

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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Office of Inspector General

<http://oig.hhs.gov>

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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.

Maine Medical Center (the Hospital) is a 637-bed acute care facility located in Portland, Maine. Medicare paid the Hospital approximately \$340 million for 23,690 inpatient and 127,833 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 \$2,675,038 in Medicare payments to the Hospital for 293 claims that we judgmentally selected as potentially at risk for billing errors. These 293 claims consisted of 188 inpatient and 105 outpatient claims.

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

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 114 of the 293 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 179 claims, resulting in net overpayments totaling \$589,705 for CYs 2008 through 2010. Specifically, 112 inpatient claims had billing errors, resulting in net overpayments totaling \$387,904, and 67 outpatient claims had billing errors, resulting in net overpayments totaling \$201,801. 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 within the selected areas of risk.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$589,705, consisting of \$387,904 in overpayments for 112 incorrectly billed inpatient claims and \$201,801 in overpayment for 67 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

MAINE MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations and stated that it has taken steps to strengthen 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.¹

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.² The OPPS 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.³ All services and items within an APC group are comparable clinically and require comparable resources.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC). 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.

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

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

Hospital Payments at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. Examples of these types of claims at risk for noncompliance included the following:

- inpatient short stays,
- inpatient transfers,
- inpatient claims billed with high severity level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient and outpatient claims paid in excess of charges,
- inpatient psychiatric facility (IPF) emergency department adjustments,
- inpatient hospital-acquired conditions and present on admission indicator reporting,⁴
- outpatient billing for dental services,
- outpatient intensity modulated radiation therapy (IMRT) planning services,
- outpatient claims billed with modifiers,
- outpatient claims billed during inpatient stays,
- outpatient claims billed with evaluation and management (E&M) services, and
- outpatient claims billed for doxorubicin hydrochloride.

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.

⁴ “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.

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

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

Maine Medical Center

Maine Medical Center (the Hospital) is a 637-bed acute care hospital located in Portland, Maine. Medicare paid the Hospital approximately \$340 million for 23,690 inpatient and 127,833 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 \$2,675,038 in Medicare payments to the Hospital for 293 claims that we judgmentally selected as potentially at risk for billing errors. These 293 claims consisted of 188 inpatient and 105 outpatient claims. Of these 293 claims, 285 had dates of service in CYs 2009 and 2010. Eight of the 293 claims (involving replacement medical devices) had dates of service in CY 2008.

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 January and 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 the 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 293 claims (188 inpatient and 105 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation 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;
- used CMS's 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;
- 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 114 of the 293 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 179 claims, resulting in net overpayments totaling \$589,705 for CYs 2008 through 2010. Specifically, 112 inpatient claims had billing errors, resulting in net overpayments totaling \$387,904, and 67 outpatient claims had billing errors, resulting in net overpayments totaling \$201,801. 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 within the selected areas of risk.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 112 of the 188 sampled inpatient claims that we reviewed. These errors resulted in net overpayments totaling \$387,904.

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.” 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 52 of the 77 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services (50 errors) or billed for incorrect diagnosis codes that resulted in a DRG code change (2 errors). The Hospital attributed the errors to inadequate controls over case management and utilization review for monitoring short stays. In addition, the Hospital attributed the incorrect DRG coding to human error. As a result of these errors, the Hospital received net overpayments totaling \$189,824.⁵

⁵ The Hospital may bill Medicare Part B for a limited range of services related to some of the incorrect Medicare Part A 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 Transfers

Section 1862(a)(1)(A) of the Act states that no Medicare payment may 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.” Federal regulations (42 CFR § 412.4(c)) state that a discharge of a hospital inpatient is considered to be a transfer when the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to a skilled nursing facility or to home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge. A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient’s stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For all 17 sampled claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers (16 errors) or for a beneficiary stay that should have been billed as outpatient or outpatient with observation services (1 error). For these claims, the Hospital should have coded the discharge status either as a transfer to a skilled nursing facility or to home under a written plan of care for the provision of home health services. However, the Hospital incorrectly coded the discharge status to home or left against medical advice; thus, the Hospital should have received the per diem payment instead of the full DRG. The Hospital stated the errors occurred because its clinical staff did not always communicate changes in the discharge status to the Hospital’s coding staff and because coders did not always review discharge plans prior to assigning a discharge status code. As a result of these errors, the Hospital received overpayments totaling \$125,594.⁶

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.” Chapter 25, section 75.2, lists and defines patient discharge status codes.

