



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



July 24, 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 Boston Medical Center for  
Calendar Years 2009 and 2010 (A-01-11-00530)

Attached, for your information, is an advance copy of our final report on our most recent hospital compliance review. We will issue this report to Boston Medical Center within 5 business days.

This report is 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](mailto:Brian.Ritchie@oig.hhs.gov), or your staff may contact Michael J. Armstrong, Regional Inspector General for Audit Services, at (617) 565-2684 or through email at [Michael.Armstrong@oig.hhs.gov](mailto:Michael.Armstrong@oig.hhs.gov).

Attachment

cc: Daniel Converse  
Office of Strategic Operations and Regulatory Affairs  
Centers for Medicare & Medicaid Services



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



OFFICE OF AUDIT SERVICES, REGION I  
JFK FEDERAL BUILDING  
15 NEW SUDBURY STREET, ROOM 2425  
BOSTON, MA 02203

July 26, 2012

Report Number: A-01-11-00530

Mr. Richard W. Silveria  
Senior Vice-President of Finance and Chief Financial Officer  
Boston Medical Center  
One Boston Medical Center Place  
Boston, MA 02118-2999

Dear Mr. Silveria:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Boston Medical Center for Calendar Years 2009 and 2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kimberly Rapoza, Audit Manager, at (617) 565-2695 or through email at [Kimberly.Rapoza@oig.hhs.gov](mailto:Kimberly.Rapoza@oig.hhs.gov). Please refer to report number A-01-11-00530 in all correspondence.

Sincerely,

/Michael J. Armstrong/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 East 12<sup>th</sup> Street, Room 235  
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF  
BOSTON MEDICAL CENTER FOR  
CALENDAR YEARS 2009 AND 2010**



Daniel R. Levinson  
Inspector General

July 2012  
A-01-11-00530

# ***Office of Inspector General***

<http://oig.hhs.gov>

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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.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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# *Notices*

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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.

Boston Medical Center (the Hospital) is a 508-bed acute care facility located in Boston Massachusetts. Medicare paid the Hospital approximately \$324 million for 17,312 inpatient and 439,484 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$5,005,544 in Medicare payments to the Hospital for 330 claims that we judgmentally selected as potentially at risk for billing errors. These 330 claims consisted of 199 inpatient and 131 outpatient claims. This report does not address audit results for 60 inpatient short stay claims, valued at \$671,442, that were originally selected for review because these claims require further evaluation by medical review personnel.

### **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 138 of the 270 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 132 claims, resulting in net overpayments totaling \$1,000,802 for CYs 2009 and 2010. Specifically, 87 inpatient claims had billing errors, resulting in net overpayments totaling \$818,518, and 45 outpatient claims had billing errors, resulting in net overpayments totaling \$182,284. 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 \$1,000,802, consisting of \$818,518 in overpayments for 87 incorrectly billed inpatient claims and \$182,284 in overpayments for 45 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **BOSTON MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the Hospital concurred with our findings and recommendations and stated that it has refunded the overpayments. We acknowledge the Hospital's efforts to implement stronger controls to ensure full compliance with Medicare requirements. The Hospital's comments are included in their entirety as the Appendix.

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# INTRODUCTION

## BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.<sup>1</sup>

### **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.<sup>2</sup> The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.<sup>3</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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<sup>1</sup> 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). This transition occurred between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For the purposes of this report, the term "Medicare contractor" means fiscal intermediary, carrier, or MAC, whichever is applicable.

<sup>2</sup> In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

<sup>3</sup> 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. Examples of these types of claims at risk for noncompliance included the following:

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level DRG codes,
- inpatient and outpatient claims paid in excess of charges,
- inpatient hospital-acquired conditions and present on admission indicator<sup>4</sup> reporting,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed for doxorubicin hydrochloride,
- outpatient claims billed for Lupron injections,
- outpatient claims billed with evaluation and management (E&M) services,
- outpatient claims billed with modifiers, and
- outpatient claims billed on the date of an inpatient admission.

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.”

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

## **Medicare Requirements for Hospital Claims and Payments**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” In addition, section 1833(e) of the

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<sup>4</sup> “Present on admission” refers to diagnoses that are present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter—including during emergency department, observation, or outpatient surgery—are also considered present on admission. Acute care hospitals are required to complete the present on admission indicator field on the Medicare inpatient claim for every diagnosis billed.

Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

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.

