DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

March 13, 2012

TO: Peter Budetti
Deputy Administrator and Director
Center for Program Integrity
Centers for Medicare & Medicaid Services

Deborah Taylor
Director and Chief Financial Officer
Office of Financial Management
Centers for Medicare & Medicaid Services

FROM: /Brian P. Ritchie/
Assistant Inspector General for the
Centers for Medicare & Medicaid Audits

SUBJECT: Medicare Compliance Review of Brigham and Women's Hospital for Calendar Years 2009 and 2010 (A-01-11-00521)

Attached, for your information, is an advance copy of our final report on our most recent hospital compliance review. We will issue this report to Brigham and Women's Hospital within 5 business days.

This report is part of a series of the Office of Inspector General's hospital compliance initiative, designed to review multiple issues concurrently at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov, or your staff may contact Michael J. Armstrong, Regional Inspector General for Audit Services, at (617) 565-2684 or through email at Michael.Armstrong@oig.hhs.gov.

Attachment

cc: Daniel Converse
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION I
JFK FEDERAL BUILDING
15 NEW SUDBURY STREET, ROOM 2425
BOSTON, MA 02203

March 16, 2012

Report Number: A-01-11-00521

Mr. James Bryant
Chief Compliance Officer
Brigham and Women's Hospital
801 Massachusetts Avenue, Suite 610
Boston, MA 02118

Dear Mr. Bryant:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Brigham and Women's Hospital for Calendar Years 2009 and 2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kimberly Rapoza, Audit Manager, at (617) 565-2695 or through email at Kimberly.Rapoza@oig.hhs.gov. Please refer to report number A-01-11-00521 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF BRIGHAM AND WOMEN'S HOSPITAL FOR CALENDAR YEARS 2009 AND 2010

Daniel R. Levinson
Inspector General

March 2012
A-01-11-00521

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Brigham and Women's Hospital (the Hospital) is a 793-bed teaching affiliate of Harvard Medical School located in Boston, Massachusetts. The Hospital was paid approximately $554 million for 30,571 inpatient and 361,343 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered $5,717,325 in Medicare payments to the Hospital for 359 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 293 inpatient and 66 outpatient claims, and 354 of the claims had dates of service in CYs 2009 and 2010. Because of credits that the Hospital received from a medical device manufacturer, five of the claims had dates of service in CY 2008.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 140 of the 359 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, 219 claims had errors, resulting in net overpayments totaling $1,518,895 for CYs 2008 through 2010. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims or did not fully understand the Medicare billing requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $1,518,895, consisting of $1,500,556 in net overpayments for the 193 incorrectly billed inpatient claims and $18,339 in overpayments for the 26 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

BRIGHAM AND WOMEN'S HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations with the exception of five inpatient short stay claims that the Hospital states were paid appropriately as inpatient. The Hospital also stated that it has dedicated substantial resources and staff to prevent, detect, and correct any errors that are identified and is committed to implementing stronger internal controls and monitoring to minimize the risk of errors. We acknowledge the Hospital's efforts to implement stronger controls. However, with respect to the five inpatient hospital short stay claims, we maintain our position that the Hospital billed these claims in error. The Hospital's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.[1]

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays 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, 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) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.[2] The OPPS 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.[3] All services and items within an APC group are comparable clinically and require comparable resources.

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[1] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For the purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

[2] In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

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

Hospital Payments at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis of claims. Examples of the types of claims at risk for noncompliance included the following:

- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient same-day discharges and readmissions,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient claims for blood clotting factor drugs,
- outpatient claims billed with modifier -59,
- outpatient evaluation and management services billed with surgical services,
- outpatient claims billed during inpatient stays,
- outpatient and inpatient manufacturer credits for medical devices, and
- outpatient and inpatient claims paid in excess of charges.

For the purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas."

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and 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." In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment.

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

Brigham and Women's Hospital

Brigham and Women's Hospital (the Hospital) is a 793-bed teaching affiliate of Harvard Medical School located in Boston, Massachusetts. Medicare paid the Hospital approximately $554 million for 30,571 inpatient and 361,343 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

Scope

Our audit covered $5,717,325 in Medicare payments to the Hospital for 359 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 293 inpatient and 66 outpatient claims, and 354 of the claims had dates of service in CYs 2009 and 2010. Because of credits that the Hospital received from a medical device manufacturer, five of the claims had dates of service in CY 2008.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected only a limited number of 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. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the 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 during August and September 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2008, 2009, and 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 359 claims (293 inpatient and 66 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- used CMS's Medicare contractor medical review staff to determine whether a limited selection of sampled 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 objective.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 140 of the 359 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 219 claims, resulting in overpayments totaling $1,518,895 for CYs 2008 through 2010. Specifically, 193 inpatient claims had billing errors that resulted in net overpayments totaling $1,500,556, and 26 outpatient claims had billing errors that resulted in overpayments totaling $18,339. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims and did not fully understand Medicare billing requirements.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 193 of the 293 sampled inpatient claims that we reviewed. These errors resulted in net overpayments totaling $1,500,556.

