

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF MARY WASHINGTON
HOSPITAL FOR CALENDAR
YEARS 2009 THROUGH 2011**

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**Stephen Virbitsky
Regional Inspector General**

October 2013
A-03-12-06106

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Mary Washington Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of approximately \$327,000 over 3 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Mary Washington Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is a 437-bed hospital located in Fredericksburg, Virginia. Medicare paid the Hospital approximately \$377.4 million for 27,940 inpatient and 204,259 outpatient claims for services provided to beneficiaries during CYs 2009 through 2011 based on CMS's National Claims History data.

Our audit covered \$2,677,584 in Medicare payments to the Hospital for 195 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 157 inpatient and 38 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 142 of the 195 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 53 claims, resulting in net overpayments of \$327,180 for CYs 2009 through 2011. Specifically, 40 inpatient claims had billing errors resulting in net overpayments of \$217,038, and 13 outpatient claims had billing errors resulting in overpayments of \$110,142. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$327,180, consisting of \$217,038 in net overpayments for 40 incorrectly billed inpatient claims and \$110,142 in overpayments for 13 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations and described corrective actions it had taken to address them. The Hospital did not fully concur with the finding that it had not properly reported credits received for medical devices originally claimed for outpatient services. The Hospital stated that, for several claims, it had received a credit only for the leads used with the devices (pacemakers) and that reporting the credits using the “FB” modifier would have resulted in a reduction in the Medicare payment for the pacemaker as well as the leads. The Hospital questioned the reasonableness of CMS’s instructions to use the FB modifier in such cases. However, the Hospital stated that it had submitted corrected claims for replacement medical devices for which a credit was received.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether Mary Washington Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

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

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services

within each APC group.¹ All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level DRG codes,
- inpatient short stays,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims paid in excess of charges, and
- outpatient claims billed with modifier -59.

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

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Social Security Act (the Act), § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)).

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

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Mary Washington Hospital

The Hospital is a 437-bed hospital located in Fredericksburg, Virginia. Medicare paid the Hospital approximately \$377.4 million for 27,940 inpatient and 204,259 outpatient claims for

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

services provided to beneficiaries during CYs 2009 through 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$2,677,584 in Medicare payments to the Hospital for 195 claims that we judgmentally selected as potentially at risk for billing errors. These 195 claims consisted of 157 inpatient and 38 outpatient claims with dates of service in CYs 2009 through 2011 (audit period). We focused our review on the risk areas that we had identified as a result of previous 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. 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 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.

See Appendix A for the details of our scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 142 of the 195 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 53 claims, resulting in net overpayments of \$327,180 for the audit period. Specifically, 40 inpatient claims had billing errors resulting in net overpayments of \$217,038, and 13 outpatient claims had billing errors resulting in overpayments of \$110,142. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 40 of 157 selected inpatient claims, which resulted in net overpayments of \$217,038.

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 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 onto a single claim.

For 13 of the 157 selected claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. Hospital officials stated that the errors occurred because the manual system of same day discharge and readmission in place at the time was not effective. As a result of these errors, the Hospital received net overpayments of \$77,701. The Hospital received overpayments of \$77,876 (12 claims) and was underpaid \$175 (1 claim).

Incorrectly Billed Diagnosis-Related Group Codes

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, §1862(a)(1)(A)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 11 of the 157 selected claims, the Hospital billed Medicare for incorrect DRG codes. Hospital officials attributed this to human error made by individual coders. As a result of these errors, the Hospital received net overpayments of \$69,230. The Hospital received overpayments of \$87,817 (8 claims) and was underpaid \$18,587 (3 claims).

Incorrectly Billed as Inpatient

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

For 13 of the 157 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Hospital officials stated that the errors occurred because of human error in the billing process, lack of clear physician documentation supporting admission status, insufficient case manager staffing and training, and a need to alter the structure and use of physician advisors. As a result of these errors, the Hospital received overpayments of \$53,097.²

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code “FD” (chapter 3, § 100.8).