### **Boston Medical Center**

Boston Medical Center (the Hospital) is a 508-bed acute care hospital located in Boston, Massachusetts. Medicare paid the Hospital approximately \$324 million for 17,312 inpatient and 439,484 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

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

### **Scope**

Our audit covered \$5,005,544 in Medicare payments to the Hospital for 330 claims that we judgmentally selected as potentially at risk for billing errors. These 330 claims consisted of 199 inpatient and 131 outpatient claims. Of these 330 claims, 324 had dates of service in CYs 2009 and 2010. Six of the 330 claims (involving replacement medical devices) had dates of service in CY 2008.

This report does not address audit results for 60 inpatient short stay claims, valued at \$671,442, that were originally selected for review because these claims require further evaluation by medical review personnel. Therefore, we based our review upon a reduced sample of 270 claims, covering \$4,334,103 in Medicare payments to the Hospital.

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 and subjected only a limited number of claims to 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. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital during October 2011 through February 2012.

## **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;
- obtained information on known credits for replacement cardiac medical devices from selected device manufacturers for CYs 2008 through 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 330 claims (199 inpatient and 131 outpatient) for detailed review and subsequently removed 60 inpatient short stay claims, valued at \$671,442, for further evaluation by medical review personnel;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- utilized Medicare contractor medical review staff to determine whether a limited selection of sampled claims met medical necessity requirements;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;

- requested that the Medicare contractor provide an educational session in the form of a webinar to the Hospital addressing the Medicare requirements for inpatient, outpatient, and observation status;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Hospital officials.

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

## **FINDINGS AND RECOMMENDATIONS**

The Hospital complied with Medicare billing requirements for 138 of the 270 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 132 claims, resulting in net overpayments totaling \$1,000,802 for CYs 2009 and 2010. Specifically, 87 inpatient claims had billing errors, resulting in net overpayments totaling \$818,518, and 45 outpatient claims had billing errors, resulting in net overpayments totaling \$182,284. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements.

### **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 87 of the 139 sampled inpatient claims that we reviewed. These errors resulted in net overpayments totaling \$818,518.

#### **Inpatient Short Stays**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

For all of the 46 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital stated that its case management protocol did not always include coverage for weekends and evening shifts. As a result of these errors, the Hospital received overpayments totaling \$344,170.<sup>5</sup>

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<sup>5</sup> The Hospital may bill Medicare Part B for a limited range of services related to some of these 46 incorrect Medicare Part A short-stay claims. 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 MAC prior to the issuance of our report.

## **Inpatient Same-Day Discharges and Readmissions**

The Manual, chapter 3, section 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 15 of the 17 sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that these errors occurred because clinicians did not always review suspended or flagged claims in the Hospital's case management system to determine whether the stays were related. As a result of these errors, the Hospital received net overpayments totaling \$179,387.

## **Inpatient Claims Billed With High Severity Level Diagnosis-Related Group Codes**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." In addition, 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 11 of the 34 sampled claims, the Hospital billed Medicare for incorrect DRG codes (8 errors) or for beneficiary stays that should have been billed as outpatient or outpatient with observation (3 errors). The Hospital stated these errors primarily occurred due to significant turnover of its vendor coding staff. As a result of these errors, the Hospital received net overpayments totaling \$66,424.

## **Inpatient Claims Paid in Excess of Charges**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." In addition, 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 10 of the 22 sampled claims, the Hospital either billed Medicare for incorrect DRG codes (9 errors) or billed Medicare separately for a related discharge and readmission (1 error). The Hospital stated these errors primarily occurred due to significant turnover of its vendor coding staff. As a result of these errors, the Hospital received overpayments totaling \$204,926.

## **Inpatient Hospital-Acquired Conditions and Present on Admission Indicator Reporting**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury

or to improve the functioning of a malformed body member.” In addition, 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 all of the 10 sampled claims, the hospital correctly billed the present on admission indicators; however, the Hospital billed Medicare for incorrect DRG codes on 2 of these claims. The Hospital stated these errors primarily occurred due to significant turnover of its contracted outside vendor coding staff. As a result of these errors, the Hospital received net overpayments totaling \$3,755.

### **Inpatient Manufacturer Credits for Replaced Medical Devices**

Federal regulations (42 CFR § 412.89) 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 cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device. The Manual, chapter 3, section 100.8, states that to correctly bill 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.”

For 3 of 10 sampled claims, the Hospital received a reportable medical device credit for a replaced device from a manufacturer but did not adjust its inpatient claims with the proper value and condition codes to reduce payment as required. The Hospital stated these errors occurred because the Hospital’s clinical departments did not always use the unique transaction codes created to notify the finance department that a credit was requested or because the flagged accounts were not linked to the billing system. As a result of these errors, the Hospital received overpayments totaling \$19,856.