Inpatient Short Stays

Section 1862(a)(1)(A) of the Act states that 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."

For 126 of the 178 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. The Hospital attributed the errors to an inadequate case management review process and flaws in its admission ordering system. As a result, the Hospital received overpayments totaling $989,559.[4]

Inpatient Manufacturer Credits for Medical Devices

Federal regulations (42 CFR § 412.89) 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 a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

Billing Requirements for Medical Device Credits

The Manual, chapter 3, section 100.8, states that to bill correctly for a replacement device that was provided with a credit, the hospital must use the combination of condition code 49 or 50 along with value code "FD."

[4] The Hospital may bill Medicare Part B for a limited range of services related to some of these 126 incorrect Medicare Part A short stay claims. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the MAC prior to the issuance of our report.

Prudent Buyer Principle

Pursuant to 42 CFR § 413.9, "All payments to providers of services must be based on the reasonable cost of services …." The CMS *Provider Reimbursement Manual*, part I, section 2102.1, states:

> Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

Section 2103 of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example:

> Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.

For 47 of the 53 sampled claims, the Hospital either received full credit for a replaced device but did not report the "FD" modifier or reduced charges on its claim, or the Hospital did not obtain credits for replaced medical devices that were available under the terms of the manufacturers' warranties. The Hospital stated that the 47 medical device errors occurred because there were inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result, the Hospital received overpayments totaling $433,505.

Inpatient Claims Billed With High Severity Level Diagnosis-Related Group Codes

Section 1862(a)(1)(A) of the Act states that 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."

For 11 of the 35 sampled claims, the Hospital billed Medicare with incorrect diagnosis codes that resulted in incorrect DRG codes for 9 of the claims. The Hospital stated that the incorrect diagnosis codes occurred primarily because the Hospital did not have procedures for notifying coders when new or updated documentation became available or due to human error. As a result, the Hospital was underpaid a total of $49,539 (three claims) and received overpayments totaling $48,851 (six claims).

Inpatient Claims Paid in Excess of Charges

Section 1862(a)(1)(A) of the Act states that 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."

For 3 of the 11 sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that the incorrect codes occurred because of human error. As a result, the Hospital received overpayments totaling $67,059.

Inpatient Same-Day Discharges and Readmissions

The Manual, chapter 3, section 40.2.5, states:

> When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay on a single claim.

For three of the five sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that the incorrect billing for same-day discharges and readmissions occurred because the Hospital's predefined system report for targeting review of Medicare inpatient readmissions within 30 days of a prior stay excluded same-day discharges and readmissions from the report criteria. As a result, the Hospital received overpayments totaling $15,957 (two claims) and an underpayment of $4,836 (one claim).

Inpatient Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting

Pursuant to section 1886(d)(4)(D) of the Act and Medicare Learning Network Matters article, No. MM5499, Related Change Request 5499, CMS requires the completion of a present-on-admission indicator for every diagnosis on an inpatient acute care hospital claim. As of October 1, 2008, Medicare no longer assigns an inpatient hospital discharge to a higher paying Medicare Severity DRG if the condition is not present on admission. Instead, Medicare pays the claim as though the secondary diagnosis were not present.

For 3 of the 10 sampled claims, the Hospital billed Medicare for incorrect present-on-admission indicators. The Hospital stated the errors occurred because medical record documentation was not sufficient to determine whether these conditions were present on admission, and the Hospital did not have a coder-physician query process. These errors did not affect payments to the Hospital.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 26 of the 66 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling $18,339.

Outpatient Claims Billed With Modifier -59

The Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately." In addition, chapter 23, section 20.9.1.1, states: "The '-59' modifier is used to indicate a distinct procedural service .... This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)."

For 14 of the 32 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that were insufficiently documented in the medical records (7 errors) or did not meet criteria for the use of modifier -59 (7 errors). The Hospital stated these errors occurred primarily because of human error, including staff misinterpreting the billing requirements for modifier -59. As a result, the Hospital received overpayments totaling $9,637.

Outpatient Evaluation and Management Services Billed With Surgical Services

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

For 7 of the 25 sampled claims, the Hospital incorrectly billed Medicare for outpatient services with incorrectly appended modifiers (4 errors) and for services that were insufficiently documented in the medical record (3 errors). The Hospital stated that these errors occurred because its computer software had limited edits related to evaluation and management codes, procedure codes, and modifiers. As a result, the Hospital received overpayments totaling $201.

Outpatient Claims Billed During Inpatient Stays

The Manual, chapter 3, section 10.4, states that Part A covers certain items and nonphysician services furnished to inpatients and consequently the inpatient prospective payment rate covers these services.

For all three sampled claims, the Hospital incorrectly billed Medicare for outpatient services provided during inpatient stays that should have been included on the Hospital's inpatient bills to Medicare. The Hospital stated that these errors occurred because billing software edits did not identify outpatient services that occurred during inpatient stays. As a result, the Hospital received overpayments totaling $1,087.

