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July 11, 2011

Report Number: A-01-10-00530
Lynn Shields, RN, BSN, MBA
Director of Clinical and Research Compliance
Cape Cod Healthcare, Inc.
17 East Main Street
West Yarmouth, MA 02673

Dear Ms. Shields:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Cape Cod Hospital for Calendar Years 2008 and 2009*. 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.

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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. Please refer to report number A-01-10-00530 in all correspondence.

Sincerely,

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

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
CAPE COD HOSPITAL FOR CALENDAR
YEARS 2008 AND 2009**



Daniel R. Levinson
Inspector General

July 2011
A-01-10-00530

Office of Inspector General

<http://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

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 prospective payment system for inpatient hospital services (IPPS). 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.

Cape Cod Hospital (the Hospital) is a 259-bed acute care hospital located in Hyannis, Massachusetts. Medicare paid the Hospital approximately \$253 million for 18,792 inpatient and 446,326 outpatient claims for services provided to beneficiaries during calendar years (CYs) 2008 and 2009 based on CMS's National Claims History data.

Our audit covered \$4,422,130 in Medicare payments to the Hospital for 157 inpatient and 225 outpatient claims that we identified as potentially at risk for billing errors. These 382 claims had dates of service in CYs 2008 and 2009.

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 178 of the 382 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for

selected inpatient and outpatient claims. Specifically, of the 382 claims, 204 claims had errors, resulting in overpayments totaling \$379,182 for CYs 2008 and 2009. 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 \$379,182, consisting of \$310,936 in overpayments for 68 incorrectly billed inpatient claims and \$68,246 in overpayments for 136 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

CAPE COD HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that it has refunded overpayments to the Medicare contractor. In addition, the Hospital stated that it has strengthened controls to comply 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 prospective payment system (IPPS) for inpatient hospital 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, requires CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) 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 purposes of this report, the term "Medicare contractor" means the 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. The types of payments to hospitals reviewed by this and related audits included payments for claims billed for:

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims with payments greater than \$150,000,
- inpatient hospital-acquired conditions and present on admission indicator reporting,
- outpatient claims for intensity modulated radiation therapy planning services,
- outpatient claims billed with modifier -59,
- outpatient claims billed during an inpatient stay,
- outpatient claims for evaluation and management services billed with surgical services,
- outpatient claims involving manufacturer credits for replaced medical devices, and
- inpatient and outpatient claims paid in excess of charges.

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 diagnosing or treating illness or injury or for improving 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.

Cape Cod Hospital

Cape Cod Hospital (the Hospital) is a 259-bed acute care hospital located in Hyannis, Massachusetts. Medicare paid the Hospital approximately \$253 million for 18,792 inpatient and 446,326 outpatient claims for services provided to beneficiaries during calendar years (CYs) 2008 and 2009 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 \$4,422,130 in Medicare payments to the Hospital for 157 inpatient and 225 outpatient claims that we identified as potentially at risk for billing errors. These 382 claims had dates of service in CYs 2008 and 2009.

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 based our review on selected billing requirements and did not include a 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 2011.

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 2008 and 2009;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2008 and 2009;
- 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 382 claims (157 inpatient and 225 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;
- 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 178 of the 382 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, of 382 sampled claims, 204 claims had billing errors that resulted in overpayments totaling \$379,182 for CYs 2008 and 2009. 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.

Of 157 sampled inpatient claims, 68 claims had billing errors, resulting in overpayments totaling \$310,936 (10 claims had 2 types of errors).

- For inpatient claims with short stays, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services (52 errors). Additionally, 10 of these 52 claims did not have valid physician orders to admit beneficiaries for inpatient care (52 errors totaling \$221,682).
- For inpatient claims with same-day discharges and readmissions, the Hospital billed Medicare separately for related discharges and readmissions within the same day (11 errors totaling \$50,149 in overpayments).
- For inpatient claims paid in excess of charges, the Hospital billed Medicare with an incorrect DRG (five errors totaling \$39,105 in overpayments).