### **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 45 of the 131 sampled outpatient claims that we reviewed. These errors resulted in net overpayments totaling \$182,284.

#### **Outpatient Billing for Lupron Injections**

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. The Local Coverage Determination (LCD) for Luteinizing Hormone Releasing Analogs (Lupron) (effective November 14, 2008, March 1, 2009, and June 5, 2009) states that HCPCS code J1950 is indicated for the treatment of endometriosis, uterine leiomyomas, and malignant neoplasms of the breast. HCPCS code J9217 is indicated for treatment of numerous types of cancers, including malignant neoplasms of the prostate and lung.

For 3 of the 9 sampled claims, the Hospital billed Medicare with an incorrect HCPCS code for injections of Lupron provided to male beneficiaries whose diagnoses did not support the medical

necessity of the HCPCS code billed based on the coverage requirements of the LCD. Specifically, the Hospital used HCPCS code J1950 for its male patients with a diagnosis of prostate or lung cancer rather than billing the correct HCPCS code J9217. The Hospital stated these errors occurred because it did not have adequate prebilling edits to ensure that HCPCS codes for injections of Lupron were assigned based on the beneficiary's supporting diagnosis. As a result of these errors, the Hospital received overpayments totaling \$5,282.

### **Outpatient Claims Billed With Evaluation and Management Services**

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. In addition, the Manual, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

For 8 of the 22 sampled claims, the Hospital incorrectly billed Medicare for E&M services that were part of the usual preoperative and postoperative care associated with the procedure. All of these incorrectly billed E&M services were associated with a cystoscopy procedure. The Hospital attributed the errors to a single Hospital department that did not fully understand the Medicare billing requirements for E&M services. As a result of these errors, the Hospital received overpayments totaling \$503.

### **Outpatient Claims Billed With Modifiers**

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. In addition, the Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

The Manual, 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)." Section 20.9.1.1 also states: "The '-91' modifier is used to indicate a repeat laboratory procedural service on the same day to obtain subsequent reportable test values. The physician may need to indicate that a procedure or service was distinct or separate from other lab services performed on the same day."

For 18 of the 25 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that were included in payments for other services billed on the same claim (8 errors), did not require modifier -59 or -91 (8 errors), contained incorrect HCPCS codes (8 errors), or for services that were insufficiently documented in the medical records (4 errors). Several of the claims billed in error contained more than one type of error. The Hospital stated the errors occurred due to the need for an enhanced internal review and audit process. As a result of these errors, the Hospital received net overpayments totaling \$8,106.

## **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. Additionally, 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. Chapter 4, section 20.4, states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

The Manual, 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 11 of the 26 sampled claims, the Hospital submitted claims to Medicare with incorrect units of service for the drug baclofen (9 errors), an incorrect HCPCS code (1 error), or with a HCPCS code that was missing modifier -59 (1 error). The Hospital stated that these errors primarily occurred because the unit standard for the drug baclofen was incorrectly set up in the pharmacy system. As a result of these errors, the Hospital received net overpayments totaling \$119,182.

## **Outpatient Manufacturer Credits for Replaced Medical Devices**

Federal regulations (42 CFR § 419.45) 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.

CMS guidance in Transmittal 1103, dated November 3, 2006, and in the Manual explains how a provider should report no-cost and reduced-cost devices under the OPPS. 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.

For 5 of the 11 sampled claims, the Hospital received full credit for a replaced device but did not report the “FB” modifier or reduced charges on its claim. The Hospital stated that these overpayments occurred because the clinical departments did not always use the unique transaction codes created to notify the finance department that a credit was requested or because the flagged accounts were not linked to the billing system. As a result of these errors, the Hospital received overpayments totaling \$49,211.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$1,000,802, consisting of \$818,518 in overpayments for 87 incorrectly billed inpatient claims and \$182,284 in overpayments for 45 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **OTHER MATTERS**

We identified 25 outpatient claims for services provided at provider-based federally qualified health centers (FQHC) on the date of the beneficiaries' inpatient admissions to the Hospital. These services were billed separately to Medicare Part B under the Hospital's provider number and paid under the OPSS. The Hospital stated that these outpatient services should not be included on the inpatient bills because (1) Federal regulations exclude services provided at a provider-based FQHC from this billing requirement and (2) the Hospital does not wholly own or wholly control the FQHCs. Accordingly, we will forward these claims to CMS for further clarification as to whether these outpatient services should have been included on the Hospital's inpatient (Part A) bills to Medicare.

