Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE FOLLOWUP REVIEW OF BOSTON MEDICAL CENTER

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

David Lamir
Acting Regional
Inspector General

May 2013
A-01-12-00524

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

Boston Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of $612,063 over 3 years.

WHY WE DID THIS REVIEW

A previous Office of Inspector General review found that Boston Medical Center (Boston Medical) did not fully comply with Medicare billing requirements for billing selected inpatient and outpatient claims. The incorrectly billed claims included Medicare Part A inpatient short stays and Part B outpatient evaluation and management (E&M) services billed with cystoscopy procedures for calendar years (CY) 2009 and 2010. The previous report did not address audit results for 60 inpatient short stays because these claims required further evaluation by medical review personnel. Our current review focuses on these 60 inpatient short-stay claims and expands the review of outpatient E&M services.

The objective of this review was to determine whether Boston Medical complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Boston Medical is a 508-bed acute care hospital located in Boston, Massachusetts. Medicare paid Boston Medical approximately $496 million for 26,088 inpatient and 663,529 outpatient claims for services provided to beneficiaries during CYs 2009 through 2011 based on CMS's National Claims History data.

Our current audit covered $899,115 in Medicare payments to Boston Medical, consisting of $671,442 for 60 inpatient claims and $227,673 for 371 outpatient claims.

WHAT WE FOUND

Boston Medical complied with Medicare billing requirements for 105 of the 431 inpatient and outpatient claims we reviewed. However, Boston Medical did not fully comply with Medicare billing requirements for the remaining 326 claims, resulting in overpayments of $612,063 for CYs 2009 through 2011. Specifically, 54 inpatient claims had billing errors, resulting in overpayments of $593,169, and 272 outpatient claims had billing errors, resulting in overpayments of $18,894. These errors occurred primarily because Boston Medical did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the

Medicare billing requirements related to inpatient short stays and outpatient E&M services billed with cystoscopy procedures.

WHAT WE RECOMMEND

We recommend that Boston Medical:

- refund to the Medicare contractor $612,063, consisting of $593,169 in overpayments for 54 incorrectly billed inpatient claims and $18,894 in overpayments for 272 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

BOSTON MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Boston Medical concurred with our finding and recommendations for the incorrectly billed outpatient E&M services and stated that it has refunded the full amount to the Medicare contractor and has improved controls and strengthened audit processes related to these services.

With respect to our finding related to claims incorrectly billed as inpatient, Boston Medical stated that it has made improvements to ensure compliance with Medicare and has engaged a third-party vendor to review these claims. Boston Medical stated that the vendor's review will assist it in making a final determination as to which claims it will appeal and which claims it will refund to the Medicare contractor.

We acknowledge Boston Medical's efforts to implement stronger controls.

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INTRODUCTION

WHY WE DID THIS REVIEW

A previous Office of Inspector General (OIG) review found that Boston Medical Center (Boston Medical) did not fully comply with Medicare billing requirements for billing selected inpatient and outpatient claims.[1] The incorrectly billed claims included Medicare Part A inpatient short stays and outpatient evaluation and management (E&M) services associated with cystoscopy procedures for calendar years (CY) 2009 and 2010.[2] The previous report did not address audit results for 60 inpatient short stays because these claims required further evaluation by medical review personnel. Our current review focuses on these 60 inpatient short-stay claims and expands the review of outpatient E&M services.

OBJECTIVE

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

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

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

Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

[1] In July 2012, we issued a report entitled *Medicare Compliance Review of Boston Medical Center for Calendar Years 2009 and 2010* (A-01-11-00530).

[2] A cystoscopy is a diagnostic examination of the bladder and bladder canal (urethra) using an endoscope.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.[3] All services and items within an APC group are comparable clinically and require comparable resources.

