Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF SANFORD MEDICAL CENTER IN FARGO FOR CALENDAR YEARS 2010 AND 2011

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

September 2013
A-07-12-05031

Office of Inspector General

https://oig.hhs.gov/

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EXECUTIVE SUMMARY

Sanford Medical Center in Fargo did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately $65,000 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 Sanford Medical Center in Fargo (the Hospital) 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.

The Hospital is a 583-bed acute care hospital located in Fargo, North Dakota. Medicare paid the Hospital approximately $222 million for 16,581 inpatient and 131,474 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered $3,827,949 in Medicare payments to the Hospital for 252 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 170 inpatient and 82 outpatient claims. Of these 252 claims, 250 had dates of service in CYs 2010 and 2011. Two claims, involving replaced medical devices, had dates of service in CY 2009.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 226 of the 252 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 26 claims, resulting in overpayments of $64,526 for CYs 2010 and 2011 (24 claims) and CY 2009 (2 claims). Specifically, 11 inpatient claims had billing errors, resulting in overpayments of $50,640, and 15 outpatient claims had billing errors, resulting in overpayments of $13,886. 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 $64,526, consisting of $50,640 in overpayments for 11 incorrectly billed inpatient claims and $13,886 in overpayments for 15 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital described corrective actions that it had taken in accordance with our recommendations. Specifically, the Hospital stated that it had refunded the $64,526 in overpayments. The Hospital also described corrective actions that it had taken to further enhance and strengthen its controls.

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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 Sanford Medical Center in Fargo (the Hospital) 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. 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 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 Claims at Risk for Incorrect Billing

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

- inpatient claims paid in excess of charges,
- 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 hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient transfers,
- outpatient manufacturer credits for replaced medical devices,
- outpatient dental services,
- outpatient claims paid in excess of charges,
- outpatient claims billed with Doxorubicin Hydrochloride,
- outpatient claims billed with modifier -25,
- outpatient claims with payments greater than $25,000,
- outpatient claims billed with modifier -74, 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." We reviewed these risk areas as part of this review.

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

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).

Sanford Medical Center in Fargo

The Hospital is a 583-bed acute care hospital located in Fargo, North Dakota. Medicare paid the Hospital approximately $222 million for 16,581 inpatient and 131,474 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $3,827,949 in Medicare payments to the Hospital for 252 claims that we judgmentally selected as potentially at risk for billing errors. These 252 claims consisted of 170 inpatient and 82 outpatient claims. Of these 252 claims, 250 had dates of service in CYs 2010 and 2011. Two claims, involving replaced medical devices, had dates of service in CY 2009. 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 226 of the 252 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 26 claims, resulting in overpayments of $64,526 for CYs 2010 and 2011 (24 claims) and CY 2009 (2 claims). Specifically, 11 inpatient claims had billing errors, resulting in overpayments of $50,640, and 15 outpatient claims had billing errors, resulting in overpayments of $13,886. 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.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 11 of 170 selected inpatient claims, which resulted in overpayments of $50,640.

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)). The Manual, chapter 1, § 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For 3 out of 170 selected claims, the Hospital submitted claims to Medicare with incorrectly coded DRG codes. Specifically, on these three claims, the Hospital billed Medicare with incorrect diagnosis codes that resulted in the assignment of incorrect DRG codes. The Hospital attributed these errors to coder misinterpretation of clinical documentation. As a result of these errors, the Hospital received overpayments of $37,185.

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)).

For 5 out of 170 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services.[2] The Hospital attributed the errors to staff members misunderstanding the process and criteria. As a result of these errors, the Hospital received overpayments of $9,975.

[2] 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 or adjudicated by the Medicare administrative contractor prior to the issuance of our draft report.

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 170 selected claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that the errors occurred because internal controls did not call for the evaluation of all same-day readmissions. As a result of these errors, the Hospital received overpayments of $2,995.

Unsupported Charges

Under Federal regulations, CMS provides for additional payments, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary (42 CFR § 412.80). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2). The Manual also states that a hospital may bill only for services provided (chapter 3, § 10).

For 1 out of 170 selected claims, the Hospital incorrectly billed Medicare for unsupported charges. The Hospital incorrectly included charges for these items in cost outlier computations, thus creating an overpayment. The Hospital stated that this error occurred because staff did not identify and remove these duplicate charges during review. As a result of this error, the Hospital received an overpayment of $485.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 15 of 82 selected outpatient claims, which resulted in overpayments of $13,886.

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 2 out of 82 selected claims, the Hospital received full credit for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims. 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 $6,638.

Services Not Billable to Medicare

Section 1862(a)(12) of the Act states: "No payment may be made under Part A or Part B for any expenses incurred for items or services where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth…."

For 8 out of 82 selected claims, the Hospital incorrectly billed Medicare for services related to the removal of teeth. The Hospital attributed these errors to an oversight during a change to provider-based billing in the legacy billing system. This change prevented the system from recognizing the specific internal billing class for dental cases. Specifically, during coding review, the charge records for these eight claims were updated to remove Medicare as the payer. However, because of an error in the design of the system, the changes did not carry forward to the actual claims. As a result of these errors, the Hospital received overpayments of $4,514.

Incorrectly Billed Healthcare Common Procedure Coding System Code

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 1 out of 82 selected claims, the Hospital submitted the claim to Medicare with an incorrect HCPCS code. The Hospital attributed this error to a transposition of digits resulting in an incorrect, but valid, HCPCS code that was not identified during internal quality control checks. As a result of this error, the Hospital received an overpayment of $2,066.

Incorrectly Billed Number of Units

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). The Manual also states: "It is … of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent

[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).

with the quantity of a drug … that was used in the care of the patient" (chapter 17, § 90.2.A). If the provider is billing for a drug, according to the Manual, "[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4.…" (chapter 17, § 70).