## **BOSTON MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the Hospital concurred with our findings and recommendations and stated that it has refunded the overpayments. We acknowledge the Hospital's efforts to implement stronger controls to ensure full compliance with Medicare requirements. The Hospital's comments are included in their entirety as the Appendix.

# **APPENDIX**



EXCEPTIONAL CARE. WITHOUT EXCEPTION.

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June 29, 2012

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

Report Number: A-01-1-00530

Dear Mr. Armstrong:

Boston Medical Center (the "Hospital") appreciates the opportunity to comment on the Government's report. The Hospital reaffirms its commitment to comply with all regulations and standards governing federal health care programs. On a continual basis, it agrees to strengthen controls to ensure full compliance with all requirements.

The Hospital's responses to the Government's specific recommendations are set forth below. Except as otherwise stated, the Hospital accepts the Government's findings and has reprocessed the claims to the Medicare Administrative Contractor.

**Inpatient Short Stays.** The Hospital agrees to resolve the 46 identified claims under a reservation of rights and has returned the claim payments. As part of its demonstration to comply with all standards, the Hospital has assigned case managers to assist the Emergency Department physicians on a daily (7 days a week) basis. It has also instituted processes to ensure that all inpatient cases billable to the Medicare program undergo validation of the assigned level of care and to ensure that the physician orders support the intended level of care in each case. The Hospital has also availed itself of educational opportunities on the Government's expectations with respect to inpatient short stays.

**Inpatient Same-Day Discharges and Readmissions.** The Hospital established a new process for identifying and suspending claims that may trigger inpatient same-day discharge and readmission criteria.

**Inpatient Claims Billed with High Severity Level Diagnosis-Related Group Codes; Inpatient Claims Paid In Excess of Charges; Inpatient Hospital-Acquired Conditions and Present on Admission Indicator Reporting.** The Hospital has undertaken significant steps to improve the quality of its coding processes, including enhancing its coding

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management infrastructure, strengthening education and quality standards, establishing a clinical documentation improvement program, and reducing reliance on outsourced staff.

**Inpatient Manufacturer Credits for Medical Devices.** The Hospital introduced a new billing process to capture claims related to devices. It also asks that vendors who provide products identified as having an enhanced probability of generating warranty credits give the Hospital monthly reports. The Hospital will use these reports to verify that it has appropriately applied manufacturer credits and to ensure proper submission of Medicare claims.

**Outpatient Billing for Lupron Injections.** The Hospital has taken corrective measures, including use of pre-billing edits. It has also enhanced the communication and coordination between the Pharmacy Department and Revenue Integrity to ensure proper billing.

**Outpatient Claims Billed with Evaluation and Management Services.** The Hospital enhanced its internal review and audit processes. In addition, it provided education and training to the Hospital department identified in the Government's report.

**Outpatient Claims Billed with Modifiers.** The Hospital enhanced its internal review and audit processes. These processes include assessing and providing, as necessary, education and training to Hospital departments.

**Outpatient Claims Paid In Excess of Charges.** The Hospital made system corrections to address the underlying reason identified as the cause of this group of claims. The Hospital continues to validate that the system corrections are properly processing claims.

**Outpatient Manufacturer Credits for Medical Devices.** The Hospital introduced a new billing process to capture claims related to devices. It also asks that vendors who provide products identified as having an enhanced probability of generating warranty credits give the Hospital monthly reports. The Hospital will use these reports to verify that it has appropriately applied manufacturer credits and to ensure proper submission of Medicare claims.

**3-Day DRG Window.** The Hospital states that the 3-Day DRG Window rule does not apply to outpatient claims originating at the four federally qualified health centers on its hospital license (FQHCs) because (1) the FQHCs qualify for provider-based status under 42 C.F.R. 413.65(n) and therefore do not need to qualify for status under 42 C.F.R. 413.65(g), which imposes compliance with the 3-Day DRG Window as a condition for qualification, and (2) the Hospital does not wholly own or wholly control the FQHCs, which are the only other instances when the 3-Day DRG Window applies to a provider-based entity.

**Response to Recommendations.** The Hospital has refunded overpayments the Government identified to the Medicare contractor. It also agrees to strengthen its controls to ensure full compliance with Medicare requirements.

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

Sincerely,

*/ Richard W. Silveria /*

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