

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
GOOD SAMARITAN HOSPITAL FOR
CALENDAR YEARS 2010 AND 2011**

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Lori A. Ahlstrand
Regional Inspector General
for Audit Services

July 2014
A-09-13-02008

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Good Samaritan Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$904,000 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) 2012, Medicare paid hospitals \$148 billion, which represented 43 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 Good Samaritan Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

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

The Hospital is an acute-care hospital located in Los Angeles, California. Medicare paid the Hospital approximately \$174 million for 9,847 inpatient and 46,996 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011.

Our audit covered \$2,438,725 in Medicare payments to the Hospital for 132 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 110 inpatient and 22 outpatient claims and had dates of service in CY 2010 or CY 2011.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 48 of the 132 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 84 claims, resulting in overpayments of \$904,164. Specifically, 65 inpatient claims had billing errors, resulting in overpayments of \$874,360, and 19 outpatient claims had billing errors, resulting in overpayments of \$29,804. 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 \$904,164, consisting of \$874,360 in overpayments for the incorrectly billed inpatient claims and \$29,804 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital agreed with all of our findings except for one finding related to inpatient claims that should have been billed as outpatient or outpatient with observation services. The Hospital's comments indicated that it had refunded \$566,172 of the \$904,164 in overpayments. However, for 20 of the 48 inpatient claims, the Hospital disagreed that the inpatient status was not supported by adequate documentation and did not agree to refund the overpayments. The Hospital stated that it obtained the services of outside, independent medical review experts, who evaluated each claim and provided detailed explanations of the patient factors that supported the inpatient status. For our other findings, the Hospital provided information on corrective actions that it had taken.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether the 20 inpatient claims met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims in compliance with Medicare requirements. On the basis of the contractor's conclusions, we determined that the Hospital should have billed the inpatient claims as outpatient or outpatient with observation services.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
The Medicare Program	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System	1
Hospital Claims at Risk for Incorrect Billing	2
Medicare Requirements for Hospital Claims and Payments	2
Good Samaritan Hospital	3
How We Conducted This Review	3
FINDINGS	3
Billing Errors Associated With Inpatient Claims	4
Incorrect Billing of Medicare Part A for Beneficiary Stays That Should Have Been Billed as Outpatient or Outpatient With Observation Services	4
Incorrect Diagnosis-Related Groups	4
Manufacturer Credits for Replaced Medical Devices Not Reported	4
Billing Errors Associated With Outpatient Claims	5
Incorrect Billing of Number of Units	5
Incorrect Billing of Intensity-Modulated Radiation Therapy Planning Services	5
RECOMMENDATIONS	6
HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	6
Hospital Comments	6
Office of Inspector General Response	6
APPENDIXES	
A: Audit Scope and Methodology	8
B: Results of Review by Risk Area	10
C: Hospital Comments	11

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) 2012, Medicare paid hospitals \$148 billion, which represented 43 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 Good Samaritan Hospital (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.¹ All

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

services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient claims related to hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient claims paid in excess of charges,
- inpatient claims billed for kyphoplasty services,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient mechanical ventilation,
- inpatient manufacturer credits for replaced medical devices,
- inpatient claims with payments greater than \$150,000,
- outpatient surgeries billed with units greater than one,
- outpatient intensity-modulated radiation therapy (IMRT) planning services, and
- outpatient claims billed with evaluation and management (E&M) services.

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).

Good Samaritan Hospital

The Hospital is an acute-care hospital located in Los Angeles, California. Medicare paid the Hospital approximately \$174 million for 9,847 inpatient and 46,996 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011.²

Our audit covered \$2,438,725 in Medicare payments to the Hospital for 132 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 110 inpatient and 22 outpatient claims and had dates of service in CY 2010 or CY 2011. 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 and subjected 41 inpatient and 3 outpatient claims to focused medical review to determine whether the services were medically necessary and/or met coding requirements. 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.

For the details of our audit scope and methodology, see Appendix A.