Of 225 sampled outpatient claims, 136 claims had billing errors, resulting in overpayments totaling \$68,246.

- For outpatient claims billed for intensity modulated radiation therapy planning services, the Hospital incorrectly billed Medicare for services that were performed as part of developing an intensity modulated radiation therapy plan (76 errors totaling \$18,007 in overpayments).
- For outpatient claims billed with modifier -59, the Hospital incorrectly billed Medicare for HCPCS codes that did not require modifier -59 (31 errors), were included in the payments for other services that were billed on the same claims (4 errors), or contained incorrect HCPCS codes (3 errors) (38 errors totaling \$2,220 in overpayments).
- For outpatient claims billed during an inpatient stay, 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 (eight errors totaling \$2,681 in overpayments).
- For outpatient evaluation and management service claims billed with surgical services, the Hospital incorrectly billed Medicare for services that were performed as part of developing an intensity modulated radiation therapy plan (five errors) or were

insufficiently documented in the medical records (two errors)(seven errors totaling \$2,109 in overpayments).

- For outpatient claims paid in excess of charges, the Hospital submitted claims to Medicare with incorrect HCPCS codes (four errors totaling \$3,164 in overpayments).
- For outpatient claims involving manufacturer credits for replaced medical devices, the Hospital either did not obtain credits for replaced devices that were available under the terms of the manufacturers' warranties (two errors), or the Hospital received full credit for a replaced device but did not report the "FB" modifier or reduced charges on its claim (one error) (three errors totaling \$40,065 in overpayments).

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 68 of the 157 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$310,936 (10 claims had 2 types of errors).

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 diagnosing or treating illness or injury or for improving the functioning of a malformed body member." Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if, "with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment"

For 52 of the 71 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Additionally, 10 of these 52 claims did not have valid physician orders to admit beneficiaries for inpatient care. The Hospital attributed the patient admission errors to inadequate internal controls over its Case Management Department's processes and procedures. Specifically, case management review did not always occur due to the short nature of patient stays. The Hospital stated that human error caused the incomplete or missing physician orders. As a result, the Hospital received overpayments totaling \$221,682.

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 11 of the 25 sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that the errors occurred because an existing protocol for combining same-day readmissions was not followed. As a result, the Hospital received overpayments totaling \$50,149.

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 diagnosing or treating illness or injury or for improving the functioning of a malformed body member.”

For 5 of the 48 sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that the errors occurred because of human error. As a result, the Hospital received overpayments totaling \$39,105.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 136 of 225 sampled outpatient claims, which resulted in overpayments totaling \$68,246.

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 intensity modulated radiation therapy plan.

For 76 of the 139 sampled claims, the Hospital incorrectly billed Medicare for services that were performed as part of developing an intensity modulated radiation therapy plan. These errors occurred because Hospital personnel were unaware or did not fully understand the intensity modulated radiation therapy billing requirements, and consequently they did not have controls in place to prevent incorrect intensity modulated radiation therapy coding. As a result, the Hospital received overpayments totaling \$18,007.

Outpatient Claims Billed With Modifier -59

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 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 38 of the 43 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that did not require modifier -59 (31 errors), were included in payments for other services billed on the same claim (4 errors), or contained incorrect HCPCS codes (3 errors). These errors occurred

primarily because one Hospital staff member misunderstood the billing requirements for modifier -59. As a result, the Hospital received overpayments totaling \$2,220.

Outpatient Claims Billed During an Inpatient Stay

The Manual, chapter 3, section 10.4, states that Part A covers certain items and nonphysician services furnished to inpatients and consequently the inpatient prospective payment rate covers these services.

For eight of the eight 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 claims billed in error were for radiation therapy. The Hospital stated that these errors occurred because of human error in transferring charges to the inpatient bill. As a result, the Hospital received overpayments totaling \$2,681.

Outpatient Evaluation and Management Services Billed With Surgical Services

Section 1833(e) of the Social Security Act (the Act) precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly. 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 intensity modulated radiation therapy plan.

