

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF  
SAINT MICHAEL'S MEDICAL CENTER  
FOR THE PERIOD JANUARY 1, 2009,  
THROUGH JUNE 30, 2011**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



**James P. Edert  
Regional Inspector General**

**March 2013  
A-02-12-01005**

# *Office of Inspector General*

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## **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. CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

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.

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 the 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 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.

Saint Michael's Medical Center (the Hospital) is a 357-bed acute care hospital located in Newark, New Jersey. Based on CMS's National Claims History data, Medicare paid the Hospital approximately \$231 million for 16,071 inpatient and 52,750 outpatient claims with service dates from January 1, 2009, through June 30, 2011.

Our audit covered approximately \$4.2 million in Medicare payments to the Hospital for 174 inpatient and 56 outpatient claims that we identified as potentially at risk for billing errors. These 230 claims had service dates from January 1, 2009, through June 30, 2011.

### **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 132 of the 230 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 98 claims, resulting in overpayments totaling \$492,046 during the period January 1, 2009, through June 30, 2011. Specifically, 71 inpatient claims had billing errors resulting in overpayments totaling \$450,942, and 27 outpatient claims had billing errors resulting in overpayments totaling \$41,104. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and its staff 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 \$492,046, consisting of \$450,942 in overpayments for 71 incorrectly billed inpatient claims and \$41,104 in overpayments for 27 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **SAINT MICHAEL'S MEDICAL CENTER COMMENTS**

In written comments to our draft report, the Hospital concurred with our findings and provided information on actions that it had taken or planned to take to address our recommendations. The Hospital's comments are included in their entirety as the Appendix.

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# INTRODUCTION

## BACKGROUND

### The Medicare Program

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.

### Hospital Inpatient Prospective Payment System

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

### Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>1</sup> The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.<sup>2</sup> All services and items within an APC group are comparable clinically and require comparable resources. In addition to the basic prospective payment under the IPPS or OPPS, hospitals may be eligible for an additional payment (called an outlier payment) when the hospital's costs exceed certain thresholds.

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<sup>1</sup> In 2009, SCHIP was formally redesignated as the Children's Health Insurance Program.

<sup>2</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

## **Hospital Payments at Risk for Incorrect Billing**

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. 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 claims billed with high severity level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims with payments greater than \$25,000,
- outpatient claims billed with evaluation and management services,
- outpatient claims billed with modifiers,
- outpatient intensity modulated radiation therapy planning services,
- outpatient claims billed with observation services that resulted in outlier payments, and
- outpatient 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.

## **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.

### **Saint Michael's Medical Center**

Saint Michael's Medical Center (the Hospital) is a 357-bed acute care hospital located in Newark, New Jersey. Based on CMS's National Claims History data, Medicare paid the Hospital approximately \$231 million for 16,071 inpatient and 52,750 outpatient claims for services provided to beneficiaries from January 1, 2009, through June 30, 2011.

## **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 \$4,238,578 in Medicare payments to the Hospital for 230 claims that we judgmentally selected as potentially at risk for billing errors. These 230 claims consisted of 174 inpatient and 56 outpatient claims with dates of service from January 1, 2009, through June 30, 2011.

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 from January through March 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 the period January 1, 2009, through June 30, 2011;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for the period January 1, 2009, through June 30, 2011;
- 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 230 claims (174 inpatient and 56 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 132 of the 230 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 98 claims, resulting in overpayments totaling \$492,046 during the period January 1, 2009, through June 30, 2011. Specifically, 71 inpatient claims had billing errors resulting in overpayments totaling \$450,942, and 27 outpatient claims had billing errors resulting in overpayments totaling \$41,104. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and its staff did not fully understand the Medicare billing requirements within the selected areas of risk.

Only risk areas with errors are listed in the findings and recommendations section below.

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

The Hospital incorrectly billed Medicare for 71 of the 174 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$450,942.