FINDINGS

The Hospital complied with Medicare billing requirements for 48 of the 132 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 84 claims, resulting in overpayments of \$904,164. Specifically, 65 inpatient claims had billing errors, resulting in overpayments of \$874,360, and 19 outpatient claims had billing errors, resulting in overpayments of \$29,804. 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.

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

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 65 of 110 selected inpatient claims, which resulted in overpayments of \$874,360.

Incorrect Billing of Medicare Part A for Beneficiary Stays That Should Have Been Billed as Outpatient or Outpatient With Observation 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 110 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 Hospital stated that these errors occurred because “at the time the cases under review were billed, we had not put into place the requirements that the records needed to include specific documentation to support the clinical decisions to admit patients for inpatient care.” As a result of these errors, the Hospital received overpayments of \$664,447.³

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 12 of 110 selected inpatient claims, the Hospital billed Medicare with incorrect DRGs. For these claims, to determine the DRG, the Hospital used a diagnosis code that was incorrect. For example, for one claim, the Hospital billed a DRG for use of a mechanical ventilator for 96 hours or more rather than billing the DRG for use of a mechanical ventilator for fewer than 96 hours. The Hospital stated that human error caused the incorrect diagnosis code to be selected. As a result of these errors, the Hospital received overpayments of \$182,613.

Manufacturer Credits for Replaced Medical Devices Not Reported

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

³ 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 administrative contractor before issuance of our report.

“FD” (which identifies the amount of the credit or cost reduction received by the hospital for the replaced device) (chapter 3, § 100.8).

For 5 of 110 selected inpatient claims, the Hospital received reportable medical device credits from a manufacturer but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required. The Hospital stated that these errors were a result of confusion in the process for rebilling when credits were received for separate components. As a result of these errors, the Hospital received overpayments of \$27,300.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 19 of 22 selected outpatient claims, which resulted in overpayments of \$29,804.

Incorrect Billing of 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 16 of 22 selected outpatient claims, the Hospital submitted claims to Medicare with the incorrect number of units of service for a surgical procedure. For example, for one claim, rather than billing one unit for a procedure performed on the right breast, the Hospital billed five units. The Hospital stated that human error was the cause of the incorrect billing. As a result of these errors, the Hospital received overpayments of \$29,206.

Incorrect Billing of Intensity-Modulated Radiation Therapy Planning Services

The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). The Manual also states that certain services should not be billed when they are performed as part of developing an IMRT plan (chapter 4, § 200.3.2).

For 3 of 22 selected outpatient claims, the Hospital incorrectly billed Medicare for services that were already included in the payment for IMRT planning services billed on the same claim. These services were performed as part of developing an IMRT plan and should not have been billed in addition to the HCPCS code for IMRT planning. The Hospital stated that its understanding was that these services could be separately billed from IMRT planning services if they were provided on a different date. As a result of these errors, the Hospital received overpayments of \$598.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$904,164, consisting of \$874,360 in overpayments for the incorrectly billed inpatient claims and \$29,804 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital agreed with all of our findings except for one finding related to inpatient claims that should have been billed as outpatient or outpatient with observation services. The Hospital's comments indicated that it had refunded \$566,172 of the \$904,164 in overpayments. For 20 of the 48 inpatient claims, with \$308,844 in remaining overpayments, the Hospital disagreed that the inpatient status was not supported by adequate documentation. For our other findings, the Hospital provided information on corrective actions that it had taken. The Hospital's comments are included in their entirety as Appendix C.

HOSPITAL COMMENTS

Regarding our finding on incorrect billing of Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services, the Hospital had the following comments:

- The Hospital stated that it obtained the services of outside, independent medical review experts, who evaluated each claim and provided detailed explanations of the patient factors that supported the inpatient status. The Hospital stated that it had not agreed to refund the overpayments because it believed that the inpatient status for the 20 claims was justified.
- The Hospital stated that although we suggested in our report that it could bill Medicare Part B for the disallowed inpatient stays, these cases are long past the 12-month billing deadline. The Hospital also stated that, as a result, it did not have the option of securing any payment other than the minimal Part B payment for ancillary tests because the billing for the procedure itself is disallowed.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether the 20 inpatient claims met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims in compliance with Medicare

requirements. On the basis of the contractor's conclusions, we determined that the Hospital should have billed the inpatient claims as outpatient or outpatient with observation services.

