failure to review all inpatient accounts for accurate admission status orders before billing Medicare. As a result of these errors, the Hospital received overpayments of \$401,519.

### **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 5 of 210 selected inpatient claims, the Hospital billed Medicare with incorrect DRGs. For example, for two claims, the Hospital billed a DRG for use of a mechanical ventilator for more than 96 hours rather than billing the DRG for use of a mechanical ventilator for fewer than 96 hours. The Hospital stated that additional education, monitoring, and auditing was needed to identify possible areas of concern. As a result of these errors, the Hospital received overpayments of \$68,436.

### **Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained**

Federal regulations require reductions in the IPPS payments 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 device cost (42 CFR § 412.89(a)). The Manual states that to correctly bill 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). Federal regulations state: “All payments to providers of services must be based on the reasonable cost of services ...” (42 CFR § 413.9). The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements in additional detail.<sup>3</sup>

For 3 of 210 selected inpatient claims, the Hospital either (1) received a reportable medical device credit from a manufacturer but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required (2 claims) or (2) did not obtain a credit for a replaced medical device for which a credit was available under the terms of the manufacturer’s warranty (1 claim). The Hospital stated that an enhanced internal control was needed to identify, obtain, and properly report credits from device manufacturers. As a result of these errors, the Hospital received overpayments of \$27,025.

### **Incorrect Provider Number Used**

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

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<sup>3</sup> The PRM states: “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program” (part I, § 2102.1). Section 2103 further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example: “Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.”

For 1 of 210 selected inpatient claims, the Hospital billed Medicare using its own provider number for services provided by a different hospital within its hospital chain. The Hospital attributed this to an error in its billing system, which failed to recognize that the wrong provider number was used. As a result of this error, the Hospital received an overpayment of \$15,404.

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

The Hospital incorrectly billed Medicare for 87 of 91 selected outpatient claims, which resulted in overpayments of \$156,277 (1 claim had 2 types of errors).

### **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 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 73 of 91 selected outpatient claims, the Hospital submitted claims to Medicare with the incorrect HCPCS code or an incorrect number of units:

- For 59 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 one of these claims, the Hospital also billed the incorrect number of units.
- For 14 claims, the Hospital billed Medicare with an incorrect number of units. For example, for seven claims, the Hospital billed for a full vial of a cancer drug when only a partial vial was administered.

The Hospital stated that these errors occurred because its system was configured to select the incorrect HCPCS code and was not set up to charge for partial “single dose” vials. As a result of these errors, the Hospital received overpayments of \$131,327.

### **Incorrect Billing of Medicare Part B for Outpatient Services Provided Before or During Inpatient Stays**

Medicare Part A covers certain items and nonphysician services furnished to inpatients; consequently, the IPPS rate covers these services (the Manual, chapter 3, § 10.4).

For 10 of 91 selected outpatient claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided within 72 hours before or during inpatient stays. For seven of these claims, the Hospital had provided services, such as endoscopies, to inpatients of other hospitals. However, the Hospital incorrectly billed Medicare Part B for these services rather than the other

hospitals. In each of these cases, the outpatient services should have been included as part of the Part A IPPS payment to the other hospital. For the remaining three claims, the services should have been included on the Hospital's inpatient (Part A) claims to Medicare. The Hospital stated that human error caused the incorrect billing. As a result of these errors, the Hospital received overpayments of \$12,285.

### **Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained**

Federal regulations require a reduction in the OPSS 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)).

CMS guidance explains how a provider should report no-cost and reduced-cost devices under the OPSS.<sup>4</sup> 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. In addition, Federal regulations state: "All payments to providers of services must be based on the reasonable cost of services ..." (42 CFR § 413.9). The PRM reinforces these requirements in additional detail. See footnote 3 on page 5.

For 2 of 91 selected outpatient claims, the Hospital either (1) received full credit for a replaced device but did not report the -FB modifier and reduced charges on its claim (1 claim) or (2) did not obtain a credit for a replaced device for which a credit was available under the terms of the manufacturer's warranty (1 claim). The Hospital stated that an enhanced internal control was needed to identify, obtain, and properly report credits from device manufacturers. As a result of these errors, the Hospital received overpayments of \$8,454.

