Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF WING MEMORIAL HOSPITAL FOR CALENDAR YEARS 2009 AND 2010

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

Michael J. Armstrong
Regional Inspector General

October 2012
A-01-11-00536

Office of Inspector General

http://oig.hhs.gov

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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.

Wing Memorial Hospital (the Hospital), a member of the UMass Memorial Health Care system, is a 74-bed hospital located in Palmer, Massachusetts. Medicare paid the Hospital approximately $36.8 million for 4,369 inpatient and 124,288 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered $749,399 in Medicare payments to the Hospital for 172 claims that we judgmentally selected as potentially at risk for billing errors. These 172 claims had dates of service in CYs 2009 and 2010 and consisted of 80 inpatient and 92 outpatient claims.

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 113 of the 172 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 59 claims, resulting in overpayments totaling $89,257 for CYs 2009 through 2010. Specifically, 21 inpatient claims had billing errors, resulting in overpayments totaling $81,644, and 38 outpatient claims had billing errors, resulting in overpayments totaling $7,613. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $89,257, consisting of $81,644 in overpayments for 21 incorrectly billed inpatient claims and $7,613 in overpayments for the 38 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

WING MEMORIAL HOSPITAL COMMENTS

In written comments on our draft report, the Hospital generally concurred with our findings. However, the Hospital stated that it plans to appeal 3 of 21 inpatient claims that we found with billing errors. In addition, the Hospital stated that it has submitted adjustments for the remaining claims billed in error and has taken steps to strengthen its controls to ensure compliance with Medicare regulations. The Hospital's comments are included in their entirety as Appendix B.

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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). This transition occurred 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 fiscal intermediary, carrier, or MAC, whichever is applicable.

[2] In 2009 SCHIP was formally renamed 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 techniques. Examples of these types of claims at risk for noncompliance included the following:

- inpatient short stays,
- inpatient claims paid in excess of charges,
- inpatient transfers,
- inpatient psychiatric facility (IPF) emergency department adjustments,
- inpatient hospital-acquired conditions and present on admission indicator reporting,
- outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed with modifiers,
- outpatient claims billed during a skilled nursing facility (SNF) stay,
- outpatient claims billed with evaluation and management (E&M) services,
- outpatient surgeries with billed units greater than one,
- outpatient claims billed during an inpatient stay, and
- outpatient 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.

Wing Memorial Hospital

Wing Memorial Hospital (the Hospital), a member of the UMass Memorial Health Care system, is a 74-bed hospital located in Palmer, Massachusetts. Medicare paid the Hospital approximately $36.8 million for 4,369 inpatient and 124,288 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 $749,399 in Medicare payments to the Hospital for 172 claims that we judgmentally selected as potentially at risk for billing errors (see the Appendix A). These 172 claims had dates of service in CYs 2009 and 2010 and consisted of 80 inpatient and 92 outpatient claims.

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 from January through March 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 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 172 claims (80 inpatient and 92 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 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 113 of the 172 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 59 claims, resulting in overpayments totaling $89,257 for CYs 2009 and 2010. Specifically, 21 inpatient claims had billing errors, resulting in overpayments totaling $81,644, and 38 outpatient claims had billing errors, resulting in overpayments totaling $7,613. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 21 of 80 sampled inpatient claims, which resulted in overpayments totaling $81,644.

Incorrectly Billed as Inpatient

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 19 of 80 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital attributed most of these errors to improper physician determinations to admit to inpatient care. As a result of these errors, the Hospital received overpayments totaling $81,442.[4]

Incorrectly Billed Source-of-Admission

Pursuant to 42 CFR § 412.424, CMS increases the Federal per diem rate for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary used emergency department services. However, the IPF should not receive the additional payment if the beneficiary was discharged from the acute-care section of the same hospital.

The Manual, chapter 3, section 190.6.4.1, states that source-of-admission code "D" is reported by an IPF to identify patients who have been transferred to the IPF from the same hospital. The IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 2 of 80 sampled claims, the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to the IPF upon discharge from the Hospital's acute-care section. The Hospital stated that these overpayments occurred because of clerical errors in

[4] The Hospital may bill Medicare Part B for a limited range of services related to some of these 19 incorrect Part A 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.

coding the admission source on the IPF claims. As a result of these errors, the Hospital received overpayments totaling $202.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 38 of 92 sampled outpatient claims, which resulted in overpayments totaling $7,613.

Incorrectly Billed Medical Device Credit

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 in the Manual, chapter 4, section 61.3, 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 1 of 92 sampled claims, the Hospital received full credit for a replaced device but did not report the "FB" modifier and reduced charges on its claim. The Hospital stated that this credit went unreported because it did not establish adequate procedures for coordinating functions among the various departments (i.e., accounts payable, patient accounts, and Medicare billing) to ensure that it submitted claims with the appropriate modifier and reduced charges to initiate reduced payments for credits received from manufacturers. As a result of this error, the Hospital received overpayments totaling $5,182.

