DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

April 12, 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 Bay Medical Center for Calendar Years 2009 and 2010 (A-04-11-08006) and Medicare Compliance Review of Kent County Hospital for Calendar Years 2009 and 2010 (A-01-11-00537)

Attached, for your information are advance copies of two of our final reports for hospital compliance reviews. We will issue these reports to Bay Medical Center and Kent County Hospital within 5 business days.

These reports are 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 the respective Regional Inspectors General for Audit Services:

Bay Medical Center
Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV
(404) 562-7750, email – Lori.Pilcher@oig.hhs.gov

Kent County Hospital
Michael J. Armstrong, Regional Inspector General for Audit Services, Region I
(617) 565-2684, email – 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

April 16, 2012

Report Number: A-01-11-00537

Mr. Paul Beaudoin
Senior Vice President of Finance
Kent County Memorial Hospital
455 Toll Gate Road
Warwick, RI 02886

Dear Mr. Beaudoin:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Kent County 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 David Lamir, Audit Manager, at (617) 565-2704 or through email at David.Lamir@oig.hhs.gov. Please refer to report number A-01-11-00537 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 KENT COUNTY HOSPITAL FOR CALENDAR YEARS 2009 AND 2010

Daniel R. Levinson
Inspector General

April 2012
A-01-11-00537

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.

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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
at http://oig.hhs.gov

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 inpatient hospital 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.

Kent County Hospital (the Hospital) is a 359-bed healthcare system located in Warwick, Rhode Island. Medicare paid the Hospital approximately $40 million for 1,115 inpatient and 153,448 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 $1,546,717 in Medicare payments to the Hospital for 171 claims that we judgmentally selected as potentially at risk for billing errors. These 171 claims had dates of service in CYs 2009 and 2010 and consisted of 146 inpatient and 25 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 155 of the 171 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 16 claims resulting in overpayments totaling $26,804 for CYs 2009 and 2010. Specifically, 6 inpatient claims had billing errors, resulting in overpayments totaling $23,015, and 10 outpatient claims had billing errors, resulting in overpayments totaling $3,789. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $26,804, consisting of $23,015 in overpayments for 6 incorrectly billed inpatient claims and $3,789 in overpayments for 10 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

KENT COUNTY HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations. 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 employs 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 inpatient hospital 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. For beneficiary stays incurring extraordinarily high costs, section 1886(d)(5)(A) of the Act provides for additional payments (called outlier payments) to Medicare-participating hospitals.

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

[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.

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.

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 include the following:

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims with high severity level DRG codes,
- inpatient claims paid in excess of charges,
- inpatient claims with adverse inpatient hospital-acquired conditions and present on admission indicator reporting,
- inpatient claims with medical device replacements, and
- outpatient claims billed with observation services that resulted in outlier payments.

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.

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

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.

Kent County Hospital

Kent County Hospital (the Hospital) is a 359-bed healthcare system located in Warwick, Rhode Island. Medicare paid the Hospital approximately $40 million for 1,115 inpatient and 153,448 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 $1,546,717 in Medicare payments to the Hospital for 171 claims that we judgmentally selected as potentially at risk for billing errors. These 171 claims had dates of service in CYs 2009 and 2010 and consisted of 146 inpatient and 25 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 but did not use 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 October 2011 through January 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 171 claims (146 inpatient and 25 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 selected sampled claims to determine whether the services were billed correctly;

- 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 155 of the 171 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 16 claims resulting in overpayments totaling $26,804 for CYs 2009 and 2010. Specifically, 6 inpatient claims had billing errors, resulting in overpayments totaling $23,015, and 10 outpatient claims had billing errors, resulting in overpayments totaling $3,789. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 6 of the 146 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling $23,015.

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." Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if, "with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment …."

For 5 of the 82 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not have valid physician orders to admit beneficiaries to inpatient care (3 errors) or that should have been billed as outpatient or outpatient with observation (2 errors).

The Hospital attributed the patient admission errors to inadequate internal controls over its case management department's processes and procedures. Specifically, case management did not always have the opportunity to review patient stays of short duration or admission criteria was improperly applied due to human error. As a result, the Hospital received overpayments totaling $16,030.

Inpatient Claims for High Severity Level Diagnosis-Related Group Codes

Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if, "with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment …."

For 1 of the 29 sampled claims, the Hospital billed Medicare for an inpatient claim that did not have a valid physician order to admit the beneficiary to inpatient care. The Hospital attributed the patient admission error to inadequate internal controls over its case management department's processes and procedures. As a result, the Hospital received overpayments totaling $6,985.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 10 of 25 sampled outpatient claims, which resulted in overpayments totaling $3,789.

Outpatient Observation Services That Resulted in Outlier Payments

The Manual, chapter 4, section 290.2.1, states: "Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services." Chapter 4, section 290.2.2, states: "Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should not report, as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services."

For 10 of the 25 sampled claims, the Hospital incorrectly billed observation hours on claims submitted to Medicare, resulting in incorrect outlier payments. For nine claims, the Hospital overstated the hours of observation because it did not allow for the normal recovery period expected postoperatively. For one claim, the Hospital's claim did not contain an order for the observation level of care. As a result, the Hospital received overpayments totaling $3,789.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $26,804, consisting of $23,015 in overpayments for 6 incorrectly billed inpatient claims and $3,789 in overpayments for 10 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

KENT COUNTY HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: KENT COUNTY HOSPITAL COMMENTS

KENT HOSPITAL

February 21, 2012

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region 1
John F. Kennedy Federal Building
Room 2425
Boston, Massachusetts 02203

Re: Report Number A-01-11-00537

Dear Mr. Armstrong:

Kent County Memorial Hospital is in receipt of the draft report from the U.S. Department of Health and Human Services, Office of Inspector General (OIG) entitled Medicare Compliance Review of Kent County Hospital for Calendar Years 2009 and 2010.

The OIG identified 16 claims with billing errors that resulted in overpayments totaling $26,804. Kent County Memorial Hospital concurs with the findings and recommendations made by the OIG. The findings will be addressed by Kent County Memorial Hospital as follows:

1. Kent County Memorial Hospital will refund $26, 804 to its Medicare Contractor.
2. Additional processes have been put in place prior to billing to ensure that appropriate physician orders are present including the institution of a computerized physician order entry system.
3. Case Managers are being retrained on the application of InterQual admission criteria and all 1 day admissions are being re-reviewed prior to billing.
4. Coders have been re-educated on the proper calculation of observation billable hours, and a new worksheet is being incorporated into the 3M Data Abstraction software system to ensure that start and end times and carve-outs are properly recognized.

Kent County Memorial Hospital takes the OIG findings and recommendations very seriously, and will continually strive to ensure the appropriate safeguards are in place to demonstrate Medicare billing compliance. Please do not hesitate to contact me if any further information is necessary.

Sincerely,

Paul A. Beaudoin
Senior Vice President of Finance

cc: Sandra Coletta, President and Chief Executive Officer, Kent County Memorial Hospital