Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF MERCY MEDICAL CENTER IN DES MOINES 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.

Patrick J. Cogley
Regional Inspector General

November 2013
A-07-12-05028

Office of Inspector General

https://oig.hhs.gov/

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EXECUTIVE SUMMARY

Mercy Medical Center in Des Moines did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately $573,000 over more than 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals $151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Mercy Medical Center in Des Moines (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification. 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 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.

The Hospital is an 802-bed acute care hospital located in Des Moines, Iowa. Medicare paid the Hospital approximately $292 million for 277,157 outpatient and 27,073 inpatient claims for services provided to beneficiaries during CYs 2009 and 2010 based on CMS's National Claims History data.

Our audit covered $8,202,585 in Medicare payments to the Hospital for 557 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 155 outpatient and 402 inpatient claims. Of the 557 claims, 523 claims had dates of service in CYs 2009 or 2010, and 34 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CYs 2008 or 2011.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 466 of the 557 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 91 claims, resulting in overpayments of $573,331 for CYs 2009 and 2010 (77 claims) and CYs 2008 and 2011 (14 claims). Specifically, 35 outpatient claims had billing errors, resulting in overpayments of $391,126, and 56 inpatient claims had billing errors,

resulting in overpayments of $182,205. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor $573,331, consisting of $391,126 in overpayments for 35 incorrectly billed outpatient claims and $182,205 in overpayments for 56 incorrectly billed inpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital partially agreed with our first recommendation. The Hospital disagreed with our finding regarding 18 outpatient claims that involved the replacement of medical devices. Specifically, the Hospital said that it would have been inaccurate to report the "FB" modifier on these 18 claims and that our finding regarding these claims was an incorrect application of Medicare payment policy. The Hospital agreed with our findings and recommendations for the remaining claims and, with respect to both of our recommendations, described corrective actions that it had taken.

After reviewing the Hospital's comments, we maintain that all of our findings and recommendations are valid. Medicare payment policy regarding the reporting of manufacturer credits for replaced medical devices is clear and specific as to the devices in question.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals $151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether Mercy Medical Center in Des Moines (the Hospital) complied with Medicare requirements for billing outpatient and inpatient 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 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.[1] All services and items within an APC group are comparable clinically and require comparable resources.

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

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

(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. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Claims at Risk for Incorrect Billing

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- outpatient and inpatient manufacturer credits for replaced medical devices,
- outpatient and inpatient claims paid in excess of charges,
- outpatient claims billed with observation services that resulted in outlier payments,
- outpatient claims billed with Doxorubicin Hydrochloride,
- outpatient claims billed with modifiers,
- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims with payments greater than $150,000,
- inpatient psychiatric facility (IPF) emergency department adjustments, and
- inpatient transfers.

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

Medicare Requirements for Hospital Claims and Payments

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)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)).

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

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

Mercy Medical Center in Des Moines

The Hospital is an 802-bed acute care hospital located in Des Moines, Iowa. Medicare paid the Hospital approximately $292 million for 277,157 outpatient and 27,073 inpatient claims for services provided to beneficiaries during CYs 2009 and 2010 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $8,202,585 in Medicare payments to the Hospital for 557 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 155 outpatient and 402 inpatient claims. Of the 557 claims, 523 claims had dates of service in CYs 2009 or 2010, and 34 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CYs 2008 or 2011.[2] We focused our review on the risk areas that we had identified as a result of previous 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. 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 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.

See Appendix A for the details of our scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 466 of the 557 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 91 claims, resulting in overpayments of $573,331 for CYs 2009 and 2010 (77 claims) and CYs 2008 and 2011 (14 claims). Specifically, 35 outpatient claims had billing errors, resulting in overpayments of $391,126, and 56 inpatient claims had billing errors, resulting in overpayments of $182,205. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

[2] We selected these 34 claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 35 of 155 selected outpatient claims, which resulted in overpayments of $391,126.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations 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 (42 CFR § 419.45). 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. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than $1 for the device.[3]

For 30 out of 155 selected claims, the Hospital received full credit for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims. (Of the 30 claims, 20 had dates of service in CYs 2009 or 2010, and 10 had dates of service in CYs 2008 or 2011.) These overpayments occurred because the Hospital did not have adequate controls to report the appropriate modifier and charges to reflect credits received from manufacturers. As a result of these errors, the Hospital received overpayments of $382,842.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

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

For 3 out of 155 selected claims, the Hospital submitted the claims to Medicare with incorrect HCPCS codes. The Hospital stated that staff members erroneously transposed numbers in the HCPCS codes. As a result of these errors, the Hospital received overpayments of $4,773.