Incorrectly Billed Procedures With Modifier -59

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. In addition, the Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

The Manual, 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 18 of 92 sampled claims, the Hospital billed Medicare for HCPCS codes, appended with modifier -59, that were incorrect for the services provided. The Hospital attributed these errors

to human error and misinterpretation of coding guidelines. As a result of these errors, the Hospital received overpayments totaling $905.

Incorrectly Billed to Medicare Instead of the Skilled Nursing Facility

Under the consolidated billing provisions of sections 1862(a)(18) and 1842(b)(6)(E) of the Act, SNFs are responsible for billing Medicare for most services, including outpatient hospital services, provided to a SNF resident during a covered Part A stay. Pursuant to the interim final rule implementing the SNF consolidated billing requirement, outside suppliers, including outpatient hospitals, must bill according to the consolidated billing provisions for services furnished to SNF residents and must be paid by the SNF rather than by Medicare Part B.

For 7 of 92 sampled claims, the Hospital incorrectly billed Medicare Part B rather than the appropriate SNFs for services that were subject to the consolidated billing provisions of the Act and that had been included in Medicare Part A prospective payments to the SNFs. In each of these cases, the Medicare program paid twice for the same service: once to the SNF through the Part A prospective payment and to the Hospital through Part B. The Hospital stated these errors occurred because it did not always identify the beneficiary's point of origin. As a result of these errors, the Hospital received overpayments totaling $534.

Incorrectly Billed Evaluation and Management Services

The Manual, chapter 12, section 30.6.6(B), states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure.

For 8 of 92 sampled claims, the Hospital incorrectly billed Medicare for E&M services that were part of the usual preoperative or postoperative work of the procedure. The incorrectly billed services were associated with drug injection (four errors) and Unna boot (four errors) procedures. The Hospital was not eligible for the E&M payments since the services that the physician performed were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work. The Hospital attributed most of these errors to human error and misinterpretation of coding guidelines. As a result of these errors, the Hospital received overpayments totaling $437.

Incorrectly Billed Healthcare Common Procedure Coding System Codes and Number of Units

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, states: "In order to be processed correctly and promptly, a bill must be completed accurately." In addition, chapter 4, section 20.4, of the Manual states: "The definition of service units … is the number of times the service or procedure being reported was performed."

For 1 of 92 sampled claims, the Hospital submitted the claim to Medicare with incorrect HCPCS codes and number of units for procedures related to the excision of lesions. The Hospital stated

that the overpayment occurred due to clerical errors that went undetected. As a result of these errors, the Hospital received an overpayment of $324.

Incorrectly Billed as Outpatient

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 3 of 92 sampled claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays. These services should have been included on the Hospital's inpatient (Part A) claims to Medicare. The Hospital attributed the incorrect billing to human error in the application of Medicare guidelines. As a result of these errors, the Hospital received overpayments totaling $231.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $89,257 consisting of $81,644 in overpayments for 21 incorrectly billed inpatient claims and $7,613 in overpayments for 38 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

WING MEMORIAL HOSPITAL COMMENTS

In written comments on our draft report, the Hospital generally concurred with our findings. However, the Hospital stated that it plans to appeal 3 of 21 inpatient claims that we found with billing errors. In addition, the Hospital stated that it has submitted adjustments for the remaining claims billed in error and has taken steps to strengthen its controls to ensure compliance with Medicare regulations. The Hospital's comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A: RISK AREAS REVIEWED AND BILLING ERRORS

Risk Area	Sampled Claims	Claims With Overpayments	Value of Overpayments
Inpatient Short Stays	17	12	$39,425
Inpatient Claims Paid in Excess of Charges	9	2	$24,354
Inpatient Transfers	41	5	$17,663
Inpatient Psychiatric Facility Emergency Department Adjustments	3	2	$202
Inpatient Hospital-Acquired Conditions and Present on Admission Indicator Reporting	10	0	$0
Totals	80	21	$81,644
Outpatient Manufacturer Credits for Replaced Medical Devices	7	1	$5,182
Outpatient Claims Billed With Modifiers	44	18	$905
Outpatient Claims Billed During a Skilled Nursing Facility Stay	7	7	$534
Outpatient Claims Billed With Evaluation and Management Services	18	8	$437
Outpatient Surgeries With Billed Units Greater Than One	3	1	$324
Outpatient Claims Billed During an Inpatient Stay	7	3	$231
Outpatient Claims Paid In Excess of Charges	6	0	$0
Totals	92	38	$7,613

APPENDIX B: WING MEMORIAL HOSPITAL COMMENTS

Wing Memorial
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September 24, 2012

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Boston, MA 02203

Re: Report Number A-01-11-00536

Dear Mr. Armstrong:

Thank you for the opportunity to respond to the draft *Medicare Compliance Review of Wing Memorial Hospital for Calendar Years 2009 and 2010*, prepared by the Office of Inspector General (OIG) based on a review conducted of 13 identified risk areas for compliance with Medicare hospital billing requirements. Wing Memorial Hospital and UMass Memorial Health Care system Compliance Offices have reviewed the draft report, and generally concur with the findings, with exceptions noted below.