#### **Inpatient Short Stays**

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

For 65 of the 110 sampled claims, the Hospital incorrectly billed Medicare Part A for inpatient claims that should have been billed as outpatient or outpatient with observation services (64 claims) or did not have sufficient documentation to support the services billed (1 claim). Hospital officials attributed the patient admission errors to a lack of clear understanding of the use of screening criteria on the part of medical staff and inadequate internal controls for monitoring short stays. As a result, the Hospital received overpayments totaling \$342,825.

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

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.” The Manual, chapter 3, section 40.2.5, states “[w]hen 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 onto a single claim.”

Section 1815(a) of the Act precludes payment to any provider of services without information necessary to determine the amount due the provider.

For 4 of the 16 sampled claims, the Hospital incorrectly billed Medicare separately for a related discharge and readmission within the same day (1 claim), for an inpatient claim that should have been billed as outpatient (1 claim), or for services that did not have sufficient documentation in the medical record to support the services billed on the inpatient claim (2 claims). Hospital officials stated that the errors occurred because of staff turnover and dissolution of the Hospital's readmission task force. As a result, the Hospital received overpayments totaling \$82,091.

### **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."

For 1 of the 13 sampled claims, the Hospital incorrectly billed Medicare Part A for an inpatient claim that should have been billed as outpatient or outpatient with observation services. Hospital officials attributed the error to a lack of clear understanding of the use of screening criteria on the part of medical staff and inadequate internal controls for monitoring short stays. As a result, the Hospital received an overpayment of \$21,678.

### **Inpatient Claims with Payments Greater Than \$150,000**

The Manual, chapter 3, section 10, states that a hospital may bill only for services provided. In addition, chapter 1, section 80.3.2.2, states, "In order to be processed correctly and promptly, a bill must be completed accurately...."

For one of two sampled claims, the Hospital billed Medicare for an incorrect number of units related to pharmacy and laboratory services, and medical supplies. Due to the incorrect number of units billed, charges were overstated resulting in a higher outlier payment than was warranted. Hospital officials stated that this was due to human error. As a result, the Hospital received an overpayment of \$4,348.

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

The Hospital incorrectly billed Medicare for 27 of 56 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$41,104.

### **Outpatient Claims Billed With Modifier -59**

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

For 10 of the 14 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that were included in payments for other services billed on the claim or did not require modifier -59. Hospital officials stated these errors occurred primarily because of human error, including the hospital staff's misinterpretation of Medicare billing requirements for claims with modifier -59. As a result, the Hospital received overpayments totaling \$16,429.

### **Outpatient Doxorubicin Hydrochloride**

Section 1833(e) of the Act states: "No payment shall be made to any provider of services ... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ... for the period with respect to which the amounts are being paid ...". 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 7 of the 10 sampled claims, the Hospital billed Medicare using the incorrect HCPCS code for the doxorubicin drug administered. Hospital officials stated that these errors occurred because of human error. As a result, the Hospital received overpayments totaling \$22,867.

### **Outpatient Claims Billed With Observation Services That Resulted in Outlier Payments**

The Manual, chapter 4, section 290.2.2, states, "observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should not report, as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services."

For all five sampled claims, the Hospital billed Medicare for observation services that were part of other Part B services. Specifically, the Hospital incorrectly billed for observation services that were, in fact, postoperative monitoring or standard recovery care. Hospital officials stated that these errors occurred because Hospital personnel did not fully understand the billing requirements for observation services. As a result, the Hospital received overpayments totaling \$1,056.

### **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 (IMRT) plan.

For four of the five sampled claims, the Hospital incorrectly billed Medicare for services that were performed as part of developing an IMRT plan. Hospital officials stated that these errors occurred because Hospital staff were unaware of or did not fully understand IMRT billing requirements. As a result, the Hospital received overpayments totaling \$542.

## **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.”

For one of the five sampled claims, the Hospital incorrectly billed Medicare for a claim that did not have sufficient documentation to support the services billed. Hospital officials stated that the error occurred because of human error. As a result, the Hospital received an overpayment of \$210.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$492,046, consisting of \$450,942 in overpayments for 71 incorrectly billed inpatient claims and \$41,104 in overpayments for 27 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **SAINT MICHAEL’S MEDICAL CENTER COMMENTS**

In written comments to our draft report, the Hospital concurred with our findings and provided information on actions that it had taken or planned to take to address our recommendations. The Hospital’s comments are included in their entirety as the Appendix.