Incorrectly Billed Observation Services

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 Act, § 1862(a)(1)(A)). The Manual 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 … observation time ends when all medically necessary services related to observation care are completed" (chapter 4, § 290.2.2). The Manual also states: "Observation services must also be reasonable and necessary

[3] CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

to be covered by Medicare" (chapter 4, § 290.1). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 2 out of 155 selected claims, the Hospital billed Medicare for incorrect units of service for HCPCS code G0378 (hospital observation services). Specifically, the Hospital billed 255 and 229 units of service when the correct amounts were 80 and 108, respectively. The Hospital stated that when calculating the observation hours, no consideration was given to the medical necessity of the excessive observation hours. As a result of these errors, the Hospital received overpayments of $3,511.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 56 of 402 selected inpatient claims, which resulted in overpayments of $182,205.

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 Act, §1862(a)(1)(A)). 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 …." (the Act, § 1814(a)(3)). Additionally, Medicare Part A will pay for inpatient hospital services "… only if a physician certifies and recertifies," among other things, the reasons for continued hospitalization" (42 CFR § 424.13(a)).

For 15 out of 402 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services.[4]

The Hospital explained that the errors were a result of several causes:

- Patient Care Managers were not available to review cases on weekends or after hours.
- Inconsistency in physician documentation for the level of care led to misinterpretation of the order.
- Physicians did not always complete the level of care in the standard order sets.
- A knowledge deficit due to the ambiguity of the criteria.

[4] The Hospital 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 and adjudicated by the Medicare administrative contractor prior to the issuance of our report.

As a result of these errors, the Hospital received overpayments of $79,008.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code "FD" (chapter 3, § 100.8).

For 21 out of 402 selected claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate condition and value codes to reduce payment as required. (Of the 21 claims, 17 had dates of service in CYs 2009 or 2010, and 4 had dates of service in CYs 2008 or 2011.) These overpayments occurred because the Hospital did not have adequate controls to report the appropriate condition and value codes in order to accurately reflect credits it had received from manufacturers. As a result of these errors, the Hospital received overpayments of $73,459.

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states:

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

For 2 out of 402 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital stated that coding rules are open to interpretation and, in the cases cited, the coder believed that the claims were not related and determined that the claims should have been billed separately. As a result of these errors, the Hospital received overpayments of $14,009.

Incorrectly Billed Diagnosis-Related Group Codes

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 Act, §1862(a)(1)(A)). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 2 out of 402 selected claims, the Hospital billed Medicare for incorrect DRG codes. For each of these two claims, either the principal diagnosis or the procedure code was incorrect. The

Hospital attributed these errors to coding mistakes. As a result of these errors, the Hospital received overpayments of $10,748.

Unsupported Charges

The Act states: "[N]o such payments shall be made to any provider unless it has furnished such information … in order to determine the amounts due such provider … for the period with respect to which the amounts are being paid …." (the Act, § 1815(a)).

For 4 out of 402 selected claims, the Hospital submitted claims to Medicare with unsupported charges, resulting in a higher outlier payment than was warranted. For three claims, the Hospital billed for medications that were not supported by the medical records. For the other claim, the Hospital billed for a procedure that was not supported by the medical records. The Hospital attributed these incorrect claims to human error. As a result of these errors, the Hospital received overpayments of $4,048.