Boston Medical Center

Boston Medical is a 508-bed acute care hospital located in Boston, Massachusetts. Medicare paid Boston Medical approximately $496 million for 26,088 inpatient and 663,529 outpatient claims for services provided to beneficiaries during CYs 2009 through 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our current review covered $899,115 in Medicare payments to Boston Medical, consisting of $671,442 for 60 inpatient claims and $227,673 for 371 outpatient claims. These 431 claims had dates of service in CYs 2009 through 2011 (audit period). We focused our review on two areas at risk for incorrect billing, inpatient claims for short stays and outpatient claims containing E&M services billed with cystoscopy procedures, that we identified as a result of our prior OIG review at Boston Medical. We removed the 60 inpatient claims for short stays from the previous review because they required further evaluation. We did not review the 371 outpatient claims containing E&M services during the previous review. We evaluated compliance with selected billing requirements and subjected 60 inpatient claims to focused medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Boston Medical for Medicare reimbursement.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our scope and methodology.

FINDINGS

Boston Medical complied with Medicare billing requirements for 105 of the 431 inpatient and outpatient claims we reviewed. However, Boston Medical did not fully comply with Medicare

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

billing requirements for the remaining 326 claims, resulting in overpayments of $612,063 for the audit period. Specifically, 54 inpatient claims had billing errors, resulting in overpayments of $593,169, and 272 outpatient claims had billing errors, resulting in overpayments of $18,894. These errors occurred primarily because Boston Medical did not have adequate controls to prevent the incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements related to inpatient short stays and outpatient E&M services billed with cystoscopy procedures.

For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Boston Medical incorrectly billed Medicare for 54 of the 60 selected inpatient claims that we reviewed. These errors resulted in overpayments of $593,169.

Incorrectly Billed as Inpatient

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Social Security Act (the Act), §1862(a)(1)(A)).

For 54 of the 60 selected claims, Boston Medical incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Boston Medical officials stated that the hospital's case management protocol did not always include coverage for weekend and evening shifts. As a result of these errors, Boston Medical received overpayments of $593,169.[4]

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Boston Medical incorrectly billed Medicare for 272 of the 371 selected outpatient claims that we reviewed. These errors resulted in overpayments of $18,894.

Incorrectly Billed Evaluation and Management Services

The *Medicare Claims Processing Manual* 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 (Pub. No. 100-04, chapter 12, § 30.6.6(B)).

For 272 of the 371 selected claims, Boston Medical incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. These E&M services were billed with

[4] Boston Medical may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

cystoscopy procedures. Boston Medical officials stated that these errors occurred due to staff within a hospital department who did not fully understand the Medicare billing requirements for E&M services. As a result of these errors, Boston Medical received overpayments of $18,894.

RECOMMENDATIONS

We recommend that Boston Medical:

- refund to the Medicare contractor $612,063, consisting of $593,169 in overpayments for 54 incorrectly billed inpatient claims and $18,894 in overpayments for 272 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

BOSTON MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Boston Medical concurred with our finding and recommendations for the incorrectly billed outpatient E&M services and stated that it has refunded the full amount to the Medicare contractor and has improved controls and strengthened audit processes related to these services.

With respect to our finding related to claims incorrectly billed as inpatient, Boston Medical stated that it has made improvements to ensure compliance with Medicare and has engaged a third-party vendor to review these claims. Boston Medical stated that the vendor's review will assist it in making a final determination as to which claims it will appeal and which claims it will refund to the Medicare contractor.

We acknowledge Boston Medical's efforts to implement stronger controls. Boston Medical's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our current audit covered $899,115 in Medicare payments to Boston Medical, consisting of $671,442 for 60 inpatient claims and $227,673 for 371 outpatient claims that we judgmentally selected at risk for billing errors. These 431 claims had dates of service in CYs 2009 through 2011 (audit period).

We focused our review on inpatient claims for short stays and outpatient claims containing E&M services billed with cystoscopy procedures that we identified as a result of our prior OIG review at Boston Medical. We evaluated compliance with selected billing requirements and subjected the 60 inpatient claims to focused medical review to determine whether the services were medically necessary.