### **Incorrect Billing of Drugs Not Administered to Beneficiaries**

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 accurately" (chapter 1, § 80.3.2.2).

For 2 of 91 selected outpatient claims, the Hospital billed Medicare for drugs that were not administered to the beneficiaries. For example, for one of these claims, the physician canceled the order for a cancer drug; however, the drug was included on the Hospital's outpatient (Part B) claim to Medicare. The Hospital stated that because of human error, it did not reconcile the charges with the administered drug labels and the physicians' orders. As a result of these errors, the Hospital received overpayments of \$4,211.

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<sup>4</sup> CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$1,075,310, consisting of \$919,033 in overpayments for the incorrectly billed inpatient claims and \$156,277 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 \$3,283,707 in Medicare payments to the Hospital for 301 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 210 inpatient and 91 outpatient claims. Of the 301 claims, 280 claims had dates of service in CYs 2008 through 2011, and 21 claims (in areas with a higher risk of billing errors, i.e., inpatient transfers, Lupron injections, and other injectable drugs) had dates of service in CY 2012.

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 in September and October 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 2011 and for CY 2012 for 21 claims;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2008 through 2011;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 301 claims (210 inpatient and 91 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: RISK AREAS REVIEWED AND BILLING ERRORS**

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Over-payments</b>	<b>Value of Overpayments</b>
<b>Inpatient</b>				
Transfers	95	\$1,658,862	95	\$472,918
Short Stays	101	888,143	42	350,493
Mechanical Ventilation	2	64,548	2	42,293
Manufacturer Credits for Replaced Medical Devices	5	131,435	3	27,025
Claims Billed With High-Severity-Level DRG Codes	5	212,448	1	26,304
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	2	17,337	0	0
<b>Inpatient Totals</b>	<b>210</b>	<b>\$2,972,773</b>	<b>143</b>	<b>\$919,033</b>
<b>Outpatient</b>				
Claims Billed for Lupron Injections	61	\$161,859	61	\$103,880
Claims for Injectable Drugs	14	77,316	14	31,658
Claims Billed Before and During Inpatient Stays	10	12,285	10	12,285
Manufacturer Credits for Replaced Medical Devices	3	49,257	2	8,454
Claims Billed for Doxorubicin Hydrochloride	3	10,217	0	0
<b>Outpatient Totals</b>	<b>91</b>	<b>\$310,934</b>	<b>87</b>	<b>\$156,277</b>
<b>Inpatient and Outpatient Totals</b>	<b>301</b>	<b>\$3,283,707</b>	<b>230</b>	<b>\$1,075,310</b>

## APPENDIX C: HOSPITAL COMMENTS



### CERTIFIED MAIL DELIVERY

Lori A. Ahlstrand  
Regional Inspector General for Audit Services  
Department of Health and Human Service  
Office of Inspector General  
Office of Audit Services, Region IX  
90 – 7<sup>th</sup> Street, Suite 3-650  
San Francisco, CA 94103

Re: Audit A-09-12-02071-Medicare Compliance Review of Community Regional Medical Center for Calendar Years 2008 and 2011

Dear Ms. Ahlstrand:

I am writing on behalf of Community Regional Medical Center (the "Hospital"), which is in receipt of the above referenced draft audit report. The Hospital strives to create a culture that promotes understanding and adherence to applicable federal, state and local laws and regulations. This includes the implementation of operational procedures and controls to minimize the risk of billing errors. An effective internal control system will not prevent or detect all errors. Overpayments and underpayments can occur due to human error by an internal or external individual. An effective hospital internal control system provides reasonable, but not absolute, assurance that claims billed to Medicare will comply with Medicare laws and regulations.

We have reviewed in detail your office's findings in the draft report. In general, we agree that 230 of the 301 claims audited were found to contain some form of error that affects reimbursement. We have reimbursed the full overpayment amount as determined by your audit. We have a continuous process to review and strengthen internal billing controls to ensure compliance with Medicare requirements and we will continue to monitor.

The Hospital has reviewed the recommendations in the report and has responded as follows:

The amount of \$1,075,310 which is identified as an overpayment in the report, specifically - 143 inpatient claims had billing errors, resulting in overpayments of \$919,033, and 87 outpatient claims had billing errors, resulting in overpayments of \$156,277 has been refunded through correction and resubmission of involved claims to our CMS contractor.