Outpatient Manufacturer Credits for Replacement of Medical Devices

Federal regulations (42 CFR § 419.45) 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.

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual explains how a provider should report no-cost and reduced-cost devices under the OPPS. 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.

For one of the five sampled claims, the Hospital received full credit for a replaced device but did not report the "FB" modifier or reduced charges on its claim. The Hospital stated that this error occurred because there were inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result, the Hospital received an overpayment of $5,494.

Outpatient Claims Paid in Excess of Charges

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. Additionally, the Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For one sampled claim, the Hospital submitted the claim to Medicare with an incorrect HCPCS code. The Hospital stated that this overpayment occurred because of human error. As a result, the Hospital received an overpayment of $1,920.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $1,518,895, consisting of $1,500,556 in net overpayments for the 193 incorrectly billed inpatient claims and $18,339 in overpayments for the 26 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

BRIGHAM AND WOMEN'S HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations with the exception of five inpatient short stay claims that the Hospital states were paid appropriately as inpatient. The Hospital also stated that it has dedicated substantial resources and staff to prevent, detect, and correct any errors that are identified and is committed to implementing stronger internal controls and monitoring to minimize the risk of errors. We acknowledge the Hospital's efforts to implement stronger controls. However, with respect to the five inpatient hospital short stay claims, we maintain our position that the Hospital billed these claims in error. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: BRIGHAM AND WOMEN'S HOSPITAL COMMENTS

BRIGHAM AND
WOMEN'S HOSPITAL

BWH/BWPO Billing Compliance Office

February 16, 2012

Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of the Inspector General, Office of Audit Services
John F. Kennedy Federal Building
Boston, MA 02203

RE: Report No. A-01-11-00521 *Medicare Compliance Review of Brigham and Woman's Hospital for Calendar Years 2009 and 2010*

Dear Mr. Armstrong:

On behalf of Brigham and Women's Hospital (BWH), I am providing comments to the report entitled *Medicare Compliance Review of Brigham and Woman's Hospital for Calendar Years 2009 and 2010*. BWH generally agrees with the findings and has begun reprocessing claims to the Medicare administrative contractor, NHIC.

We stress that BWH is strongly committed to compliance. We dedicate substantial resources and staff to preventing, detecting and correcting any errors that are identified. We are committed to implementing even stronger internal controls and monitoring to minimize the risk of errors going forward.

In response to the report's specific recommendations:

Inpatient Short Stays: BWH generally concurs with OIG's findings.[1] The hospital has strengthened controls in this area by creating more specific physician inpatient orders and by providing training. In addition, BWH is assigning case managers with specific responsibility for reviewing Medicare inpatient cases, working with treating physicians on level-of-care determinations and assessing the completeness of documentation supporting admissions using accepted medical management criteria.

Inpatient and Outpatient Manufacturer Credits for Medical Devices: BWH has developed a comprehensive operational procedure to address identified control deficiencies and to identify and track potential no-cost and reduced-cost replacement devices.

Inpatient Claims Billed with High Severity Level DRG Codes, Inpatient Claims Paid in Excess of Charges and *Inpatient HACs and POA Indicators*: Controls have been

[1] For 5 of the 126 inpatient cases, BWH does not concur with the finding that they were inappropriately paid as inpatient cases.

established regarding management oversight and quality assurance of coding, and a pre-billing monitoring system and additional targeted training have been implemented. BWH is implementing a process for coders to query the relevant attending physicians to clarify any ambiguous documentation.

Inpatient Same-Day Discharges and Readmissions: Training has been given to care coordinators on the appropriate criteria for same day readmission cases. Reprogramming was initiated to ensure the reporting of same day readmits.

Outpatient Claims Billed with Modifier -59: BWH implemented a training program for coders targeting use of Modifier 59. BWH is implementing a process for coders to query the relevant attending physicians to clarify any ambiguous documentation.

Outpatient Evaluation and Management (E/M) Services Billed with Surgical Services: BWH concurs with OIG's findings and has implemented a more robust claims scrubber system with specific edits, including relating to Modifier -25, identifying claims for further coding review. BWH has also implemented a training program for coders, clinicians and other staff targeting use of Modifier -25.

Outpatient Claims Billed During Inpatient Stays: All three cases identified in the report were complex and rare patient transfer cases that had multiple visit type changes during their inpatient stay, which resulted in the system erroneously bypassing both BWH and Medicare FISS editing logic. BWH is undertaking further programming to modify hospital system logic to better capture outpatient services provided during an inpatient stay.

Outpatient Claims Paid in Excess of Charges: This claim error occurred due to incorrect data. Because the incorrect numerical digit entry still resulted in a valid HCPCS, the error was not recognized by system edits. A new pre-billing monitoring system has been implemented and is in use at BWH, which requires less manual data entry in such cases. The reduction in manual data entry should help avoid keying errors.

We appreciate the professionalism and guidance of the OIG audit team throughout this process, and thank you for this opportunity to comment upon the OIG's Report.

Sincerely,

/James Bryant/
Chief Compliance Officer
Brigham and Women's Hospital