

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW
OF MORTON HOSPITAL
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.*



David Lamir
Regional Inspector General

January 2014
A-01-13-00500

Office of Inspector General

<https://oig.hhs.gov>

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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

Morton Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of \$548,000 over 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 are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 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 Morton Hospital (Morton) 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 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. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Morton, which is part of the Steward Health Care System, is a 154-bed acute care hospital located in Taunton, Massachusetts. Medicare paid Morton approximately \$79 million for 7,904 inpatient and 134,975 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$1,480,529 in Medicare payments to Morton for 221 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 194 inpatient and 27 outpatient claims. Of these 221 claims, 219 had dates of service in CYs 2010 or 2011, and 2 claims (involving outpatient drugs) had dates of service in CY 2009.

WHAT WE FOUND

Morton complied with Medicare billing requirements for 43 of the 221 inpatient and outpatient claims we reviewed. However, Morton did not fully comply with Medicare billing requirements for the remaining 178 claims, resulting in overpayments of \$548,451 for CYs 2010 and 2011 (176 claims) and CY 2009 (2 claims). Specifically, 155 inpatient claims had billing errors, resulting in overpayments of \$516,760, and 23 outpatient claims had billing errors, resulting in overpayments of \$31,691. These errors occurred primarily because Morton 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 Morton:

- refund to the Medicare contractor \$548,451 consisting of \$516,760 in overpayments for 155 incorrectly billed inpatient claims and \$31,691 in overpayments for 23 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

MORTON HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, Morton concurred with most of our findings and recommendations. However, Morton disagreed that it incorrectly billed 12 claims as inpatient and stated that it intends to appeal the claims at issue. We maintain these claims did not comply with Medicare billing requirements.

Morton also stated that it has developed corrective action plans to address the identified errors. We acknowledge Morton's efforts to implement stronger 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 are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 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 Morton Hospital (Morton) 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. 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.

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.

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

Hospital Claims at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient manufacturer credits for replaced medical devices,
- inpatient transfers,
- inpatient same-day discharges and readmissions,
- inpatient psychiatric facility (IPF) emergency department adjustments,
- inpatient claims paid greater than charges,
- outpatient drugs,
- outpatient claims billed during inpatient stays,
- outpatient claims billed with modifiers, and
- outpatient dental services.

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

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items 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 Social Security Act (the Act), section 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 (section 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 section 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, section 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, section 20.3).

Morton Hospital

Morton, which is part of the Steward Health Care System, is a 154-bed acute care hospital located in Taunton, Massachusetts. Medicare paid Morton approximately \$79 million for 7,904 inpatient and 134,975 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 \$1,480,529 in Medicare payments to Morton for 221 claims that we judgmentally selected as potentially at risk for billing errors. These 221 claims consisted of 194 inpatient and 27 outpatient claims. Of these 221 claims, 219 had dates of service in CYs 2010 or 2011, and 2 claims (involving outpatient drugs) had dates of service in CY 2009.² We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 21 claims to focused 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 Morton 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.

Appendix A contains the details of our scope and methodology.

FINDINGS

Morton complied with Medicare billing requirements for 43 of the 221 inpatient and outpatient claims we reviewed. However, Morton did not fully comply with Medicare billing requirements for the remaining 178 claims, resulting in overpayments of \$548,451 for CYs 2010 and 2011 (176 claims) and CY 2009 (2 claims). Specifically, 155 inpatient claims had billing errors, resulting in overpayments of \$516,760 and 23 outpatient claims had billing errors, resulting in overpayments of \$31,691. These errors occurred primarily because Morton 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

Morton incorrectly billed Medicare for 155 of 194 selected inpatient claims, which resulted in overpayments of \$516,760.

² We selected these two claims for review because they were brought to our attention through another OIG analysis of high-risk outpatient drugs. We did not include these claims in the scope of the other audit.

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, section 1862(a)(1)(A)).