Incorrect Source-of-Admission Code

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 (42 CFR § 412.424). The Manual states that 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 (chapter 3, § 190.6.4). The Manual also states that IPFs report source-of-admission code "D" to identify patients who have been transferred to the IPF from the same hospital (chapter 3, § 190.6.4.1). An IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 12 out of 402 selected 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 attributed these incorrect claims to human error. As a result of these errors, the Hospital received overpayments of $933.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $573,331, consisting of $391,126 in overpayments for 35 incorrectly billed outpatient claims and $182,205 in overpayments for 56 incorrectly billed inpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital partially agreed with our first recommendation. The Hospital disagreed with our finding regarding 18 outpatient claims that involved the replacement of medical devices. For each of these claims, the replaced medical device in question was an implantable cardioverter-defibrillator (ICD), a device that includes both an impulse generator and a lead wire. Thus, the lead wire is just one component of the replaced device. The Hospital stated that because it did not receive a credit in the amount of the full cost of the ICD, it would have been inaccurate to report the "FB" modifier on these 18 claims and, therefore, no payment reduction was necessary. According to the Hospital, our finding regarding these claims was an incorrect application of Medicare payment policy.[5]

The Hospital agreed with our findings and recommendations for the other overpayments that we had identified and described corrective actions that it had taken in response to both of our recommendations. With respect to our second recommendation, the Hospital stated that it had reviewed its billing process in each area to determine how the process could be further improved, and that it had implemented improvements to ensure future compliance in each area.

The Hospital's comments appear in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, we maintain that all of our findings and recommendations are valid. Medicare payment policy regarding the reporting of manufacturer credits for replaced medical devices is clear and specific as to the devices in question. CMS lists, in the Federal Register, the devices to which the payment policy on replaced medical devices applies.[6] This list includes the ICDs that were involved in all 18 of the claims associated with the finding with which the Hospital disagreed.

Furthermore, CMS has responded to comments on its payment policy that deal with instances when a hospital receives a full credit for only one component of a pacemaker or ICD replacement procedure that involves both a lead and a generator.[7] CMS responded by confirming that the modifier should be assigned to the procedure code and that a payment offset amount should be applied.

[5] The payment policy in question is called the No Cost/Full Credit and Partial Credit Device Adjustment Policy.

[6] 74 Fed. Reg. 60316, 60464 (Nov. 20, 2009) and 77 Fed. Reg. 68210, 68357 (Nov. 15, 2012).

[7] 77 Fed. Reg. 68210, 68357 (Nov. 15, 2012). Although this volume of the Federal Register was issued after our audit period, the language to which we refer here does not establish new policy, but rather, reiterates existing policy.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $8,202,585 in Medicare payments to the Hospital for 557 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 155 outpatient and 402 inpatient claims. Of the 557 claims, 523 claims had dates of service in CYs 2009 or 2010, and 34 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CYs 2008 or 2011 (see footnote 2).

We focused our review on the risk areas that we had identified as a result of previous 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 outpatient and inpatient 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 the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital from March 2012 to March 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient and inpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2008 through 2011;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 557 claims (155 outpatient and 402 inpatient) 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 the Hospital to support the selected claims;

- requested that the Hospital conduct its own review of the selected 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 on March 28, 2013.

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
Outpatient				
Manufacturer Credits for Replaced Medical Devices	44	$989,126	30	$382,842
Claims Paid in Excess of Charges	3	10,038	3	4,773
Claims Billed With Observation Services That Resulted in Outlier Payments	10	59,133	2	3,511
Claims Billed With Doxorubicin Hydrochloride	73	242,657	0	0
Claims Billed With Modifiers	25	109,531	0	0
Outpatient Totals	**155**	**$1,410,485**	**35**	**$391,126**
Inpatient				
Short Stays	248	$1,320,917	15	$79,008
Manufacturer Credits for Replaced Medical Devices	43	1,056,547	21	73,459
Same-Day Discharges and Readmissions	12	244,962	2	14,009
Claims Billed With High Severity Level Diagnosis-Related Group Codes	41	1,013,401	2	10,748
Claims With Payments Greater Than $150,000	10	2,142,484	4	4,048
Psychiatric Facility Emergency Department Adjustments	27	226,406	12	933
Transfers	15	478,217	0	0
Claims Paid in Excess of Charges	6	309,166	0	0
Inpatient Totals	**402**	**$6,792,100**	**56**	**$182,205**
Outpatient and Inpatient Totals	**557**	**$8,202,585**	**91**	**$573,331**

Notice: The table above illustrates the results of our review by risk area. In it, we have organized outpatient and inpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX C: AUDITEE COMMENTS

Mercy
MEDICAL CENTER
DES MOINES
A member of Mercy Health Network

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October 4, 2013

Patrick J. Cogley
Office of the Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 66106

