

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF THE QUEEN'S
MEDICAL CENTER FOR THE
PERIOD JANUARY 1, 2010,
THROUGH SEPTEMBER 30, 2012**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Lori A. Ahlstrand
Regional Inspector General
for Audit Services**

October 2014
A-09-14-02014

Office of Inspector General

<http://oig.hhs.gov>

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EXECUTIVE SUMMARY

The Queen's Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of approximately \$319,000 over nearly 3 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 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 the Queen's 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 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 Honolulu, Hawaii. Medicare paid the Hospital approximately \$276 million for 23,855 inpatient and 126,165 outpatient claims for services provided to beneficiaries from January 1, 2010, through September 30, 2012.

Our audit covered \$3,437,014 in Medicare payments to the Hospital for 223 claims that we judgmentally selected as potentially at risk for billing errors. These 223 claims had dates of service from January 1, 2010, through September 30, 2012 (audit period), and consisted of 185 inpatient and 38 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 174 of the 223 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 49 claims, resulting in net overpayments of \$318,587 for the audit period. Specifically, 33 inpatient claims had billing errors, resulting in net overpayments of \$280,566, and 16 outpatient claims had billing errors, resulting in overpayments of \$38,021. 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 \$318,587, consisting of \$280,566 in net overpayments for the incorrectly billed inpatient claims and \$38,021 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 concurred with all of our findings except for our finding on inpatient claims that should have been billed as outpatient or outpatient with observation services. For 2 of the 185 inpatient claims, the Hospital disagreed that these claims should have been submitted as outpatient. However, the Hospital stated that it would refund the entire overpayment related to this finding. For our other findings, the Hospital stated that it would refund the overpayments and provided information on corrective actions that it had taken or planned to take, including strengthening internal controls.

After reviewing the Hospital's comments, we maintain that our finding on inpatient claims that should have been billed as outpatient or outpatient with observation services is valid. We used an independent medical review contractor to determine whether the two inpatient claims met medical necessity requirements. On the basis of the contractor's conclusions, we determined that the Hospital incorrectly billed Medicare Part A for these claims.

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
The Queen’s Medical Center	3
How We Conducted This Review.....	3
FINDINGS	3
Billing Errors Associated With Inpatient Claims	3
Incorrect Diagnosis-Related Groups.....	4
Incorrect Billing of Medicare Part A for Beneficiary Stays That Should Have Been Billed as Outpatient or Outpatient With Observation Services	4
Manufacturer Credits for Replaced Medical Devices Not Reported.....	4
Billing Errors Associated With Outpatient Claims.....	5
Manufacturer Credits for Replaced Medical Devices Not Reported	5
Incorrect Billing of Number of Units.....	5
RECOMMENDATIONS	6
HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	6
APPENDIXES	
A: Audit Scope and Methodology	7
B: Results of Review by Risk Area	9
C: Hospital Comments.....	10

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 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 the Queen's 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 at other hospitals identified these types of claims at risk for noncompliance:

- inpatient short stays,
- inpatient claims paid in excess of charges,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims billed for kyphoplasty services,
- outpatient surgeries billed with units greater than one,
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day), and
- outpatient claims billed with evaluation and management 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).

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

The Queen's Medical Center

The Hospital is an acute-care hospital located in Honolulu, Hawaii. Medicare paid the Hospital approximately \$276 million for 23,855 inpatient and 126,165 outpatient claims for services provided to beneficiaries from January 1, 2010, through September 30, 2012.²

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$3,437,014 in Medicare payments to the Hospital for 223 claims that we judgmentally selected as potentially at risk for billing errors. These 223 claims had dates of service from January 1, 2010, through September 30, 2012 (audit period), and consisted of 185 inpatient and 38 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 and subjected three inpatient claims to focused 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.

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

FINDINGS

The Hospital complied with Medicare billing requirements for 174 of the 223 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 49 claims, resulting in net overpayments of \$318,587 for the audit period. Specifically, 33 inpatient claims had billing errors, resulting in net overpayments of \$280,566, and 16 outpatient claims had billing errors, resulting in overpayments of \$38,021. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 33 of 185 selected inpatient claims, which resulted in net overpayments of \$280,566.

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

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 22 of 185 selected claims, the Hospital billed Medicare with incorrect DRGs. For these claims, to determine the DRG, the Hospital used a diagnosis code that was incorrect or unsupported by the medical record. The Hospital stated that these errors occurred because of human error. As a result of these errors, the Hospital received net overpayments of \$166,290. The Hospital was overpaid \$176,525 (20 claims) and underpaid \$10,235 (2 claims).

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 9 of 185 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 stated that these errors occurred because of human error. As a result of these errors, the Hospital received overpayments of \$104,486.³

Manufacturer Credits for Replaced Medical Devices Not Reported

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 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).