With respect to the Hospital's comment that it did not have the option of securing any payment for the 20 disallowed claims other than the minimal Part B payment for ancillary tests, we acknowledge its comments; however, the rebilling issue is beyond the scope of our audit. During our audit, CMS issued the final regulations on payment policies (78 Fed. Reg. 160 (Aug. 19, 2013)). The Hospital should contact its Medicare contractor for rebilling instructions.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$2,438,725 in Medicare payments to the Hospital for 132 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 110 inpatient and 22 outpatient claims and had dates of service in CY 2010 or CY 2011 (audit period).

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 and subjected 41 inpatient and 3 outpatient claims to focused medical review to determine whether the services were medically necessary and/or met coding requirements.

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 December 2012 to November 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 132 claims (110 inpatient and 22 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;
- used an independent medical review contractor and CMS's Medicare administrative contractor to determine whether 41 selected inpatient and 3 selected outpatient claims, respectively, met medical necessity and/or coding requirements;
- 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 Over-payments	Value of Over-payments
Inpatient				
Short Stays	54	\$858,061	43	\$545,604
Claims Related to Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	28	577,696	5	78,492
Claims Paid in Excess of Charges	2	123,163	1	74,523
Claims Billed for Kyphoplasty Services	4	69,660	4	56,808
Claims Billed With High-Severity-Level DRG Codes	13	185,137	6	54,555
Mechanical Ventilation	3	131,542	1	37,078
Manufacturer Credits for Replaced Medical Devices	5	216,454	5	27,300
Claims With Payments Greater Than \$150,000	1	205,691	0	0
Inpatient Totals	110	\$2,367,404	65	\$874,360
Outpatient				
Surgeries Billed With Units Greater Than One	16	\$64,365	16	\$29,206
Intensity-Modulated Radiation Therapy Planning Services	3	5,394	3	598
Claims Billed With Evaluation and Management Services	3	1,562	0	0
Outpatient Totals	22	\$71,321	19	\$29,804
Inpatient and Outpatient Totals	132	\$2,438,725	84	\$904,164

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.

APPENDIX C: HOSPITAL COMMENTS



April 21, 2014

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 -7th Street, Suite 3-650
San Francisco CA 94103

Re: Report No. A-09-13-02008

Dear Ms Ahlstrand:

Thank you for providing Good Samaritan Hospital the draft *Medicare Compliance Review of Good Samaritan Hospital for Calendar Years 2010 and 2011*, and allowing us to comment on the report.

We understand that Good Samaritan Hospital was selected for a hospital compliance review and that all its Medicare claims for the calendar years 2010 and 2011, totaling \$174 million for 9,847 inpatient claims and 46,996 outpatient claims, were analyzed using computer matching, data mining and data analysis for the purpose of identifying those claims judged to be at risk for non-compliance with Medicare billing requirements. From those claims, we understand 132 claims were “judgmentally selected as potentially at risk for billing errors,” including 110 inpatient and 22 outpatient claims.

Good Samaritan was presented with a list of those claims, and during the process of the audit, had the chance to go over the issues spotted by the Office of Inspector General (“OIG”) auditors. We appreciated the OIG audit team members’ professional review and discussions regarding the billing issues.