For 3 of the 157 selected claims, the Hospital received reportable credits from manufacturers for replaced medical devices but did not adjust its inpatient claims with the proper condition and

² 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.

value codes to reduce payment as required. Hospital officials stated that the errors occurred because of a lack of coordination between the necessary departments, as well as a lack of communication with manufacturers. As a result of these errors, the Hospital received overpayments of \$17,010.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 13 of 38 selected outpatient claims, which resulted in overpayments of \$110,142.

Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

Federal regulations require a reduction in the OPPS 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 (42 CFR § 419.45). For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.³ Federal regulations also require that all payments to providers of services must be based on the reasonable cost of services (42 CFR § 413.9). The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements in additional detail.⁴

For 9 of the 38 selected claims, the Hospital made errors related to manufacturer credits for replaced medical devices. Specifically, for seven claims, the Hospital received reportable credits from manufacturers for replaced medical devices but did not properly report the “FB” modifier. Also, for six of the seven claims, the Hospital did not properly charge for the replacement medical device.

For the remaining two claims, the Hospital did not obtain credits for replaced medical devices for which credits were available under the terms of the manufacturers’ warranties.

³ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

⁴ The PRM 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.” (part 1, § 2102.1). Section 2103 further defines prudent buyer principles and 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 or payments 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 supplied.”

Hospital officials stated that the errors occurred because of a lack of coordination between the necessary departments, lack of communication with manufacturers, and a misunderstanding of Medicare billing requirements. As a result of these errors, the Hospital received overpayments of \$102,833.

Incorrectly Billed Number of Units

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). It also states, “[w]here HCPCS is required, units are entered in multiples shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 ...” (chapter 17, § 70).

For 2 of the 38 selected claims, the Hospital billed Medicare for more units of human albumin (HCPCS P9047) than provided. Hospital officials attributed this to an error in the unit conversion calculation after the Hospital moved to a new financial system. As a result of these errors, the Hospital received overpayments of \$4,561.

Incorrectly Billed Outpatient Services With Modifier -59

The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). It also states: “The ‘-59’ modifier is used to indicate a distinct procedural service ... This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)” (chapter 23, § 20.9.1.1).

For 2 of the 38 selected claims, the Hospital incorrectly billed Medicare for HCPCS codes with modifier -59, for services that were already included in the payments for other services billed on the same claim. Hospital officials stated that, because of a lack of coordination between the department entering charges and the department coding the services, human errors were not detected. As a result of these errors, the Hospital received overpayments of \$2,748.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$327,180, consisting of \$217,038 in net overpayments for 40 incorrectly billed inpatient claims and \$110,142 in overpayments for 13 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations and described corrective actions it had taken to address them. The Hospital did not fully concur with the finding that it had not properly reported credits received for medical

devices originally claimed for outpatient services. The Hospital stated that, for several claims, it had received a credit only for the leads used with the devices (pacemakers) and that reporting the credits using the “FB” modifier would have resulted in a reduction in the Medicare payment for the pacemakers as well as the leads. The Hospital questioned the reasonableness of CMS’s instructions to use the FB modifier in such cases. However, the Hospital stated that it had submitted corrected claims for replacement medical devices for which a credit was received. The Hospital’s comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$2,677,584 in Medicare payments to the Hospital for 195 claims that we judgmentally selected as potentially at risk for billing errors. These 195 claims consisted of 157 inpatient and 38 outpatient claims with dates of service in CYs 2009 through 2011 (audit period).

We focused our review on the risk areas that we had identified as a result of previous 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.

Our audit included contacting the Hospital in Fredericksburg, Virginia, during July 2012 through July 2013.

