DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

January 30, 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 Kendall Regional Medical Center for Calendar Years 2009 and 2010 (A-04-11-07022) and Medicare Compliance Review of Springhill Medical Center for Calendar Years 2008 and 2009 (A-04-11-03067)

Attached, for your information, are advance copies of our final reports for two of our hospital compliance reviews. We will issue these reports to Kendall Regional Medical Center and Springhill Medical Center 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 Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750, or through email at Lori.Pilcher@oig.hhs.gov.

Attachment

cc:
Jacquelyn White, Director
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

February 1, 2012

Report Number: A-04-11-03067

Mr. Jeffrey St. Clair
President and CEO
Springhill Medical Center
3719 Dauphin Street
Mobile, AL 36608

Dear Mr. St. Clair:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Springhill Medical Center for Calendar Years 2008 and 2009*. 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 John T. Drake, Audit Manager, at (404) 562-7755 or through email at John.Drake@oig.hhs.gov. Please refer to report number A-04-11-03067 in all correspondence.

Sincerely,

/Lori S. Pilcher/
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 SPRINGHILL MEDICAL CENTER FOR CALENDAR YEARS 2008 AND 2009

Daniel R. Levinson
Inspector General

February 2012
A-04-11-03067

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:

Office of Audit Services

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.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

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 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.

Springhill Medical Center (the Hospital) is a 252-bed acute care hospital located in Mobile, Alabama. Medicare paid the hospital approximately $59 million for 6,586 inpatient and 36,478 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 and 2009 based on CMS's National Claims History data.

Our audit covered $1,631,288 in Medicare payments to the Hospital for 90 inpatient and 92 outpatient claims that we identified as potentially at risk for billing errors. These 182 claims had dates of service in CYs 2008 and 2009.

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 165 of the 182 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected outpatient claims. Specifically, of the 182 claims, 17 outpatient claims had errors, resulting in overpayments totaling $34,454 for CYs 2008 and 2009. 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 $34,454 in overpayments for 17 incorrectly billed outpatient claims and

- strengthen controls to ensure full compliance with Medicare billing requirements.

SPRINGHILL MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations and outlined corrective actions that it had taken or planned to take to address the deficiencies we noted. The Hospital's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

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 was 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.

---

[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 purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or Medicare administrative contractor, 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 techniques. The types of payments to hospitals reviewed by this and related audits included payments for claims billed for:

- outpatient claims with payments greater than $25,000,
- outpatient surgeries billed with units greater than one,
- outpatient services billed during home health episodes,
- outpatient claims billed with Modifier -59,
- inpatient and outpatient claims paid in excess of charges,
- inpatient hospital acquired conditions and present on admission indicator reporting,
- inpatient transfers,
- outpatient evaluation and management services billed with surgical services, and
- outpatient services billed during skilled nursing facility stays.

For 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 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.

Springhill Medical Center

Springhill Medical Center (the Hospital) is a 252-bed acute care hospital located in Mobile, Alabama. Medicare paid the Hospital approximately $59 million for 6,586 inpatient and 36,478 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 and 2009 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 $1,631,288 in Medicare payments to the Hospital for 182 claims that we judgmentally selected as potentially at risk for billing errors. These 182 claims had dates of service in CYs 2008 and 2009 and consisted of 90 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 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 allowed 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 the Hospital submitted for Medicare reimbursement.

We conducted our fieldwork at the Hospital during March 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 2008 and 2009;

- 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 182 claims (90 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 the Hospital provided to support the sampled claims;

- reviewed the remittance advices the Hospital provided to determine the charges reimbursed by Medicare;

- 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;

- discussed the incorrectly billed claims with the 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 the Hospital's 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 165 of the 182 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected outpatient claims. Specifically, of 182 sampled claims, 17 outpatient claims had errors, resulting in overpayments totaling $34,454 for CYs 2008 and 2009.

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.

We did not identify any errors in the 90 sampled inpatient claims. Of the 92 sampled outpatient claims, 17 had errors resulting in overpayments of $34,454.

- For outpatient claims paid in excess of $25,000, the Hospital incorrectly billed Medicare for HCPCS codes that were included in payments for other services billed on the same claim or for services that were not provided or were insufficiently documented in the medical records (five claims totaling $32,301 in overpayments).

- For outpatient claims involving surgeries billed with units greater than one, the Hospital submitted one claim to Medicare with missing medical record documentation to support a specific charge (one claim with an overpayment totaling $1,014).

- For outpatient services billed during home health agency (HHA) episodes, the Hospital incorrectly billed Medicare Part B rather than the appropriate HHA for services that were subject to the consolidated billing provisions of the Act and that had been included in the Medicare Part A prospective payments to the HHAs (two claims totaling $970 in overpayments).