For 101 of the 194 selected claims, Morton incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Morton officials stated that the errors occurred primarily because Morton relied on an outside consultant to review these claims and because Morton did not have enough staff to review all patients’ stays on a consistent and timely basis. Additionally, for some cases, Morton relied on an evidence-based clinical decision support tool to answer critical questions about the appropriate level of care. As a result of these errors, Morton received overpayments of \$475,499.³

Incorrect Discharge Status

Hospitals must bill inpatient discharges as transfers when (1) the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge (42 CFR section 412.4(b)). A hospital that transfers an inpatient under the above circumstance 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 section 412.4(f)).

For 2 of the 194 selected claims, Morton incorrectly billed Medicare for patient discharges that were transfers to other hospitals. For these claims, Morton coded the discharge status as “left against medical advice” based upon the highest level of care known at the time of discharge and its plan for the patient. However, our audit found that the patients were actually admitted to other acute care hospitals on the same day. Therefore, Morton should receive a per diem payment instead of the full DRG payment when the claims are billed correctly. Morton officials stated that the errors occurred primarily because the patients left against medical advice and Morton staff did not know until our audit that the patients entered other facilities. As a result of these errors, Morton received overpayments of \$24,926.

Incorrectly Billed as Separate Inpatient Stays

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

³ Morton may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor prior to the issuance of our report.

prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 2 of the 194 selected claims, Morton billed Medicare separately for related discharges and readmissions within the same day. Morton officials attributed the errors to human error. As a result of these errors, Morton received overpayments of \$11,441.

Incorrect Source-of-Admission Code

CMS adjusts the Federal per diem rate upward for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department (42 CFR section 412.424). The Manual states that CMS makes this additional payment regardless of whether the beneficiary used emergency department services; however, the IPF should not receive the additional payment if the beneficiary was discharged from the acute care section of the same hospital (chapter 3, section 190.6.4). The Manual also states that IPFs report source-of-admission code "D" to identify patients who have been transferred to the IPF from the same hospital (chapter 3, section 190.6.4.1). An IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 50 of the 194 selected claims, Morton incorrectly coded the source-of-admission for beneficiaries who were admitted to its IPF upon discharge from its acute care section. Morton officials stated that the errors occurred because of an interface problem between the medical record software and the billing software. Additionally, Morton's coding staff did not fully understand the importance of selecting an accurate source-of-admission code. As a result of these errors, Morton received overpayments of \$4,894.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Morton incorrectly billed Medicare for 23 of 27 selected outpatient claims, which resulted in overpayments of \$31,691.

Incorrectly Billed Number of Units

The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, section 80.3.2.2). It also states: "The definition of service units ... is the number of times the service or procedure being reported was performed ..." (chapter 4, section 20.4).

For 2 of the 27 selected claims, Morton submitted a claim to Medicare with an incorrect number of units. Both claims had dates of service in CY 2009. Morton officials stated that these errors occurred due to human error. As a result of these errors, Morton received overpayments of \$12,743.

Incorrectly Billed Outpatient Services Provided During an Inpatient Stay

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

For 13 of the 27 selected claims, Morton incorrectly billed Medicare Part B for outpatient services provided during an inpatient stay that should have been included on its inpatient (Part A) bills to Medicare. Morton officials stated that these errors occurred primarily because billing staff did not fully understand Morton's internal report of outpatient services provided during an inpatient stay. As a result of these errors, Morton received overpayments of \$9,710.

Incorrectly Billed Outpatient Services With Modifier -59

The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, section 80.3.2.2). It also 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 23, section 20.9.1.1).

For 6 of the 27 selected claims, Morton incorrectly billed Medicare for HCPCS codes with modifier -59 for services that were already included in the payments for other services billed on the same claim. Morton officials stated that these errors occurred because coding staff relied on recommendations in the coding software and did not verify that the medical record supported the use of modifier -59. As a result of these errors, Morton received overpayments of \$5,978.

Incorrect Billing for Noncovered Dental Services

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 ..." (section 1862(a)(12)).