For 2 of 185 selected 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 the payments as required. The Hospital stated that these errors occurred because of human error. As a result of these errors, the Hospital received overpayments of \$9,790.

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 contractor before issuance of our report.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 16 of 38 selected outpatient claims, which resulted in overpayments of \$38,021.

Manufacturer Credits for Replaced Medical Devices Not Reported

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)).

CMS guidance explains how a provider should report no-cost and reduced-cost devices under the OPPS.⁴ 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.

For 2 of 38 selected claims, the Hospital received full credits for replaced devices but did not report the -FB modifier and reduced charges on the claims. The Hospital stated that these errors occurred because of human error. As a result of these errors, the Hospital received overpayments of \$26,184.

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). The Manual also states: “It is ... of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug ... that was used in the care of the patient” (chapter 17, § 90.2.A). If the provider is billing for a drug, according to the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 ...” (chapter 17, § 70). 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 14 of 38 selected claims, the Hospital billed Medicare with an incorrect number of units of service for surgical procedures. The Hospital stated that these errors occurred because of human error. As a result of these errors, the Hospital received overpayments of \$11,837.

⁴ CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$318,587, consisting of \$280,566 in net overpayments for the incorrectly billed inpatient claims and \$38,021 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 concurred with all of our findings except for our finding on inpatient claims that should have been billed as outpatient or outpatient with observation services. For 2 of the 185 inpatient claims, the Hospital disagreed that these claims should have been submitted as outpatient. However, the Hospital stated that it would refund the entire overpayment related to this finding. For our other findings, the Hospital stated that it would refund the overpayments and provided information on corrective actions that it had taken or planned to take, including strengthening internal controls. The Hospital's comments are included in their entirety as Appendix C.

After reviewing the Hospital's comments, we maintain that our finding on inpatient claims that should have been billed as outpatient or outpatient with observation services is valid. We used an independent medical review contractor to determine whether the two inpatient claims met medical necessity requirements. On the basis of the contractor's conclusions, we determined that the Hospital incorrectly billed Medicare Part A for these claims.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$3,437,014 in Medicare payments to the Hospital for 223 claims that we judgmentally selected as potentially at risk for billing errors. These 223 claims had dates of service from January 1, 2010, through September 30, 2012, and consisted of 185 inpatient and 38 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 and subjected three inpatient claims to focused 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 June 2013 to April 2014.

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;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 223 claims (185 inpatient and 38 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 to determine whether 3 selected inpatient claims met medical necessity 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 Billing Errors	Value of Overpayments
Inpatient				
Short Stays	165	\$2,370,864	27	\$192,653
Claims Paid in Excess of Charges	15	605,074	3	71,447
Manufacturer Credits for Replaced Medical Devices	4	130,889	2	9,790
Claims Billed for Kyphoplasty Services	1	10,383	1	6,676
Inpatient Totals	185	\$3,117,210	33	\$280,566
Outpatient				
Manufacturer Credits for Replaced Medical Devices	9	\$215,989	2	\$26,184
Surgeries Billed With Units Greater Than One	18	42,017	13	10,667
Claims Billed With Modifier -59	8	57,703	1	1,170
Claims Billed With Evaluation and Management Services	3	4,095	0	0
Outpatient Totals	38	\$319,804	16	\$38,021
Inpatient and Outpatient Totals	223	\$3,437,014	49	\$318,587

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



THE QUEEN'S MEDICAL CENTER

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August 29, 2014

Ms. 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 Number A-09-14-0214

Dear Ms. Ahlstrand:

Thank you for the opportunity to review the draft Medicare Compliance Review of the Queen's Medical Center ("QMC") for the Period January 1, 2010 through September 30, 2012 prepared by the Office of Inspector General ("OIG").

Our responses to the findings referenced in the OIG draft report are detailed below. Overall, we are in agreement with the majority of information contained in this report; however, there are a few exceptions as noted.

Corrective actions have been developed to address specific findings, including strengthening internal controls, providing additional education, work flow process improvement and focused auditing and monitoring.

REPORT FINDINGS

The Hospital complied with Medicare billing requirements for 174 of the 223 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 49 claims, resulting in net overpayments of \$318,587 for the audit period. Specifically, 33 inpatient claims had billing errors, resulting in net overpayments of \$280,566, and 16 outpatient claims had billing errors, resulting in overpayments of \$38,021. 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.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 33 of 185 selected inpatient claims, which resulted in net overpayments of \$280,566.