- For outpatient claims billed with Modifier -59, the Hospital submitted claims to Medicare where the medical record documentation did not support the use of a modifier (three claims totaling $151 in overpayments).

- For outpatient claims paid in excess of charges, the Hospital submitted claims to Medicare with incorrect units of service and missing medical record documentation (six claims totaling $18 in overpayments).

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 17 of 92 sampled outpatient claims. These errors resulted in overpayments totaling $34,454.

Outpatient Claims With Payments Greater Than $25,000

Section 1833(e) of the Act precludes payment to any provider of services or other person without "information necessary to determine the amounts due the provider …." In addition, the Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 5 of the 92 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that were included in payments for other services billed on the same claim (3 claims) or for services that were not provided or insufficiently documented in the medical records (2 claims). For example, for one claim, the Hospital billed Medicare twice for the replacement of a cardiovascular defibrillator generator, while the medical records supported that the procedure was performed only once. These errors occurred due to human error. As a result of these errors, the Hospital received overpayments totaling $32,301.

Outpatient Surgeries Billed With Units Greater Than One

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."

For 1 of the 92 sampled claims, the Hospital incorrectly billed Medicare for angioplasty services on 3 vessels rather than the 2 vessels documented in the medical record. This occurred because the Hospital's coders did not thoroughly review the medical record. As a result of this error, the Hospital received an overpayment totaling $1,014.

Outpatient Services Billed During Home Health Episodes

Under the consolidated billing provisions of sections 1862(a)(21) and 1842(b)(6)(F) of the Act, the HHA that establishes the plan of care has the Medicare billing responsibility for the services included in the HHA prospective payment system rate, including certain outpatient hospital services. Medicare payment is to be made to the HHA overseeing the plan of care regardless whether the item or service was furnished by the agency, by others under arrangement to the primary agency, or "otherwise." The base 60-day episode rate includes an adjustment for any therapy services that could have been unbundled before implementation of the prospective payment system.

For 2 of the 92 sampled claims, the Hospital incorrectly billed Medicare Part B rather than the appropriate HHA for outpatient services that were subject to the consolidated billing provisions of the Act and that had been included in the Medicare Part A prospective payments to the HHA. In each of these cases, the Medicare program, paid twice for the same service: once to the HHA through the Medicare Part A prospective payment and again to the Hospital through Part B. The Hospital stated that the errors occurred because its patient registration staff did not document the patient's home health status upon admission. As a result of these errors, the Hospital received overpayments totaling $970.

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 3 of the 92 sampled claims, the Hospital incorrectly billed Medicare for services that were insufficiently documented in the medical records (2 errors) or for HCPCS codes that did not require modifier -59 (1 error). The Hospital stated that these overpayments occurred because the Hospital's coding staff had an incorrect understanding of the applicability of the modifier with respect to certain injections performed in conjunction with cardiac catheterization procedures. As a result of these errors, the Hospital received overpayments totaling $151.

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. 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, states: "The definition of services units…is the number of times the service or procedure being reported was performed."

For 6 of the 92 sampled claims, the Hospital billed Medicare with incorrect units of service. Additionally, one of these six claims was missing medical record documentation to support the procedure performed. The Hospital stated that these errors occurred because the Hospital's charge system data was not current. Human error caused the Hospital to bill a procedure that was missing supporting documentation. As a result of these errors, the Hospital received overpayments totaling $18.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $34,454 in overpayments for 17 incorrectly billed outpatient claims and

- strengthen controls to ensure full compliance with Medicare billing requirements.

SPRINGHILL MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations and outlined corrective actions that it had taken or planned to take to address the deficiencies we noted. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: SPRINGHILL MEDICAL CENTER COMMENTS

December 20, 2011

Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

RE: Report Number: A-04-11-03067

Dear Ms. Pilcher:

On behalf of Springhill Medical Center (SMC) and Jeffery M. St. Clair, President and CEO of SMC, please accept these comments to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG), draft report entitled Medicare Compliance Review of Springhill Medical Center for Calendar Years 2008 and 2009.

We concur with the two report recommendations. The following corrective action was taken or is planned: a refund totaling $34,454 to the Medicare contractor, retraining, updating charges in the chargemaster, removal of some codes from the chargemaster, and changes to the selection process for level visit charges in the ED.

Additionally, Springhill Medical Center will continue to monitor and audit claims and institute additional controls as necessary.

Thank you for the opportunity to respond to the draft report.

Sincerely,

Timothy W. Kaufman

Timothy W. Kaufman
General Counsel