Re: Draft of HHS-OIG Audit Services Report Number A-07-12-05028

Dear Mr. Cogley:

Mercy Medical Center –Des Moines appreciates the opportunity to respond to the draft report identified above. For over 120 years, Mercy has maintained its commitment to providing quality medical care to our patients and to our community. Our values guide us to do what is best for our patients while maintaining compliance with the highest standards of care. This commitment includes our obligation to process claims for services provided while ensuring compliance with all appropriate standards. The OIG review largely validates we have been successful in our efforts to ensure fair and accurate billing to the Medicare program. We disagree with one of the audit standards, which we discuss below.

OIG Audit of Replacement Medical Devices Applied Incorrect Standard

The draft report asserts that modifier FB should have been applied to 30 claims for outpatient surgery that involved the replacement of a medical device. We disagree with the audit's findings with respect to 18 of those 30 claims.[1]

Medicare has special payment rules for situations where a medical device manufacturer provides a replacement device to a hospital for no-charge or at a significant discount (typically because the device failed while under warranty). If the hospital received a replacement device for no-charge the hospital must attach modifier FB to its outpatient claim, and Medicare will reduce the APC payment by the offset amount related device. If the hospital received a credit for more than 50% of the cost of the replacement device, the hospital must attach modifier FC to its outpatient claim, and Medicare will reduce the APC payment by the partial offset an amount, which is an amount based upon a percentage of the device cost. 42 C.F.R. § 419.45; CMS Pub. 100-04, Ch. 4 § 61.3.

For 18 of the claims that the draft report asserts should have been billed with modifier FB, the procedure involved the replacement of both the impulse generator of the implantable cardioverter-defibrillator (ICD) and a lead wire. The hospital received a credit from the

[1] For the remaining 12 claims, we agree that each claim should have included modifier FB. We have submitted revised bills and refunded the related overpayments for the 12 claims.

manufacturer for the cost of the lead wire, but not for the cost of the impulse generator. The draft report asserts that modifier FB should have been attached to these claims because a credit was given for the full cost of the lead wire. That position incorrectly applies Medicare payment policy. In these 18 cases, the replaced device is the ICD, which includes both impulse generator and its lead wires. As such, the lead wire is just one component of the "replaced device." Since the hospital did not receive a credit in the amount of the full cost of the ICD, it would be inaccurate to include modifier FB on the claim. Further, since the value of the credit for the lead wire was less than 50% of the cost of the replacement ICD, it would have been inaccurate to include modifier FC on the claim. As such, we are confident that these 18 claims were correctly paid and no payment reduction based upon the manufacturer's credit for the lead is appropriate.

In sum, we respectfully disagree with the audit findings related to 18 claims involving outpatient replacement medical devices. We have not refunded those claims and fully intend to appeal.

Other OIG Audit of High Risk Areas Found Few and Only Isolated Issues

The other claims audited were in select high risk areas (outpatient HCPCS coding, observation versus inpatient admission status, readmissions, DRG coding, inpatient outliers that include expensive drugs, inpatient medical device credits, and source of admission for inpatient psychiatric facility adjustments). Despite that narrow focus, the audit found only a modest number of isolated errors and no indication of systemic deficiencies. We acknowledge that the claims identified in the draft report were incorrectly paid, and we have submitted refunds for all claims identified by the audit (other than the 18 outpatient medical device claims discussed above). Further, we reviewed our billing process in each area to determine how our process could be further improved, and we implemented improvements to ensure future compliance in each area.

Conclusion

The OIG's audit was not a random audit of all inpatient and outpatient claims, rather the audit targeted several high risk areas. As such, the audit is not representative of Mercy's overall billing compliance. Indeed, the audit report does not purport to assess overall compliance, rather the report acknowledges that it is limited to "selected risk areas." Nonetheless, of the $8,202,585 payments reviewed, we believe that only $244,688 of the payments were incorrect, which relates to a compliance rate that is better than 97%. We have taken steps to further increase that compliance rate, but we are pleased to have achieved such an positive outcome in the context of an audit targeting only high-risk areas.

We appreciate your consideration of the points raised above. Please feel free to contact me if you have any questions.

Best regards,

Robert P. Ritz
President

RPR:ds

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