For 2 of the 27 selected claims, Morton incorrectly billed Medicare for the treatment or removal of teeth. Morton officials stated that the errors occurred because the billing software did not contain an edit to identify noncovered dental services; therefore, Morton did not review these services prior to billing. As a result of these errors, Morton received overpayments of \$3,260.

RECOMMENDATIONS

We recommend that Morton:

- refund to the Medicare contractor \$548,451, consisting of \$516,760 in overpayments for 155 incorrectly billed inpatient claims and \$31,691 in overpayments for 23 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

MORTON HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, Morton concurred with most of our findings and recommendations. However, Morton disagreed that it incorrectly billed 12 claims as inpatient and stated that it intends to appeal the claims at issue. We maintain these claims did not comply with Medicare billing requirements.

Morton also stated that it has developed corrective action plans to address the identified errors. We acknowledge Morton's efforts to implement stronger controls. Morton's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$1,480,529 in Medicare payments to Morton for 221 claims that we judgmentally selected as potentially at risk for billing errors. These 221 claims consisted of 194 inpatient and 27 outpatient claims. Of these 221 claims, 219 had dates of service in CYs 2010 or 2011, and 2 claims (involving outpatient drugs) had dates of service in CY 2009 (see footnote 2).

We focused our review on the risk areas that we had identified as a result of prior Office of Inspector General reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 21 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of Morton'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 Morton for Medicare reimbursement.

Our fieldwork included contacting Morton in Taunton, Massachusetts during January through July 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Morton's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2010 and 2011, and for CY 2009 (two claims);
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2010 and 2011;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 221 claims (194 inpatient and 27 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 itemized bills and medical record documentation provided by Morton to support the selected claims;
- requested that Morton conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed Morton’s procedures for submitting Medicare claims;
- used an independent medical review contractor to determine whether 21 selected claims met medical necessity requirements;
- discussed the incorrectly billed claims with Morton 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 Morton 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 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				
Short Stays	97	\$445,198	88	\$384,352
Claims Billed With High Severity Level Diagnosis-Related Group Codes	34	239,900	10	54,478
Manufacturer Credits for Replaced Medical Devices	2	25,733	2	25,733
Transfers	2	37,506	2	24,926
Same-Day Discharges and Readmissions	4	58,534	3	22,377
Psychiatric Facility Emergency Department Adjustments	50	499,762	50	4,894
Claims Paid Greater Than Charges	5	96,965	0	0
Inpatient Totals	194	\$1,403,598	155	\$516,760
Outpatient				
Drugs	2	\$18,958	2	\$12,743
Claims Billed During Inpatient Stays	13	9,710	13	9,710
Claims Billed With Modifiers	10	45,003	6	5,978
Dental Services	2	3,260	2	3,260
Outpatient Totals	27	\$76,931	23	\$31,691
Inpatient and Outpatient Totals	221	\$1,480,529	178	\$548,451

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 Morton. 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.

Morton Hospital
A STEWARD FAMILY HOSPITAL



November 19, 2013

Mr. David Lamir
Regional Inspector General for Audit Services
Office of Audit Services, Region 1
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

RE: Audit Report A-01-13-00500, Medicare Compliance Review of Morton Hospital for Calendar Years 2010 and 2011

Dear Mr. Lamir:

Morton Hospital, a Steward Family Hospital, Inc. ("Morton Hospital" or the "Hospital") has received and reviewed the October 23, 2013 draft report provided by the Department of Health and Human Services, Office of the Inspector General (OIG) entitled "Medicare Compliance Review Morton Hospital for Calendar Years 2010 and 2011" (the "Report").¹

The Hospital understands the important role of the OIG to protect the integrity of the health and welfare of beneficiaries served by the programs of the Department of Health and Human Services (HHS). We are committed to compliance with all applicable laws and regulations and welcome the opportunity to provide comment to this draft report.