For 1 out of 82 selected claims, the Hospital billed Medicare for an incorrect number of units with Doxorubicin Hydrochloride, HCPCS code J9001. Specifically, the Hospital billed for five units when the correct amount was four. The Hospital said that it was not able to develop a precise underlying cause for this error, explaining that it was not able to retrieve information to support the size of the vial or provide documentation of a shortage of smaller vials. As a result of this error, the Hospital received an overpayment of $429.

Incorrectly Billed Evaluation and Management Services

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

For 3 out of 82 selected claims, the Hospital 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. The Hospital stated that these errors occurred due to a combination of system and human error. Specifically, during a change in the billing system, modifier 25 was automatically being added to the E&M code when charges other than an E&M or clinic lab service were provided for the same patient on the same date of service. In addition, a report meant to identify the transfer of information from one billing system to another was not used consistently. As a result of these errors, the Hospital received overpayments of $239.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $64,526, consisting of $50,640 in overpayments for 11 incorrectly billed inpatient claims and $13,886 in overpayments for 15 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital described corrective actions that it had taken in accordance with our recommendations. Specifically, the Hospital stated that it had refunded the $64,526 in overpayments. The Hospital also described corrective actions that it had taken to further enhance and strengthen its controls. The Hospital's comments appear in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $3,827,949 in Medicare payments to the Hospital for 252 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 170 inpatient and 82 outpatient claims. Of these 252 claims, 250 had dates of service in CYs 2010 and 2011. Two claims, involving replaced medical devices, had dates of service in CY 2009.

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 focused medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. 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 from July 2012 to April 2013.

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 the audit period;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2009 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 252 claims (170 inpatient and 82 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 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 April 3, 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
Inpatient				
Claims Paid in Excess of Charges	22	$383,494	2	$35,229
Short Stays	97	$415,571	5	$9,975
Same-Day Discharges and Readmissions	10	$139,345	2	$2,995
Claims Billed With High Severity Level Diagnosis-Related Group Codes	28	$893,235	1	$1,956
Claims With Payments Greater Than $150,000	3	$480,254	1	$485
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	4	$200,806	0	$0
Transfers	5	$110,290	0	$0
Acute Care Transfer to Another Acute Care	1	$34,149	0	$0
Inpatient Totals	**170**	**$2,657,144**	**11**	**$50,640**
Outpatient				
Manufacturer Credits for Replaced Medical Devices	4	$14,706	2	$6,638
Dental Services	8	$4,514	8	$4,514
Claims Paid in Excess of Charges	14	$92,807	1	$2,066
Claims Billed With Doxorubicin Hydrochloride	2	$7,082	1	$429
Claims Billed With Modifier -25	12	$84,156	3	$239
Claims With Payments Greater Than $25,000	31	$935,844	0	$0
Claims Billed With Modifier -74	9	$20,174	0	$0
Claims Billed With Observation Services That Resulted in Outlier Payments	2	$11,520	0	$0
Outpatient Totals	**82**	**$1,170,803**	**15**	**$13,886**
Inpatient and Outpatient Totals	**252**	**$3,827,947**	**26**	**$64,526**

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient 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

SANFORD HEALTH

August 26, 2013

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 East 12th Street Room 0429
Kansas City, MO 64106

Report Number: A-07-12-05031

Dear Mr. Cogley,

On behalf of Sanford Medical Center, I am providing comments to the report entitled *Medicare Compliance Review of Sanford Medical Center in Fargo for Calendar Years 2010 and 2011.*

Sanford Medical Center Fargo (Medical Center) strives to create a culture that promotes understanding and adherence to applicable federal, state and local laws and regulations. It commits substantial resources to support an effective compliance program with the goal of preventing, detecting and correcting identified issues. This includes the implementation of operational procedures and controls to minimize the risk of billing errors.

The Medical Center has reviewed the recommendations in the report and has responded as follows:

1) The amount of $64,526 which is identified as an overpayment in the report has been refunded through correction and resubmission of involved claims to our CMS contractor.

2) We appreciate the recognition of the strength of the Medical Center's controls to prevent incorrect billing which assured accurate billing in 226 out of 252 Medicare claims reviewed, however, note that errors did occur in 26 of the claims. To further enhance and strengthen the Medical Center's controls, we have taken the following steps:

   Education
   Human error accounted for 11 of the 26 billing errors noted. We have reviewed those errors with the individuals and departments involved with the purpose of avoiding recurrence.

   Medical Device Credit Process Enhancement (2)
   The process for assuring medical device credits are properly reflected on Medicare claims is complex. The Medical Center has strengthened their controls by identifying and assigning proper communication between departments to assure credits are accurately reflected and coded on claims.

Incorrectly billed as Separate Inpatient Stays (2)
The errors related to same day readmission resulted from a combination of human error and insufficient automation to identify readmissions. The Medical Center has strengthened controls by identifying and assigning proper communication between departments as well as implementing an automated notification of review in the new electronic medical record (EMR) system.

Incorrectly Billed Evaluation and Management Services (3)
The errors related to appropriately identifying claims needing the modifier 25 were due to human error and inappropriate automation. In response, the Medical Center has discontinued the automation process that required manual intervention to remove the modifier.

Services Not Billable to Medicare (8)
The errors related to the billing of Dental Services to Medicare were due to implementation of a new billing system. The Medical center has corrected the system to recognize the correct internal billing class for Dental services.

Sanford Medical Center takes its obligation to produce accurate bills for its services very seriously. As such we will continue to monitor and improve our documentation and billing processes. Thank you for the opportunity to review and comment on this report.

Sincerely,

FACHE

Dennis Millirons
President
Sanford Medical Center