P.O. Box 1232, Fresno, California 93715-1232 • [www.communitymedical.org](http://www.communitymedical.org)

Clow's Community Medical Center • Community Regional Medical Center • Fresno Heart & Surgical Hospital • California Cancer Center  
Community Behavioral Health Center • Community Health Center-Siema • Community Living Center-Fresno • Community Medical Center-Dakshini  
Dellitt Subacute & Skilled Nursing Center • Community SPORT Center • Doris Kallagan Care Center • Community Medical Foundation

**Billing errors associated with inpatient claims.**

1. **Incorrect Billing for Patient Discharges That Should Have Been Billed as Transfers.** (86 of 210 claims).

Although the Hospital had internal controls in place for "Discharge Disposition" this can continue to be a problem for hospitals. A patient is discharge home with such discharge orders noted in the medical record and is coded as such. If the patient decides after being discharge home to seek other healthcare services the hospital does not have knowledge of such. Errors occurred because patients sought alternative health care services at other facilities without the Hospital's knowledge. The intake facility and the fiscal intermediary do not notify the hospital. A few situations noted 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. We have implemented a process for retrospective review of coding/ billing disposition assignment to ensure the medical record document discharge orders and instructions match the code that was utilized for billing disposition.

2. Although the Hospital had internal controls in place to further enhance and strengthen the Hospital's controls, we have taken the following steps:

- a. **Incorrect Billing of Part A for Beneficiary Stays That Should Have Been Billed as Outpatient Services.** (48 of 210 claims).

Inpatient Claims should have been outpatient or outpatient-with-observation. The Hospital has addressed staffing and implemented new internal control process to address the patient admission errors that were due to primarily 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.

- b. **Incorrect Diagnosis-Related Groups.** (5 of 210 claims). Human Error - Education. We have reviewed those errors with the individuals and departments involved and provided additional education with the purpose of avoiding recurrence. We will continue to monitor.

- c. **Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained.** (3 of 210 claims).

The process for assuring medical device credits are properly reflected on Medicare claims is complex. The Hospital has strengthened their controls by identifying and assigning proper communication / coordination between various departments to assure credits are accurately reflected and coded on claims.

- d. **Incorrect Provider Number Used.** (1 of 210 claims). The Hospital had a system conversion and the system failed to recognize the wrong provider number and error was not captured. The systems now have edits in place to capture such errors.

**Billing errors associated with outpatient claims.**

1. Although the Hospital had internal controls in place to further enhance and strengthen the Hospital's controls, we have taken the following steps:
  - a. **Incorrect Billing of drug HCPCS Code (59 of 91 claims) or incorrect number of units (14 of 91 claims).**  
New internal control processes for communication and implementation of all charge code additions, changes and deletions have been implemented, communicated and is being monitored. Any errors identified through an edit process will be communicated to all departments and identified claims adjusted appropriately.
  - b. **Incorrect Billing of Part B for outpatient Services Provided Before or During Inpatient Stays. (10 of 91 claims).**  
Human error caused the incorrect billing. We have reviewed those errors with the individuals and departments involved and provided additional education with the purpose of avoiding recurrence.
  - c. **Manufacturer Credits for replacement Medical Devices not reported or obtained. (2 of 91 claims).**  
The process for assuring medical device credits are properly reflected on Medicare claims is complex. The Hospital has strengthened their controls by identifying and assigning proper communication / coordination between various departments to assure credits are accurately reflected and coded on claims.
  - d. **Incorrect Billing of Drugs not administrated to Beneficiaries. (2 of 91 claims).**  
Human error caused the incorrect billing. We have reviewed those errors with the individuals and departments involved and provided additional education with the purpose of avoiding recurrence.

Community Regional Medical Center takes its compliance obligations very seriously. With respect to all the claims subject to audit, the Hospital reviewed its relevant internal processes and controls and where necessary, made adjustments to enhance its compliance efforts and processes. We would like to thank the OIG auditors who conducted the review of Community Regional Medical Center Medicare Claims for their professionalism, time, collaboration,

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communication, cooperation, and collegiality. Please feel free to call me if you have any questions about the Hospital's efforts in this regard or if you require additional information. We look forward to your response.

Sincerely,



Debra A. Muscio, MBA, CHC, CCE, CFE  
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