Through this process, we agreed with the OIG auditors that 48 of the 132 claims did not have any billing errors. We also agreed that 19 of the 22 outpatient claims had billing errors resulting in an overpayment in the amount of \$29,804. We wish respectfully to point out that while we strive for an error free billing process, we do believe that 19 errors out of 46, 996 outpatient claims is a low error rate of just under 0.04%. We will review the specifics below, but in short: 16 of the 19 errors accounting for \$29, 206 of the outpatient total occurred when outpatient units were mistakenly billed as multiple units rather than 1 unit and we have built in a technical correction that will prevent that error in the future; the remaining 3 errors were in billing certain evaluation services separately from ongoing radiation treatment planning, which resulted in an over-payment in the amount of \$598, an error that will not recur now that we understand the limits on separately billing certain evaluation services from the IMRT planning.

The more serious issues arose in 65 inpatient claims in which the OIG alleged billing errors. There were 54, or most of the questioned inpatient claims, arose from the admission of cardiology patients who had cardiology interventions and were admitted for short stay pursuant to the order of their attending physician. We understand the OIG did not raise any question whatsoever about the necessity of the cardiac procedure nor the quality of care received by these patients, but instead questioned the short stay on the grounds that the patient should not have been admitted to inpatient status but rather should have been admitted to outpatient status.

Good Samaritan Hospital has an extremely well regarded cardiology program, which provides services not only for the immediate community, but for a far larger area because patients are referred due to the excellence of the services and the program's reputation. As a tertiary referral service, the Hospital treats a disproportionate number of complicated patients because their cardiologists have determined the high risk patients with co-morbidities cannot be safely treated in the local community setting. The Hospital also had a large number of one day inpatient stays due to the high volume of complex cardiology interventional procedures performed at the Hospital.

We believe that confusion continues to exist about when inpatient status is warranted versus outpatient (whether in recovery or in observation), as evidenced by the Centers for Medicare and Medicaid (CMS) issuance of the "Two Midnight" rule. The new rule seeks to resolve the inpatient-outpatient status confusion by adopting a new presumption for inpatient status for those patients expected to stay two midnights or more. However, even that new rule does not presume that a one day length of stay can never qualify for inpatient status. CMS has also tried to help address the confusion in the industry by adopting standards for what documentation is required to support the inpatient status.

As hospitals like Good Samaritan have been seeking to assure full compliance with the Medicare law on what constitutes a medically necessary inpatient admission, there has been an evolution in the expectations for when an inpatient admission will be accepted under the Medicare standards and what documentation is required in the chart to support the inpatient billing.

With respect to the rest of the inpatient errors, in short 12 of the 65 inpatient errors occurred due to using the wrong diagnosis related group code and we have instituted a new supervisory audit and review for the coding process to strive to eliminate DRG coding errors; and 3 of the 65 inpatient errors occurred due to the failure to correctly report manufacturer's credits on components of implanted devices and we have corrected our billing procedures to report such credits when they exceed 50% of the cost of a component even when they do not exceed 50% of the cost of the total implant.

None of the errors are attributable to any wrongful intent. Many of the errors resulted from human error (the entry of the wrong DRG in 12 cases or the entry of multiple outpatient units in 16 outpatient cases), which Good Samaritan will strive to prevent and eliminate; several errors resulted from honest misunderstandings about the billing rules (i.e., the 5 cases in which manufacturer credits for sub-parts of the replaced devices were not reported and 3 cases in which evaluation services were improperly billed separately from the radiation oncology planning process). And as mentioned above, most of the errors and the majority of the alleged overpayments can be attributed to the debate on what constitutes the documented indications to support an inpatient admission when the patient stays just a short time.

In the following section, we offer our specific responses to the five categories of billing errors identified during the audit.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Billing for Inpatient Medicare Part A Rather than Outpatient (With or Without Observation)

In 48 cases, the OIG audit team concluded that the patient should not have been admitted to the inpatient unit, but rather should have been admitted to outpatient status. We carefully reviewed each case. In 28 of the cases, we agreed with the assessment that the chart did not include adequate documentation to support the inpatient status. However, in 20 of the cases, we disagreed.