For 7 of the 13 sampled claims, the Hospital incorrectly billed Medicare for services that were performed as part of developing an intensity modulated radiation therapy plan (5 errors) or were insufficiently documented in the medical records (2 errors). These errors occurred because Hospital personnel were either unaware of or misunderstood certain billing requirements. As a result, the Hospital received overpayments totaling \$2,109.

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.

For four of the eight sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes. The Hospital stated that these overpayments occurred because of human error and computer software controls that were not fully implemented. As a result, the Hospital received overpayments totaling \$3,164.

Outpatient Manufacturer Credits for Replaced Medical Devices

Federal regulations (42 CFR § 419.45) require a reduction in the outpatient prospective payment system 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.

Prudent Buyer Principle

Under 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services ...” CMS’s *Provider Reimbursement Manual*, part 1, 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.

Billing Requirements for Medical Device Credits

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual explain how a provider should report no-cost and reduced-cost devices under the OPDS. 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 3 of the 14 sampled claims, the Hospital either did not obtain credits for replaced devices that were available under the terms of the manufacturers’ warranties (2 errors) or the Hospital received full credit for a replaced device but did not report the “FB” modifier or reduced charges on its claim (1 error). The Hospital stated that these overpayments occurred because there were no controls to identify, obtain, and report credits from the device manufacturers. As a result of these errors, the Hospital received overpayments totaling \$40,065.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$379,182, consisting of \$310,936 in overpayments for 68 incorrectly billed inpatient claims and \$68,246 in overpayments for 136 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

CAPE COD COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that it has refunded overpayments to the Medicare contractor. In addition, the Hospital stated that it has strengthened controls to comply with Medicare requirements. The Hospital's comments are included in their entirety as the appendix.

APPENDIX



CAPE COD HEALTHCARE

APPENDIX: CAPE COD HOSPITAL COMMENTS

June 23, 2011

BY FEDERAL EXPRESS

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General, Office of Audit Services, Region I
John F. Kennedy Federal Building, room 2425
Boston, MA 02203

Re: #A-01-10-00530

Dear Mr. Armstrong:

Cape Cod Hospital (the "Hospital") has received a draft report from the Department of Health & Human Services, Office of Inspector General ("OIG") entitled, *Medicare Compliance Review of Cape Cod Hospital for Calendar Years 2008 and 2009* (the "Report"). The Hospital has had an opportunity to review the Report and is in general agreement with the stated findings.

As you know, the OIG originally selected for review certain inpatient and outpatient claims submitted by the Hospital for dates of service in calendar years 2008 and 2009, ultimately covering ten (10) audit areas. In all, 157 inpatient claims and 225 outpatient claims were reviewed and, as set forth in the Report, your auditors identified problems with 68 inpatient and 136 outpatient claims. Based on their work, the auditors concluded that the Hospital had received \$379,182 in overpayments.

Prior to this audit, the Hospital had regularly conducted audits focused on DRG coding and the appropriate submission of claims by both its internal staff and by Hospital contracted experts. The Hospital continues to conduct such audits, and will continue to do so in the future, as an integral component of its Corporate Compliance Program. Additionally, the Hospital has provided, and will continue to provide ongoing training for its coders, patient accounts staff and associated personnel. We also will continue to utilize outside experts to verify our coding and billing practices to provide further assurance that we remain in compliance with all applicable legal requirements.

The Hospital also regularly conducts coding and compliance education sessions across key clinical and operational departments. To strengthen those efforts and to

address certain issues raised during the audit, the Hospital has implemented several measures, including the following:

- Provided education to the one certified coder who apparently was not utilizing Modifier 59 appropriately;
- Provided education to staff in certain outpatient areas about the identified errors pertaining to selecting charges that are appropriate for the service rendered. In limited cases these staff members were not aware that a charge included the insertion and removal of specific intravenous materials and, in other cases, incorrectly believed that Evaluation and Management (E&M) charges were to be used;
- Established a new process across the Hospital's clinical and financial operations to more effectively communicate decisions about the complicated (and often confusing) relationship between a patient's discharge and then readmission on the same day when the symptoms on readmission are related to or for evaluation and management of the patient's medical condition at the time of his/her original discharge from the Hospital; and
- Changed certain internal administrative processes to make sure there are appropriate written physician orders and correctly completed claims pertaining to certain Neurosurgical procedures for which Medicare requires the patient to be admitted to the Hospital as an inpatient prior to the surgery.