# **APPENDIX**

**APPENDIX: SAINT MICHAEL'S MEDICAL CENTER COMMENTS**



December 20, 2012

James P. Edert  
Office of Audit Services, Region II  
Jacob K. Javits Federal Building  
26 Federal Plaza, Room 3900  
New York, NY 10278

Re: Report #: A-02-12-01005

Dear Ms. Edert:

Enclosed please find a paper copy and an electronic CD version of Saint Michael's Medical Center ("SMMC") responses and action plan relevant to the draft report # A-02-12-01005 entitled Medicare Compliance Review of SMMC for the Period January 1, 2009 through June 30, 2011.

Should you have any questions, concerns, or require additional information please contact me at 973-877-5218 – [nbisco@smmcnj.org](mailto:nbisco@smmcnj.org) or Michael Alwell at 973-877-2853 – [malwell@smmcnj.org](mailto:malwell@smmcnj.org).

Thank you for your continued cooperation and consideration.

Regards,

/Nancy Bisco/  
\_\_\_\_\_  
Nancy Bisco  
VP, Corporate Compliance

/Michael Alwell/  
\_\_\_\_\_  
Michael Alwell  
VP, Revenue Cycle

**BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS:** As per the OIG audit findings, SMMC incorrectly billed Medicare for 71 of the 174 sampled inpatient claims that were reviewed. These errors resulted in overpayments totaling \$450,942 relating to IP claims. Identified issues are as follows:

**Inpatient Short Stays**

**OIG Findings:**

SMMC incorrectly billed Medicare Part A for Inpatient (“IP”) claims that should have been billed as Outpatient (“OP”) or OP with observation services or did not have sufficient documentation to support the services billed. As a result, SMMC received overpayments totaling \$342,825.

**Comments:**

During 2009-2010 there were misconceptions involving the use of screening criteria on the part of the medical staff. In addition, SMMC had limited case management and physician advisor coverage during that time period. SMMC relied heavily on physician intent and written orders to support the billing of an IP claim.

**Plan of Correction:**

- In early 2011, systems were changed to prevent short stay inpatient claims from being billed before being reviewed by a physician advisor;
- Case Management staffing levels were improved including the addition of a case manager in the emergency department;
- SMMC has provided extensive education to all attending physicians and residents regarding the proper use of screening criteria to support inpatient hospitalization or outpatient observation services;
- SMMC is currently exploring using an outside firm to supplement the in-house physician advisor services in an effort to provide 24 hour, 7 day per week reviews, and is utilizing a consultant to evaluate the current case management staffing and operations.

**Inpatient Same-Day Discharges and Readmissions**

**OIG Findings:**

SMMC incorrectly billed Medicare separately for a related discharge and readmission within the same day (1 claim), for an IP claim that should have been billed as OP (1 claim), and for services that did not have sufficient documentation in the medical record to support the services billed on the IP claim (2 claims). As a result, SMMC received overpayments totaling \$82,091.

**Comments:**

The cases reviewed were aged accounts. The general practice is for a physician to write a formal order for inpatient admission (when appropriate) at the same time that he/she writes post-procedure orders and notes or as a part of his/her initial admitting orders. The addition of previous admission and discharge dates to patient face sheets was not implemented until early 2011.

**Plan of Correction:**

- On February 13, 2012, the Chief Medical Officer and VP of Corporate Compliance distributed a memo reminding all physicians and residents of their obligation to provide clear orders for hospitalization at the appropriate level (inpatient admission, outpatient observation). These orders must reflect the physician's intent based on clinical findings and must be included in every set of initial orders;
- Random audits have since been performed to evaluate compliance with this requirement and the floor staff on each unit have been re-educated of the requirements. These audits will continue on a regular basis over the next 6-12 months;
- Case Management will continue to closely review the clinical conditions of all patients who are discharged and readmitted on the same day. If appropriate, claims will be combined before billing when the discharge and readmission are clinically related;
- A re-admission task force shall be reestablished to ensure that every same day readmission is reviewed for the possible need to combine for billing purposes.