Before disagreeing, we obtained the services of outside, independent medical review experts who were asked to evaluate each chart and determine whether inpatient status was supported. We then provided the results of the review to the OIG audit team, including the detailed explanations from the outside, independent medical review experts of the factors about the particular patient that supported the inpatient status. The OIG has disagreed still, and at this point, we have not agreed to refund the alleged overpayments because we believe the inpatient status was justified.

We also should point out that in a footnote, the OIG has suggested that the Hospital could still bill Medicare Part B for the disallowed inpatient stays. However, these cases are from 2010 and 2011 and we are long past the twelve month billing deadline that allows the Hospital to obtain payment for the sophisticated cardiology interventional procedures these patients had. Thus, under the current rules, we do not have the option of securing any payment other than the minimal Part B payment for ancillary tests (mostly lab tests) as the billing for the procedure itself is disallowed. The financial impact is particularly unfair in these cases since there is no question whatsoever that the patient had a medically indicated procedure and received high quality care that in many cases was life-saving.

In the 28 of cases in which there was agreement inpatient status was not supported by the documentation in the chart, the Hospital has refunded \$326,454.92 in overpayments. It also instituted a careful training program for the cardiologists and other admitting physicians, to assure that the doctors understand the expectations for when inpatient admission will be allowed and reimbursed under the Medicare program. Hospital staff work with the doctors on assuring the charts include the documentation of the physician's findings and expectation regarding the patient's need for inpatient care. If the patient does not qualify for inpatient status, there is a review of whether outpatient observation is warranted or if the patient should just remain in outpatient. And the staff and doctors are receiving new training based upon the newly enacted CMS "Two Midnight" rule.

Incorrect Diagnosis Related Groups

In 12 cases, the Hospital had entered incorrect DRG payments, and it has refunded the overpayment in the amount of \$182,613. In all cases, human error caused the coding mistake. For example, in the case of the miscoding for the ventilator patient, the mechanical ventilator was not used for 96, but rather 92 hours because the patient died. In other cases, the coding staff simply missed information in the chart. We have instituted a supervisory audit for the coding staff to assure that the coding is correct.

Manufacturer Credits for Replaced Medical Devices

In 5 cases, manufacturer credits for replaced devices or device components were not appropriately reported. We learned that the credit needed to be applied to each component and not to the total cost of the device and all components. In the past, we had not rebilled when the credit did not reach over 50% of the total cost of all components. As a result of this misunderstanding, rebilling was not completed as required when credits were received for separate components. The Hospital has corrected its billing for credits to address each component separately and has refunded the overbilled amount of \$27,300.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Incorrect Number of Units

In 16 cases, the Hospital billed outpatient services with multiple units rather than one unit. This was a result of human error. The Hospital adjusted its billing program so it prevents billing more than one unit for the outpatient services and has refunded the \$29,206 in overpayments that resulted from this error.

Incorrect Billing of Intensity-Modulated Radiation Therapy Planning Services

In 3 cases the Hospital billed for imaging services provided on a different day than the date for the completion of the Intensity-Modulated Radiation Therapy (IMRT) plan. This resulted from a misunderstanding about when services can be separately billed from the IMRT planning code, based upon the guidance that has been provided that certain services can be billed separately from the planning. We understand the position that the imaging would be used in the planning and that only such imaging completed after the plan was completed would qualify for the separate planning. This error resulted from a misunderstanding of this rule, which has now been corrected. The Hospital has refunded the \$598 in overpayment for this error.

Again, we wish to emphasize our commitment to fully complying with all the Medicare laws and regulations. We learned from this review and promptly addressed any problems that we identified. And while we disagree with the OIG auditors on the propriety of certain of the cases they concluded should not be inpatient, we did institute a far more careful evaluation of the need for inpatient admission and the documentation to support the order. We believe the short stay issues has prompted a healthy debate about what Medicare should cover and what expectations are reasonable for retrospective denial of payment for services, and we appreciate the efforts of CMS to bring clarity to that issue with the Two Midnight rule.

We wish to thank your auditors for their courtesy and cooperation through this process.

Sincerely,



Andrew B. Leeka
President and Chief Executive Officer