Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# MEDICARE COMPLIANCE REVIEW OF SIERRA VIEW MEDICAL CENTER FOR 2012 AND 2013

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## EXECUTIVE SUMMARY

***Sierra View Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately $798,000 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 Sierra View Medical Center (the Medical Center) 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 Medical Center is a 167-bed acute-care facility located in Porterville, California. Medicare paid the Medical Center approximately $65 million for 4,439 inpatient and 46,901 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013.

Our audit covered $850,226 in Medicare payments to the Medical Center for 30 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 28 inpatient and 2 outpatient claims and had dates of service in CY 2012 or CY 2013.

## WHAT WE FOUND

The Medical Center complied with Medicare billing requirements for 5 of the 30 inpatient and outpatient claims we reviewed. However, the Medical Center did not fully comply with Medicare billing requirements for the remaining 25 claims, resulting in overpayments of $798,064 for CYs 2012 and 2013. Specifically, 23 inpatient claims had billing errors, resulting in overpayments of $228,969, and 2 outpatient claims had billing errors, resulting in overpayments of $569,095. These errors occurred primarily because the Medical Center 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 Medical Center:

- refund to the Medicare program $798,064, consisting of $228,969 in overpayments for the incorrectly billed inpatient claims and $569,095 in overpayments for the incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

## MEDICAL CENTER COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Medical Center agreed with our findings for five claims (three inpatient and two outpatient claims) and described actions that it had taken to address those findings. However, the Medical Center disagreed with our findings for 20 claims that we identified as incorrectly billed as inpatient and provided an explanation of its position for each claim. The Medical Center stated that because of the beneficiaries' medical histories, many of the beneficiaries needed continuous monitoring, and it would not have been reasonable to monitor patients in a less intensive setting, such as observation. In addition, the Medical Center stated that our independent medical reviewer relied on a retrospective analysis of the clinical data and that CMS instructed contractors to review the reasonableness of each inpatient admission decision on the basis of information known to the physician at the time of admission. The Medical Center did not explicitly address our recommendations.

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

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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 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 Sierra View Medical Center (the Medical Center) 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 and
- outpatient claims for injectable drugs.

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 to 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).

## Sierra View Medical Center

The Medical Center is a 167-bed acute-care facility located in Porterville, California. Medicare paid the Medical Center approximately $65 million for 4,439 inpatient and 46,901 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013.[2]

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

## HOW WE CONDUCTED THIS REVIEW

Our audit covered $850,226 in Medicare payments to the Medical Center for 30 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 28 inpatient and 2 outpatient claims and had dates of service in CY 2012 or CY 2013.[3] 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 all 30 claims to focused medical review to determine whether the services were medically necessary and met coding requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Medical Center 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 audit scope and methodology.

## FINDINGS

The Medical Center complied with Medicare billing requirements for 5 of the 30 inpatient and outpatient claims we reviewed. However, the Medical Center did not fully comply with Medicare billing requirements for the remaining 25 claims, resulting in overpayments of $798,064 for CYs 2012 and 2013. Specifically, 23 inpatient claims had billing errors, resulting in overpayments of $228,969, and 2 outpatient claims had billing errors, resulting in overpayments of $569,095. These errors occurred primarily because the Medical Center 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 Medical Center incorrectly billed Medicare for 23 of 28 selected inpatient claims, which resulted in overpayments of $228,969.

### Incorrectly Billed as Inpatient

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 22 of 28 selected inpatient claims, the Medical Center incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. For 2 of the 28 claims, the Medical Center stated that the errors were the result of a physician not

[3] The 28 inpatient claims had dates of service in CY 2012 or in CY 2013 before October 1, 2013.

documenting the intended observation status until 3 days after discharge and the result of a clerical error. For the remaining 20 claims, the Medical Center did not offer a cause for the errors and stated that it believed these claims were billed appropriately. As a result of the 22 errors, the Medical Center received overpayments of $225,785.[4]

### Incorrect Diagnosis-Related Group

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 1 of 28 selected inpatient claims, the Medical Center billed Medicare with the incorrect DRG. For this claim, to determine the DRG, the Medical Center used a diagnosis code that was incorrect or unsupported by the medical record. The Medical Center stated that the coder did not follow the Medical Center's coding guidelines related to the selection of the principal diagnosis code. As a result of this error, the Medical Center received an overpayment of $3,184.

## BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Medical Center incorrectly billed Medicare for both of the two selected outpatient claims, which resulted in overpayments of $569,095.

### Incorrect Healthcare Common Procedure Coding System Code

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 two of two selected outpatient claims, the Medical Center submitted claims to Medicare with the incorrect HCPCS code. Specifically, the Medical Center billed J0178 (aflibercept, a drug used in the treatment of wet macular degeneration) when it should have billed C9296 (ziv-aflibercept, a drug used in the treatment of metastatic colorectal cancer). The Medical Center stated that these errors occurred because its system was configured to select the incorrect HCPCS code. As a result of these errors, the Medical Center received overpayments of $569,095.

[4] The Medical Center 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.

## RECOMMENDATIONS

We recommend that the Medical Center:

- refund to the Medicare program $798,064, consisting of $228,969 in overpayments for the incorrectly billed inpatient claims and $569,095 in overpayments for the incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

## MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

### MEDICAL CENTER COMMENTS

In written comments on our draft report, the Medical Center agreed with our findings for five claims (three inpatient and two outpatient claims) and described actions that it had taken to address those findings. However, the Medical Center disagreed with our findings for 20 claims that we identified as incorrectly billed as inpatient. The Medical Center did not explicitly address our recommendations.

In its comments, the Medical Center addressed each of the 20 inpatient claims and included the reasons for its disagreement with our findings. The following summarizes the Medical Center's position:

- Because of their medical histories, many beneficiaries needed continuous monitoring, and it would not have been reasonable to monitor patients in a less intensive setting, such as observation. The Medical Center stated that observation is not appropriate for continuous monitoring.

- OIG's independent reviewer relied on a retrospective analysis of the clinical data.

- CMS instructed contractors to review the reasonableness of each inpatient admission decision on the basis of information known to the physician at the time of admission.

The Medical Center's comments are included in their entirety as Appendix C.

### OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Medical Center's comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether claims met medical necessity requirements. The contractor examined all the medical records and documentation submitted and carefully considered this information to determine whether the Medical Center billed the inpatient claims according to Medicare requirements. Each claim that was found to be improperly billed was reviewed by two clinicians (one of whom was a physician), who confirmed our finding. On the basis of the contractor's conclusions, we

determined that the Medical Center should have billed the inpatient claims as outpatient or outpatient with observation services.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered $850,226 in Medicare payments to the Medical Center for 30 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 28 inpatient and 2 outpatient claims and had dates of service in CY 2012 or CY 2013.[5]

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 all 30 claims to focused medical review to determine whether the services were medically necessary and met coding requirements.

We limited our review of the Medical Center'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 Medical Center for Medicare reimbursement.

We conducted our audit from October 2014 to June 2015. Our fieldwork included contacting the Medical Center in Porterville, California.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Medical Center's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2012 and 2013;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 30 claims (28 inpatient and 2 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;

[5] The 28 inpatient claims had dates of service in CY 2012 or in CY 2013 before October 1, 2013.

- requested that the Medical Center 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 Medical Center to support the selected claims;

- reviewed the Medical Center's procedures for assigning HCPCS codes and submitting Medicare claims;

- used an independent medical review contractor to determine whether 28 selected inpatient claims met medical necessity and coding requirements and 2 selected outpatient claims met coding requirements;

- discussed the incorrectly billed claims with Medical Center 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 Medical Center 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 Overpayments |
|---|---|---|---|---|
| **Inpatient** | | | | |
| Short Stays | 28 | $274,924 | 23 | $228,969 |
| **Inpatient Totals** | **28** | **$274,924** | **23** | **$228,969** |
| | | | | |
| **Outpatient** | | | | |
| Claims for Injectable Drugs | 2 | $575,302 | 2 | $569,095 |
| **Outpatient Totals** | **2** | **$575,302** | **2** | **$569,095** |
| | | | | |
| **Inpatient and Outpatient Totals** | **30** | **$850,226** | **25** | **$798,064** |

**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 Medical Center. 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.