The following represents a summary of corrective actions already initiated by Morton Hospital for each identified error category:

Inpatient Incorrectly Billed as Inpatient (Short Stays)

The OIG determined that 101 inpatient claims should have been billed as outpatient or observation services. Of the 101 claims from the OIG's judgmentally selected sample, the Hospital agrees that 89 likely do not meet the current standards of review utilized by the OIG. As indicated in the Report, the Hospital is working to re-bill claims from the sample in which the OIG and the Hospital have agreed, using the OIG's current review methodology, likely should have been billed as outpatient or outpatient with observation services. The hospital respectfully disagrees with the remaining 12 claims and will pursue appeal of the Medical Review Findings in accordance with Medicare procedures.

¹ Most of the claims subject to the Report were filed prior to the acquisition of the Hospital on October 1, 2011.

Morton Hospital
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The Hospital has enhanced its Utilization Review Policy and is working to increase care management staffing levels to better assess level of care determinations in a timelier manner. The Hospital is also working with its medical staff to ensure that improved education and communication lead to more accurate level of care determinations.

Incorrect Discharge Status

As noted in the Report, for the two discharge disposition code errors identified, the Hospital was not made aware that patients who left the hospital against medical advice were subsequently admitted to another acute care hospital on the same day. The Hospital will continue to make claim corrections, from discharge to transfers, when it is informed or learns of a subsequent admission to another hospital on the same day.

Incorrectly Billed as Separate Inpatient Stays

The Hospital has enhanced its care management procedures and revenue cycle coordination to identify all inpatients readmitted within 24 hours of discharge. Hospital management has worked to improve interdepartmental processes that facilitate timely claims evaluation prior to submission. This includes care management review of identified claims and timely claims adjustment by the Patient Financial Services department. The Hospital has trained applicable staff on the enhanced procedures.

Incorrect Source-of-Admission Code

Errors in this area related to an identified software interface issue, which has been corrected. The Hospital has also implemented a procedure that requires the Patient Access department to review a report which identifies all patients discharged from a Hospital acute care bed and admitted to a Hospital Inpatient Psychiatric Facility (IPF) bed in order to verify that the claim was properly coded with source of admission code D. Patient Access staff and coders have been educated on the report and verification process, and monitoring is in place.

Incorrectly Billed Number of Units

For the two claims found to have an error in the number of medication units charged, the Hospital re-educated all pharmacy staff on the type of error identified on these claims.

Incorrectly Billed Outpatient Services Provided During an Inpatient Stay

The Hospital has revised its policy related to services provided within 72 hours of an inpatient admission to reflect the current regulatory requirements, and staff has been provided with the necessary education and training. Additionally, billing software improvements have led to enhanced reporting that identifies accounts that require additional review and potential adjustment prior to claim submission.

Incorrectly Billed Services with Modifier -59

The Hospital provided additional education to coding staff related to the correct identification of procedures or services that are distinct or independent from other services performed on the same day. The Hospital has verified that its billing software identifies any potentially inappropriate use of

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the modifier, and that the coding department's lead coder reviews these identified claims with the coder who coded the claim to ensure the correct modifier is used.

Incorrect Billing for Dental Services

Dental procedures at the Hospital are generally performed only in emergency circumstances. The two claims found in error were identified as elective procedures where the patient required full anesthesia. The Hospital has expanded its billing edit software to identify any dental procedures performed in the Hospital, and has provided its coders with education to ensure that covered dental procedures are properly charged, including correct modifier selection as appropriate.

Nothing herein should be deemed an admission by the Hospital of any regulatory violations; and the Hospital reserves the right to appeal any and all claims denied by Medicare Administrative Contractors.

Morton Hospital takes its obligation to comply with laws, regulations and requirements of payers seriously and will continue its efforts to strengthen internal controls around billing and documentation practices. We are confident that the corrective measures outlined in this report will be effective in addressing the identified errors.

Thank you for the opportunity to review and provide comment to this report, and for the courtesy and level of professionalism extended to our staff by the OIG team throughout this audit process.

Please feel free to contact me if you have questions or require additional information.

Sincerely,

Kim Bassett

Kim Bassett, RN, MBA, BSN
President

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