

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF HOSPITAL ESPAÑOL
AUXILIO MUTUO
DE PUERTO RICO, INC.,
FOR CALENDAR YEARS
2010 AND 2011**

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**James P. Edert
Regional Inspector General**

**June 2013
A-02-12-01026**

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.

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, intended to be 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 the 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 hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis of claims. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Hospital Español Auxilio Mutuo de Puerto Rico, Inc., (the Hospital) is a 653-bed acute care nonprofit hospital located in San Juan, Puerto Rico. Medicare paid the Hospital approximately \$49 million for 7,072 inpatient and 74,203 outpatient claims for services provided to beneficiaries during calendar years 2010 and 2011 (audit period) based on CMS's National Claims History data.

Our audit covered \$3,467,641 in Medicare payments to the Hospital for 899 claims that we judgmentally selected as potentially at risk for billing errors. These 899 claims had dates of service in our audit period and consisted of 344 inpatient and 555 outpatient claims.

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 745 of the 899 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 154 claims, resulting in overpayments of \$43,046 for our audit period. Specifically, 3 inpatient claims had billing errors, resulting in overpayments of \$9,589, and 151 outpatient claims had billing errors, resulting in overpayments of \$33,457. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements within the selected risk areas that contained errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$43,046, consisting of \$9,589 in overpayments for 3 incorrectly billed inpatient claims and \$33,457 in overpayments for 151 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL ESPAÑOL AUXILIO MUTUO DE PUERTO RICO COMMENTS

In its written comments on our draft report, the Hospital concurred with our findings and recommendations and described corrective actions it had taken or planned to take to address them.

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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.

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, 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) 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. 106-113.¹ 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.² All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

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

¹ In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

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

- inpatient claims paid in excess of charges,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed with modifier -59,
- outpatient claims paid in excess of charges, and
- outpatient claims billed with evaluation and management (E&M) services.

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, § 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, § 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, § 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

Hospital Español Auxilio Mutuo de Puerto Rico

Hospital Español Auxilio Mutuo de Puerto Rico, Inc., (the Hospital) is a 653-bed acute care nonprofit hospital located in San Juan, Puerto Rico. Medicare paid the Hospital approximately \$49 million for 7,072 inpatient and 74,203 outpatient claims for services provided to beneficiaries during calendar years 2010 and 2011 (audit period) 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 \$3,467,641 in Medicare payments to the Hospital for 899 claims that we judgmentally selected as potentially at risk for billing errors (see Appendix A). These 899 claims had dates of service in our audit period and consisted of 344 inpatient and 555 outpatient claims.

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, but did not use 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. 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 the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital from July through September 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 our audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for our audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 899 claims (344 inpatient and 555 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;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;

- 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 objectives.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 745 of the 899 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 154 claims, resulting in overpayments of \$43,046 for our audit period. Specifically, 3 inpatient claims had billing errors, resulting in overpayments of \$9,589, and 151 outpatient claims had billing errors, resulting in overpayments of \$33,457. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements within the selected risk areas that contained errors. For a detailed list of the risk areas that we reviewed and associated billing errors, see Appendix A.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 3 of the 344 selected inpatient claims, which resulted in overpayments of \$9,589.

Incorrectly Billed as Inpatient

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 3 of the 344 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation

services. The Hospital attributed the incorrect billing to human error. As a result of these errors, the Hospital received overpayments of \$9,589.³

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 151 of the 555 selected outpatient claims, which resulted in overpayments of \$33,457.

Incorrect Number of Units

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 1, § 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly. In addition, chapter 4, § 20.4, of the Manual defines service units as the number of times the service or procedure being reported was performed.

For 2 of the 555 selected outpatient claims, the Hospital received Medicare payments for the incorrect number of units. Specifically, the Hospital billed Medicare for the wrong number of units for one claim and the Medicare contractor revised the number of units after the Hospital submitted the other claim. The Hospital attributed the incorrect billing to human error and misinterpretation of Medicare guidelines. As a result of these errors, the Hospital received overpayments of \$7,432.

Incorrectly Billed Procedures With Modifier -59

The Manual, chapter 1, § 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly. In addition, chapter 23, § 20.9.1.1(B), states that modifier -59 is used to indicate a distinct procedural service, which 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 139 of the 555 selected outpatient claims, the Hospital incorrectly billed Medicare for HCPCS codes appended with modifier -59 that were incorrect for the services provided. The Hospital attributed the incorrect billing to human error and misinterpretation of Medicare guidelines. As a result of these errors, the Hospital received overpayments of \$25,214.

Incorrectly Billed Evaluation and Management Services

The Manual, chapter 12, § 30.6.6(B), states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual pre- and post-operative work of the procedure.

³ The Hospital 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 or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

For 10 of the 555 selected outpatient claims, the Hospital incorrectly billed Medicare for HCPCS codes appended with modifier -25 that were incorrect for the services provided. The Hospital attributed the incorrect billing to human error and misinterpretation of Medicare guidelines. As a result of these errors, the Hospital received overpayments of \$811.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$43,046, consisting of \$9,589 in overpayments for 3 incorrectly billed inpatient claims and \$33,457 in overpayments for 151 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL ESPAÑOL AUXILIO MUTUO DE PUERTO RICO COMMENTS

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

APPENDIXES

APPENDIX A: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Claims Paid in Excess of Charges	342	\$2,485,908	3	\$9,589
Manufacturer Credits for Replaced Medical Devices	2	16,445	0	0
Inpatient Totals	344	\$2,502,353	3	\$9,589
Outpatient				
Claims Billed With Modifier -59	290	\$514,945	139	\$25,214
Claims Paid in Excess of Charges	200	376,756	2	7,432
Claims Billed With Evaluation and Management Services	64	58,498	10	811
Manufacturer Credits for Replaced Medical Devices	1	15,088	0	0
Outpatient Totals	555	\$965,288	151	\$33,457
Inpatient and Outpatient Totals	899	\$3,467,641	154	\$43,046

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 the Hospital. 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.

APPENDIX B: HOSPITAL ESPAÑOL AUXILIO MUTUO
DE PUERTO RICO COMMENTS



Auxilio Mutuo
Aquí se respira salud.

April 29, 2013

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

RE: REPORT NUMBER A-02-12-01026

Dear Mr. Edert:

According to your request on your letter dated April 3, 2013 we are stating our concurrence with the recommendation for the report number A-02-12-01026.

For the recommendation of refunding \$43,046.00 we want to clarify that the biggest amount have been already recouped by our Fiscal Intermediary FCSO, due to our submitted requests for adjustment.

It is important to mention that the issue of out patient claims paid in excess of charges was an error at the intermediary level the overpayment since hospital submitted the correct amount of units and reported immediately the amount paid in excess.

We also concur with the statement of strengthen controls to ensure full compliance with Medicare requirements. A correction plan have been taken consisting in the establishment of an internal policy which no system edits override is allowed. Also a training and retraining program was given to coders, registration supervisors, clerks and billing staff and will be mandatory annually.

Sincerilly,


Rafael Jaca
Business Office Director