Notably, the vast majority of inpatient claim errors identified on audit were attributed to incorrect claims for one day stays. The Hospital had identified this issue as a potential problem area prior to the audit and, as part of its Corporate Compliance Program, had already begun to implement measures to improve existing internal processes to assure the correct classification of these patients as either inpatients or outpatients. A root cause analysis of existing processes revealed that weekend days and holidays were time periods when the review process was insufficient. Consequently, the Hospital has recently increased the number of staff in its Case Management Department in order to facilitate the review of all cases where an admission is being contemplated.

The majority of the outpatient claims errors identified were attributed to the use of various codes during the planning phases of Intensity Modulated Radiation Therapy ("IMRT") which may not be used when a comprehensive planning code is used. The Hospital utilizes coding software to identify situations where specific codes may not be used together, but that software had not been used on recurring accounts because there would have been unacceptably long delays while the software reviewed several months of oncology-related charges. In addition it was discovered after the audit that the software is not sophisticated enough to adequately identify the difference between the planning phase and the treatment phase of this important clinical service. However, the Hospital has now implemented alternative internal controls whereby the Radiation

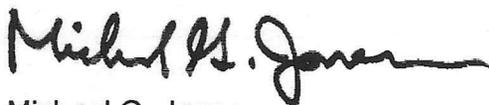
Therapist is able to readily identify and then edit those charges that may not be used in combination on Medicare claims, despite being allowed by other payers. Due to the clinical complexity of IMRT planning, the Hospital believes its Radiation Therapists are best situated to make these determinations because the identification of the "end" of the "planning phase" for each patient is a highly technical decision.

With respect to the outpatient manufacturer credits for medical devices, the Hospital historically relied on device vendors to determine appropriate warranty payments due to the Hospital. With respect to the fourteen (14) claims reviewed, it was agreed that during a twenty-two (22) month time frame there was a failure to identify only three (3) devices that may have been covered under warranty. In response to this audit, the Hospital has established enhanced internal controls which include a review by Hospital staff to determine the availability of a warranty in cases where the Hospital performed the procedure for both the original device and then a replacement device. The Hospital has met with vendor representatives and reviewed these new internal controls. Vendors are now required to notify the Hospital at the time of the procedure that the device may be covered under warranty. In addition, for cases where the Hospital provides both the initial implant and then a replacement, the Hospital has established a new tracking system to help monitor receipt of vendor responses. The Hospital also has established a new procedure to make sure that the correct value codes, condition codes and modifiers are included on any claim when a credit has been received.

All in, the auditors recommended that the Hospital refund to its Medicare contractor \$379,182, consisting of \$310,936 in overpayments for the 68 incorrectly billed inpatient claims, and \$68,246 in overpayments for the 136 incorrectly billed outpatient claims. The auditors also recommended that the Hospital strengthen its controls to ensure full compliance with Medicare requirements. The Hospital has processed the recommended refunds and, to the extent permitted by Medicare rules, has completed rebilling claims as appropriate. In addition and as outlined above, the Hospital has implemented stronger internal controls aimed at reducing the risk that these types of errors will recur.

The Hospital takes its compliance obligations very seriously and will continue to monitor all of the audited areas as part of its Compliance Program and will update its controls when identified as necessary to ensure continued compliance with applicable legal requirements. Please feel free to call me if you have any questions about the Hospital's efforts in this regard or if you require any additional information.

Very truly yours,



Michael G. Jones
Compliance Officer