1

Founded in 1859 by Queen Emma and King Kamehameha IV
The Queen's Medical Center is a 501(c)(3) nonprofit corporation

Incorrect Diagnosis-Related Groups

For 22 of 185 selected claims, the Hospital billed Medicare with incorrect DRGs. For these claims, to determine the DRG, the Hospital used a diagnosis code that was incorrect or unsupported by the medical record. The Hospital stated that these errors occurred because of human error. As a result of these errors, the Hospital received net overpayments of \$166,290. The Hospital was overpaid \$176,525 (20 claims) and underpaid \$10,235 (2 claims).

Response:

We concur with the OIG's findings that for 22 of the 185 selected inpatient claims, QMC billed Medicare incorrect DRG codes. The results of this review will be discussed with coding staff and re-education provided upon conclusion of the audit. Currently, QMC engages an external auditor to conduct quarterly inpatient (DRG) and outpatient coding audits. QMC provides coding education after each audit and on an ongoing basis provides coding education to all coding staff. QMC will continue to monitor the risk areas identified in this audit through their audit program.

As recommended, the Hospital will refund \$166,290 in net overpayments.

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

For 9 of 185 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 stated that these errors occurred because of human error. As a result of these errors, the Hospital received overpayments of \$104,486.

Response:

We concur with the OIG's findings that for 7 of the 185 selected inpatient claims, QMC billed Medicare incorrectly as inpatients.

For 2 of the 185 claims, QMC also billed Medicare as inpatients, but for the following reasons disagrees with the OIG's findings that these claims should have been submitted as outpatients.

The first of the 2 claims was billed as inpatient due to comorbidities, the extent of the procedure and the risks of post-operative complications. The second of the 2 claims was for an appendectomy that was also billed as inpatient because the circumstances of the case at the time, met admission criteria for emergent abdominal pain requiring surgery. In 2012 however, a change was implemented to review admission criteria for appendectomies after completion of the surgery.

As recommended, the Hospital will refund \$104,486 in overpayments.

Manufacturer Credits for Replaced Medical Devices Not Reported

For 2 of 185 selected 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 the payments as required. The Hospital stated that these errors occurred because of human error. As a result of these errors, the Hospital received overpayments of \$9,790.

Response:

We concur with the OIG's findings that for 2 of the 185 selected inpatient claims, QMC billed Medicare incorrectly by not reporting credit amounts, correct value codes and condition codes for manufacturer device credits reported by the vendor. QMC received a warranty credit for only 1 of the 2 selected inpatient claims. In order to strengthen internal controls, QMC will be modifying existing workflow processes to ensure device credits received are properly handled and accounted for. QMC will continue to monitor and review Medicare billing related to this regulation.

As recommended, the Hospital will refund \$9,790 in overpayments.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 16 of 38 selected outpatient claims, which resulted in overpayments of \$38,021.

Manufacturer Credits for Replaced Medical Devices Not Reported

For 2 of 38 selected claims, the Hospital received full credits for replaced devices but did not report the -FB modifier and reduced charges on the claims. The Hospital stated that these errors occurred because of human error. As a result of these errors, the Hospital received overpayments of \$26,184.

Response:

We concur with the OIG's findings that for 2 of the 38 selected outpatient claims, QMC billed Medicare incorrectly by not reporting credit amounts, modifiers and reduced charges for manufacturer device credits reported by the vendor. QMC received a warranty credit for only 1 of the 2 selected outpatient claims. In order to strengthen internal controls, QMC will be modifying existing workflow processes to ensure device credits received are properly handled and accounted for. QMC will continue to monitor and review Medicare billing related to this regulation.

As recommended, the Hospital will refund \$26,184 in overpayments.

Incorrect Billing of Number of Units

For 14 of 38 selected claims, the Hospital billed Medicare with an incorrect number of units of service for surgical procedures. The Hospital stated that these errors occurred because of human error. As a result of these errors, the Hospital received overpayments of \$11,837.

Response:

We concur with the OIG's findings that for 14 of the 38 selected outpatient claims, QMC billed Medicare the incorrect number of units of service. In May 2011, QMC implemented a Medicare claim edit that captures units of service greater than 1 for Revenue Code 360 categories. These units of service that are greater than 1 are manually reviewed and validated prior to finalizing the claim.

As recommended, the Hospital will refund \$11,837 in overpayments.

We appreciate the support, cooperation and professionalism extended by the OIG audit staff throughout the review process. Please feel free to contact me if you have any questions regarding this response.

Sincerely,

Renee Shimabukuro

Renee Shimabukuro, MSA, RHIA, CHC, CHPC, CHRC
Corporate Compliance Administrator and Privacy Officer

cc: Arthur A. Ushijima, QHS, President/CEO QMC, President
Mark H. Yamakawa, QHS and QMC, Executive VP & COO
John S. Nitao, Esq., QHS, General Counsel