For 15 of the 40 sampled claims, the Hospital assigned an incorrect patient discharge status code (10 errors), incorrectly billed Medicare for beneficiary stays that should have been billed as outpatient or outpatient with observation (4 errors), or billed for an incorrect DRG code (1 error). The Hospital stated the errors primarily occurred because the correct patient discharge status codes were not always available in its billing software or due to inadequate controls over case management and utilization review. As a result of these errors, the Hospital received overpayments totaling \$38,527.⁷

⁶ See footnote 5.

⁷ See footnote 5.

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 use the combination of condition code 49 or 50, along with value code “FD.”

For 7 of the 15 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 attributed these errors to personnel changes and miscommunication between different departments coordinating device credits. As a result, the Hospital received overpayments totaling \$18,388.

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 1 of the 11 sampled claims, the Hospital billed Medicare for an incorrect DRG code. The Hospital attributed this to human error. As a result, the Hospital received an overpayment of \$14,190.

Inpatient Psychiatric Facility Emergency Department Adjustments

Pursuant to 42 CFR § 412.424, 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. 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.

The Manual, chapter 3, section 190.6.4.1, states that source-of-admission code “D” is reported by an IPF to identify patients who have been transferred to the IPF from the same hospital. The IPF’s proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For all 18 sampled 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 stated the errors occurred because its internal computerized selection list of admission source codes did not include admission source “D.” As a result of these errors, the Hospital received overpayments totaling \$1,381.

Inpatient Hospital-Acquired Conditions and Present on Admission Indicator Reporting

For inpatient discharges on or after October 1, 2007, CMS requires hospitals to report a present on admission indicator for every diagnosis on an inpatient acute care hospital claim (CMS Transmittal 289, July 20, 2007). 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 2 of the 10 sampled claims, the Hospital incorrectly reported that a secondary diagnosis was present on admission. The Hospital attributed the incorrect billing to human error. There was no incorrect payment because of this error.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 67 of the 105 sampled outpatient claims that we reviewed. These errors resulted in net overpayments totaling \$201,801.

Outpatient Manufacturer Credits for Replaced Medical Devices

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.”

Federal regulations (42 CFR § 419.45) require a reduction in the OPSS 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.

Billing Requirements for Medical Device Credits

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPSS. 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.

Prudent Buyer Principle

Pursuant to 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services” The CMS *Provider Reimbursement Manual*, part I, section 2102.1, states:

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

Section 2103 of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example:

Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.

For 10 of the 15 sampled claims, the Hospital received full credit for replaced devices but did not properly report the “FB” modifier or reduced charges on the claims (8 errors) or did not obtain credits for replaced devices that were available under the terms of the manufacturers’ warranties (2 errors). Additionally, four of these claims contained services that were insufficiently documented in the medical record. The Hospital attributed these errors to personnel changes and miscommunication between different departments coordinating device credits. As a result of these errors, the Hospital received net overpayments totaling \$159,044.

Outpatient Billing for Dental Services

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 10 of the 11 sampled claims, the Hospital incorrectly billed Medicare for the treatment or removal of teeth. The Hospital stated the errors occurred because its computer software was programmed incorrectly during the transition to a new software program. As a result of these errors, the Hospital received overpayments totaling \$32,952.

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

For 17 of the 25 sampled claims, the Hospital incorrectly billed Medicare with the following types of errors:

- HCPCS codes with modifier -59 where the services were already included in the payments for other services billed on the same claim (14 errors),
- services that were insufficiently documented in the medical record (2 errors),
- incorrect HCPCS codes for the type of service provided (1 error), and
- incorrect units of service (1 error).

One of these claims contained more than one type of error. The Hospital attributed these errors to the use of clinical interpretations to determine whether a modifier was appropriate instead of certified coding interpretations. As a result of these errors, the Hospital received overpayments totaling \$7,677.

Outpatient Intensity Modulated Radiation Therapy Planning Services

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, section 200.3.2, requires that certain services should not be billed when they are performed as part of developing an IMRT plan.

For all 15 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that were already included in the payment for other services billed on the same claim. These services were performed as part of developing an IMRT plan and should not have been billed in addition to the HCPCS code for IMRT planning. The Hospital stated that the oncology department was not aware of the IMRT billing requirements and the billing system did not include a review of IMRT planning codes. As a result of these errors, the Hospital received overpayments totaling \$1,469.