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

**OIG Findings:**

For 1 of the 13 sampled claims, SMMC incorrectly billed Medicare Part A for an inpatient claim that should have been billed as OP or OP with observation services. As a result, SMMC received overpayments totaling \$21,678.

**Comments:**

Inpatient reservations for scheduled procedures or direct admissions are booked through the admitting department based on physician's expectations for need of post procedure inpatient hospitalization or a medical condition warranting an inpatient stay. The general practice is for a physician to write a formal order for IP admission (when appropriate) at the same time that he/she writes post-procedure orders & notes or as a part of his/her initial admitting orders.

**Plan of Correction:**

- On February 13, 2012, the Chief Medical Officer and VP of Corporate Compliance distributed a memo reminding all physicians and residents of their obligation to provide clear orders for hospitalization at the appropriate level (inpatient admission, outpatient observation). These orders must reflect the physician's intent based on clinical findings and must be included in every set of initial orders;
- Random audits have since been performed to evaluate compliance with this requirement and the floor staff on each unit have been re-educated of the requirements. These audits will continue on a regular basis over the next 6-12 months.

**Inpatient Claims with Payments Greater than \$150,000**

**OIG Findings:**

For one of the two sampled claims, SMMC billed Medicare for an incorrect number of units related to pharmacy and laboratory services, and medical supplies. Due to the incorrect number of units billed, charges were overstated resulting in a higher outlier payment than was warranted. As a result, SMMC received overpayments totaling \$4,348.

**Comments:**

The error related to medications that were dispensed to the patient unit but weren't administered to the patient for various reasons. The pharmacy system in place at that time charged on the dispensing of the medication and was dependent on medications being returned to the pharmacy for crediting when they were not administered. At times the medications were returned to the pharmacy but were not labeled with patient information for proper crediting thereby causing the inability to post the proper credits.

**Plan of Correction:**

- In March 2012, the hospital's pharmacy computer system was upgraded whereby medication charges are now applied at the point of administration via bar code scanning.

**BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS:** As per the OIG audit findings, SMMC incorrectly billed Medicare for 27 of 56 outpatient claims that were reviewed. As a result, SMMC received overpayments totaling \$41,104 relating to OP claims. Identified issues are as follows:

**Outpatient Claims Billed with Modifier -59**

**OIG Findings:**

For 10 of the 14 sampled claims, SMMC incorrectly billed Medicare for HCPCS codes that were included in payments for other services billed on the claim or did not require Modifier-59. As a result, SMMC received overpayments totaling \$16,429.

**Comments:**

Each OP clinical department maintains a medical record for each patient which includes documentation to support the services billed. Charges are entered and applicable modifiers applied by the department staff on a daily basis based on the documentation contained in the medical record. Charges for ancillary services including EKGs are entered by the OP department based on physician orders, however there are situations where the established standards of care for specific services required additional ancillary services as part of the treatment or procedure but are not separately billable based on Correct Coding Initiatives ("CCI"). The identified issues were primarily human error and associates misinterpreting Medicare billing requirements for claims with Modifier-59.

The coding and billing of the claims that did not require Modifier-59 was correct, however the application of the modifier was not required as there weren't any CCI edits for the combination of billed procedures. The associate who entered the procedure charges added the modifier in error.

There were sampled claims reviewed whereby it was identified that there were inappropriate charges for EKGs. These services were performed however they should not have been billed separately because the EKG is considered bundled with the cardiac procedure that was performed.

The claims which had incorrect charges were primarily related to the billing of cardiac monitoring that are considered integral to the procedure that was performed but not necessarily billable as separate services.

**Plan of Correction:**

- Staff was re-educated in the proper use of Modifier-59;
- Additional education was provided by an outside consultant in June 2012 during a 10 day on-site intensive coding/billing boot camp;
- Staff was specifically re-educated as to when an EKG is considered to be a separately billable service item.