We limited our review of Boston Medical's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from 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 Boston Medical for Medicare reimbursement.

Our fieldwork included contacting Boston Medical, located in Boston, Massachusetts, from November 2012 through February 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Boston Medical's inpatient and outpatient paid claim data from CMS's National Claims History file for the audit period;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 431 claims (60 inpatient and 371 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by Boston Medical to support the selected claims;

- requested that Boston Medical conduct its own review of the selected claims to determine whether the services were billed correctly;

- used an independent medical review contractor to determine whether 60 selected claims met medical necessity requirements;

- discussed the incorrectly billed claims with Boston Medical 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 Boston Medical officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Short Stays	60	$671,442	54	$593,169
Outpatient				
Evaluation and Management Services Billed With Cystoscopy Procedures	371	$227,673	272	$18,894
Inpatient and Outpatient Totals	**431**	**$899,115**	**326**	**$612,063**

April 30, 2013

Michael Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region I
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Re: Report Number: A-01-12-00524 "Medicare Compliance Followup Review of Boston Medical Center"

Dear Mr. Armstrong:

Boston Medical Center (the "Hospital") appreciates the opportunity to respond to the Government's report referenced above, which addresses a review of 60 inpatient short stays that required further evaluation by medical review personnel and an expansion of the Government's earlier review of outpatient evaluation and management ("E&M") services provided in conjunction with cystoscopy procedures. The Hospital takes compliance with Medicare requirements seriously and reaffirms its commitment to ensuring that the Hospital's internal controls are adequate and effective.

The Hospital's responses to the Government's recommendations are set forth below.

Inpatient Short Stays. The Government's report found that 54 of the 60 inpatient short stay claims included in the review had billing errors, resulting in alleged overpayments totaling $593,169. Since the time these claims were submitted (2009 – 2011), BMC has implemented a number of improvements to its level of care determination process to ensure compliance with Medicare requirements. Among other things, BMC has worked to increase the involvement of case managers in the Emergency Department, secure additional staff training, and increase the number of case management positions to allow for better coverage on weekends and evening shifts. BMC also has worked to provide physicians and case managers with additional support tools to help ensure that relevant factors are considered when determining the appropriate level of care for patients. Additionally, since February 2012, BMC has instituted specific processes to ensure that all inpatient cases billable to Medicare undergo validation of the assigned level of care. Further reviews of Medicare claims are also conducted to ensure that the physician orders support the intended level of care in each case.

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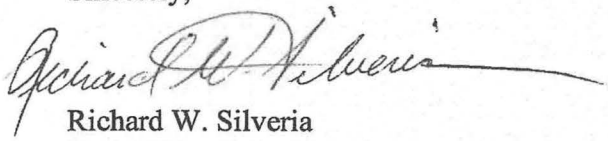
BMC has engaged a third party vendor review the 54 short stay claims that the Government has concluded were billed with errors. Upon completion of the vendor's review, which is expected within the next 30 days, BMC will make a final determination as to whether and for which claims it will submit appeals and for which claims it will issue a prompt refund to the Medicare contractor. To the extent that additional controls issues are identified by the third party vendor as part of their review, BMC will also consider and implement appropriate measures to further ensure compliance with Medicare requirements.

Outpatient E&M Claims

The outpatient E&M claims that are the subject of this review were associated with cystoscopy procedures performed at the Hospital. BMC agrees with the findings in the Government's report with regard to these claims and has already refunded $18,894 to the Medicare contractor to resolve those claims. BMC has taken steps to strengthen its internal review and audit processes related to these services. Furthermore, the Hospital has re-educated the staff in the Department responsible for performing cystoscopy procedures regarding the circumstances under which E&M services may be billed on the same day as a cystoscopy procedure.

Thank you again for the opportunity to respond to the Government's report.

Sincerely,



Richard W. Silveria
Senior Vice President of Finance and Chief Financial Officer

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