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 audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 195 claims (157 inpatient and 38 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;
- reviewed the medical record documentation provided by the Hospital to support the selected claims;

- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for 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.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Underpayments/Overpayments	Value of Net Overpayments
Inpatient				
Same-Day Discharges and Readmissions	28	\$583,440	13	\$77,701
Claims Billed With High Severity Level Diagnosis-Related Group Codes	32	659,877	11	69,230
Short Stays	74	439,645	13	53,097
Manufacturer Credits for Replaced Medical Devices	23	484,061	3	17,010
Inpatient Totals	157	\$2,167,023	40	\$217,038
Outpatient				
Manufacturer Credits for Replaced Medical Devices	25	\$468,740	9	\$102,833
Claims Paid in Excess of Charges	2	5,701	2	4,561
Claims Billed With Modifier -59	11	36,120	2	2,748
Outpatient Totals	38	\$510,561	13	\$110,142
Inpatient and Outpatient Totals	195	\$2,677,584	53	\$327,180

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 C: HOSPITAL COMMENTS



September 13, 2013

VIA FEDERAL EXPRESS

Stephen Virbitsky
Regional Inspector General for Audit Services
U S Department of Health & Human Services
Office of the Inspector General
Public Ledger Building, Suite 316
150 South Independence Mall West
Philadelphia, PA 19106

**Re: Report Number A-03-12-06106
Mary Washington Hospital**

Dear Mr. Virbitsky:

I write on behalf of Mary Washington Hospital (the “Hospital” or “Mary Washington”) in response to the U.S. Department of Health and Human Services, Office of Inspector General’s (“OIG”) August 20, 2013 draft report entitled *Medicare Compliance Review of Mary Washington Hospital for Calendar Years 2009 Through 2011*. Mary Washington is strongly committed to compliance with all applicable Medicare billing requirements, and we appreciate the opportunity to review and provide comments on the OIG’s draft audit report.

We understand, as noted in the draft report, that Mary Washington was selected for audit as part of the OIG’s ongoing series of hospital compliance reviews. The audit covered \$2,677,584 in Medicare payments to the Hospital for 195 claims (157 inpatient; 38 outpatient) during the 2009-2011 time period that were judgmentally selected as potentially at risk for billing errors, based on the OIG’s data analysis of nationwide hospital claims. The OIG determined that the Hospital complied with Medicare billing requirements for 142 of the 195 claims it reviewed. The OIG’s audit report states that the Hospital did not fully comply with Medicare billing requirements for the remaining 53 claims, resulting in net overpayments of \$217,038 for inpatient claims, and \$110,142 for outpatient claims. The OIG recommended that the Hospital make repayment of \$327,180 to its Medicare contractor and strengthen controls to ensure full compliance with Medicare requirements.

We generally agree with the OIG’s findings and have made repayment to Palmetto GBA in accordance with the OIG’s recommendations. The following constitutes the Hospital’s response to the OIG’s specific findings, as noted in the draft audit report.

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I. Billing Errors Associated with Inpatient Claims

A. Incorrectly Billed as Separate Inpatient Stays

The OIG found that the Hospital billed Medicare separately for related discharges and readmissions within the same day for 13 of the 157 inpatient claims, resulting in net overpayments of \$77,701.

Hospital Response

We concur with the OIG's findings and have made repayment as recommended by the OIG. During the time period in question, the Hospital had a manual process to identify potential same-day readmissions. The Hospital has since implemented an automated process to flag potential same-day readmissions for evaluation by the case management and billing departments to ensure that related same-day readmissions are not separately billed to Medicare.

B. Incorrectly Billed Diagnosis-Related Group ("DRG") Codes

The OIG found that the Hospital billed Medicare for incorrect DRG codes for 11 of the 157 claims, resulting in net overpayments of \$69,230.

Hospital Response

We concur with the OIG's findings and have made repayment as recommended by the OIG. The incorrectly assigned DRG codes were a result of human error by individual coders. The Hospital has invested in extensive education and training for its coding staff and implemented a Coders Auditing Program to conduct quality reviews to ensure compliance with Medicare coding requirements.

C. Incorrectly Billed as Inpatient

The OIG found that the Hospital incorrectly billed Medicare Part A for inpatient stays that should have been billed as outpatient or outpatient with observation services for 13 of the 157 claims, resulting in net overpayments of \$53,097.