Outpatient Claims Billed During Inpatient Stays

According to the Manual chapter 3, section 10.4, certain items and nonphysician services furnished to inpatients are covered under Part A and consequently are covered by the inpatient prospective payment rate.

For all six sampled claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays that should have been included on the Hospital’s inpatient (Part A) bills to Medicare. The Hospital stated the errors occurred because its billing software was not

programmed to identify all outpatient services provided during inpatient stays. As a result, the Hospital received overpayments totaling \$353.

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, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” Chapter 12, section 30.6.6(B), states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure.

For 9 of the 15 sampled claims, the Hospital incorrectly billed Medicare with the following types of errors:

- E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedures (4 errors),
- incorrect HCPCS codes for the level of E&M services provided (3 errors),
- incorrect number of units of drugs administered (2 errors), and
- vaccine services either billed with an incorrect HCPCS code or not performed (2 errors).

Two of these claims contained more than one type of error. The Hospital attributed the incorrect billing to human error and stated that its coding staff did not always understand the billing requirements for E&M services. As a result of these errors, the Hospital received net overpayments totaling \$306.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$589,705, consisting of \$387,904 in overpayments for 112 incorrectly billed inpatient claims and \$201,801 in overpayments for 67 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

MAINE MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations and stated that it has taken steps to strengthen controls to ensure full compliance with Medicare requirements. The Hospital’s comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: MAINE MEDICAL CENTER COMMENTS



August 24, 2012

DHHS, Office of Inspector General
Office of Audit Services, Region 1
JFK Federal Building
15 New Sudbury Street, Room 2425
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Attn: Michael J. Armstrong, CPA
Regional Inspector General for Audit Services

RE: Report No. A-O1-11-00535 *Medicare Compliance Review of Maine Medical Center for Calendar Years 2009 and 2010.*

On behalf of Maine Medical Center, I am providing comments to the report entitled *Medicare Compliance Review of Maine Medical Center for Calendar Years 2009 and 2010.*

Maine Medical Center is committed to continued compliance with Medicare program regulations. Based on the results of this review, we have completed corrective actions necessary to improve procedures and controls to address the errors identified.

As noted in the draft report, the Office of Inspector General (OIG) reviewed 293 inpatient and outpatient claims that were judgmentally selected as potentially at risk for billing errors. These 293 claims consisted of 188 inpatient and 105 outpatient claims that were determined to be at risk for non-compliance and covered \$2,675,038 in Medicare payments to Maine Medical Center.

Maine Medical Center concurs with the OIG's recommendations noted below:

1. Refund to Medicare contractor \$589,705 consisting of \$387,904 in overpayments for 112 incorrectly billed inpatient claims and \$201,801 in overpayments for 67 incorrectly billed outpatient claims, and
2. Strengthen controls to ensure full compliance with Medicare requirements.

Our responses to the OIG's findings and recommendations are as follows:

1. Maine Medical Center will refund to the Medicare contractor overpayments of \$589,705. The refund of \$589,705 will be completed through the OIG's recommended claims adjustment process after the final report has been issued.

2. Maine Medical Center has taken steps to strengthen controls to ensure full compliance with Medicare requirements. Maine Medical Center will conduct appraisals of various systems by regularly monitoring and auditing internal controls. In addition, Maine Medical Center will continue to conduct coding and compliance education on a routine basis. In order to strengthen these efforts and to address the issues raised by the OIG's findings, we have implemented several measures, including the following:
 - a. Maine Medical Center redesigned and implemented a more comprehensive utilization review approach. Maine Medical Center is assigning case managers with specific responsibility for reviewing Medicare patients being evaluated for admission, working with physicians on level-of-care and admission status determinations and assessing the completeness of documentation supporting admissions using accepted medical management criteria. In addition to the redesign, physician education was completed to promote understanding and support of the utilization review activities;
 - b. Simplified, clarified, and streamlined processes for documentation and communication regarding admission status and coding;
 - c. Provided additional coding education, training and monitoring, including implementation of peer reviews to validate proficiency;
 - d. Developed a "fail safe" work flow to ensure device credits are applied and reported appropriately; and
 - e. Conducted applicable system reviews and updates of billing software to ensure data accuracy.

Thank you for the opportunity to respond to this report.

Sincerely,

/Richard W. Petersen/

Richard W. Petersen, FACHE
President and Chief Executive Officer