**Outpatient Doxorubicin Hydrochloride****OIG Findings:**

For 7 of the 10 sampled claims, SMMC billed Medicare using the incorrect HCPCS code for the doxorubicin drug administered. As a result, SMMC received overpayments totaling \$22,867.

**Comments:**

Internal controls rely upon the Pharmacy Manager and Chargemaster Coordinator to ensure that pharmaceutical "J-codes" are assigned properly and mapped correctly. The identified issues were a result of human error.

**Plan of Correction:**

- Chargemaster mapping was corrected and appropriate associates in the Pharmacy Department received additional education and training relevant to this issue;
- Entire Pharmacy Chargemaster has been reviewed for accuracy as part of the CHE system-wide standardization.

**Outpatient Claims Billed With Observation Services That Resulted in Outlier Payments****OIG Findings:**

For 5 sampled claims, SMMC billed Medicare for observation services that were part of other Part B services. Specifically, SMMC incorrectly billed for observation services that were, in fact, postoperative monitoring or standard recovery room care. As a result, SMMC received overpayments totaling \$1,056.

**Comments:**

At the time of these cases, there was a misconception on the part of the physicians regarding the proper use of observation services post procedure. Physicians were of the understanding that any patient that was kept in the hospital overnight would meet the criteria for observation services given the fact that the patient was being "observed" for an extended period of time post-procedure.

**Plan of Correction:**

- SMMC has provided extensive education to the medical staff and resident house staff in regard to the proper use of OP observation services and OP extended recovery;
- Case Management will continue to monitor and work with the physicians regarding the appropriateness of status of all inpatient and observation patients.

**Outpatient Intensity Modulated Radiation Therapy Planning Services**

**OIG Findings:**

For 4 of the 5 sampled claims, SMMC incorrectly billed Medicare for services that were performed as part of developing an Intensity Modulated Radiation Therapy (“IMRT”) plan. As a result, SMMC received overpayments totaling \$542.

**Comments:**

The clerical staff in the Radiation Therapy department performs charge entry based on the technician’s charge entry documentation. CPT-4 coding changes were implemented during the time that these services were performed. It appeared that the updated coding requirements may not have been disseminated to all charge entry personnel.

**Plan of Correction:**

- All charging departments received chargemaster education from an outside consultant between June 11 and June 19, 2012;
- The Oncology Services Director received additional training which was shared with staff.

**Outpatient Claims Billed With Evaluation and Management (“E&M”) Services**

**OIG Findings:**

For 1 of the 5 sampled claims, SMMC incorrectly billed Medicare for a claim that did not have sufficient documentation to support the services billed. As a result, SMMC received an overpayment of \$210.

**Comments:**

OP clinical departments maintain a medical record for each patient which includes documentation to support the services billed. Charges are entered by the department staff on a daily basis and charge entry is based on the documentation contained in the patient’s medical record. Regarding the one claim mentioned above, the associate that entered the charges interpreted the documented nursing interaction with the patient to be separate and distinct from the scheduled clinical services. It has been determined that the nursing interaction and education was related to the scheduled infusion. Therefore, the billing of a separate evaluation and management code with a modifier was incorrect.

**Plan of Correction:**

- Staff was re-educated in the proper use of E&M codes and modifiers;
- All charging departments received chargemaster education from an outside consultant between June 11 and June 19, 2012.

**CONCLUSIONS:**

- OIG auditor findings were shared with SMMC management;
- The audit concluded with the identification of \$492,046 in overpayments made to SMMC by CMS;

- SMMC has already processed a repayment of \$21,419 relating to the billing of cancer treatment drugs (Doxorubicin Hydrochloride), leaving a gross overpayment of \$470,627;
- SMMC will contact the Medicare Administrative Contractor (“MAC”) to arrange for the reprocessing of all claims that were found to have been paid in error and to verify that any improperly billed short stay inpatient claims may be resubmitted as Outpatient claims – reducing the net pay back to the Medicare program.