Hospital Response

We concur with the OIG's findings and have made repayment as recommended by the OIG. The incorrectly billed inpatient claims were a result of clerical errors by staff, lack of clear documentation by the physician as to the admission status designation and justification for the status, the need for further training of case managers on admission status and use of the InterQual tool, the need for increased staffing levels and coverage of case managers, and a need to alter the structure and use of physician advisors. The Hospital has taken numerous steps to ensure that Medicare claims are billed with the correct patient status, including extensive education of admitting physicians, case management staff, and billing

staff related to patient status; updates to physician admission order sets; and increasing the Hospital's physician advisor resources.

D. Manufacturer Credits for Replaced Medical Devices Not Reported

The OIG found that the Hospital received reportable credits from manufacturers for replaced medical devices but did not adjust its inpatient claims with proper condition and value codes for 3 of the 157 claims, resulting in overpayments of \$17,010.

Hospital Response

We concur with the OIG's findings and have made repayment as recommended by the OIG. These errors occurred because of a lack of communication between necessary departments, as well as a lack of communication with manufacturers. The Hospital has conducted education of necessary departments related to reporting device credits that are received, and has implemented new processes to track and monitor the status of device credits.

II. Billing Errors Associated with Outpatient Claims

A. Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

The OIG found that the Hospital did not report device credits it obtained or did not obtain available device credits for 9 of the 38 outpatient claims, resulting in overpayments of \$102,833.

Hospital Response

We have made repayment as recommended by the OIG, but we do not fully concur with the OIG's findings that the Hospital failed to properly report obtained device credits. CMS' policy on reporting device credits requires hospitals to use modifier -FB when it receives full credit for the cost of the replaced device. The modifier is appended to the APC on the claim, which triggers a reduction in payment for the full cost of the device.

For several of the claims at issue, the Hospital did not receive a full credit for the cost of a pacemaker, but only a credit for a pacemaker lead, which is a less costly component of the procedure. Because the modifier is reported on the anchoring procedure's APC, the entire reimbursement for the claim is affected, even if a patient received a new pacemaker for which no credit was available or obtained. CMS' system of discounting the entire procedure's reimbursement mistakenly assumes that the Hospital received a credit for the entire device (pacemaker and lead), when many times, credit is only available for the lead component.

The Hospital has implemented new processes for properly tracking and obtaining device credits when available, including increased communications between

departments, and increased communication with manufacturers, to ensure that future device credits are properly reported to the Hospital's Medicare contractor.

B. Incorrectly Billed Number of Units

The OIG found that the Hospital billed Medicare for more units of human albumin than provided for 2 of the 38 outpatient claims, resulting in overpayments of \$4,561.

Hospital Response

We concur with the OIG's findings and have made repayment as recommended by the OIG. This finding can be attributed to an error in the unit conversion calculation after the Hospital moved to a new financial system. The system error has been corrected and processes have been put in place to ensure that conversion calculations are accurate.

C. Incorrectly Billed Outpatient Services with Modifier -59

The OIG found that the Hospital incorrectly billed Medicare for HCPCS codes with modifier -59 for 2 of the 38 outpatient claims, resulting in net overpayments of \$2,748.

Hospital Response

We concur with the OIG's findings and have made repayment as recommended by the OIG. This finding can be attributed to human errors that were not detected. The Hospital has provided training and education to necessary staff on proper use of modifier -59 and implemented processes to ensure that use of modifier -59 is monitored for compliance.

We appreciate the opportunity to respond to the OIG's draft audit report findings, and appreciate the OIG auditors' professionalism, collaboration, and communication during the audit process. We believe that the corrective actions the Hospital has taken, as described above, have strengthened the Hospital's compliance program, especially with respect to the issues identified in the OIG's draft audit report. If you have any questions about the Hospital's response to the draft audit report, or need any additional information, please feel free to contact me.

Sincerely,

/Jina Haikey/

Jina Haikey
Senior Vice President
Regulatory Affairs and Risk Management
Corporate Compliance Officer