As stated in the report, 172 claims with dates of service in calendar years 2009 and 2010 were judgmentally selected as potentially at risk for billing errors, including 80 inpatient and 92 outpatient claims. Originally, 41 of these inpatient cases were identified by the auditors as at risk for potential non-compliance with the Medicare Post Acute Transfer rules, and nine (9) were selected for review because payments exceeded charges. No compliance issues were identified related to these risk areas. However, the auditors requested that the Hospital further review these cases for the appropriateness of the level of care billed. The auditors concluded that 21 out of the 80 inpatient cases reviewed were billed in error, due to inappropriate determinations regarding the level of care. We disagree with the findings of the OIG and the Fiscal Intermediary reviewer in 3 of these cases, which we plan to appeal. We agree that the remaining 18 inpatient claims reviewed were billed in error. In addition, we agree with the auditors' findings that 38 out of the 92 outpatient hospital claims reviewed were determined to be billed in error.

Wing Memorial Hospital has substantially complied with the recommendation to refund our Fiscal Intermediary (FI) $89,257 in overpayments based on these findings. To date, Wing

Memorial Hospital has submitted adjusted claims for all agreed upon identified errors, and is awaiting the final return remittance advice statements to confirm processing of these refunds by the FI.

In addition, Wing Memorial Hospital has taken the following actions to strengthen controls to ensure full compliance with the Medicare requirements:

Short Stays Incorrectly Billed As Inpatient Claims

- *Continued ongoing physician education regarding the appropriate application of Medicare criteria for inpatient admission level of care determinations. Wing Memorial Hospital is also in the process of implementing a new software system designed to facilitate accurate level of care determinations through systematic application of inpatient criteria. Additionally, the Hospital has developed a staffing and hiring plan to improve case management coverage on weekends.*

Admission Source Codes

- *Developed a report to assist in identifying discharges and admissions to a different unit of the hospital on the same day. This report includes the admission source code for the second admission, and is used as an additional layer of review.*

Medical Device Credits

- *Wing had identified this potential risk area and updated its process for confirming Device Credits from the Manufacturer by tracking explanted devices and responses to Warranty Claim Forms prior to the start of this audit. Additionally, Wing has implemented a process to monitor the central A/P system for credits applicable to devices explanted at Wing.*

Outpatient Claims Billed with Modifiers (59 and 91)

- *Educated Coding Staff with respect to the applicable coding, Medicare National Correct Coding initiative guidance, and the appropriate use of Modifier 59. Education specifically addressed how those rules apply to bone marrow aspirations performed at the same site and on the same day as a bone marrow biopsy – the one type of Modifier 59 billing error identified in this review. There were no errors identified with respect to the OIG's review of claims sampled with Modifier 91.*

Skilled Nursing Facility Consolidated Billing

- *Edits to the Registration Module of the hospital's computer system are under development. Training with respect to the data entry requirements for these new fields in the hospital's registration module, and the corresponding steps in the registration process will be provided to all registration staff responsible for registering outpatient clinic visits.*

Evaluation and Management Services Billed with Modifier 25

- *The Hospital has enhanced its Encounter Form Quality Review process and developed a formal documented procedure, which includes a review by the Nurse Manager who oversees each clinic and the Operations Manager for the Multi-Specialty Clinics. Additionally, all of these staff were provided re-education regarding Modifier 25 coding and CMS guidelines. In addition, the outpatient certified Coding Staff now review all physician documentation for encounters that include an outpatient procedure and E/M coded on the same date of service to ensure appropriate use of Modifier 25.*

Incorrectly Billed HCPCS Codes and Number of Units Associated with certain Outpatient Procedures

- *Although there were multiple units associated with one particular HCPCS code on the claim that was found to be in error, the number of units was not considered medically unlikely as the HCPCS code on the claim in question was a surgical excision code, which can be appropriately associated with multiple units. The Hospital will continue to perform routine Quality Assurance Reviews of outpatient coding, and will specifically include encounters that contained HCPCS codes representing excision procedures in the samples to be reviewed.*

Outpatient Services Billed During the 3 Day DRG Payment Window

- *Re-education for billing staff with respect to MLN Matters Number: MM7142- Related Change Request Number: 7142, specifically the requirement that services provided by the hospital, on the same date of the inpatient admission, are deemed related to the admission and are not separately billable. Staff were also re-educated with respect to the list of diagnostic revenue codes subject to the 3 Day Payment Rule.*

Wing Memorial Hospital is committed to strengthening its internal controls to ensure compliance with Medicare billing requirements. Accordingly, the hospital will continue to enhance the monitoring and internal auditing functions of its Compliance Program with support from the UMass Memorial Health Care Compliance Office.

Sincerely,

Janice Kucewicz

Janice Kucewicz, SVP & Chief Compliance Officer
Wing Memorial Hospital & Medical Centers