

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
SOMERSET HOSPITAL  
FOR CALENDAR YEARS  
2009 THROUGH 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).*



**Stephen Virbitsky  
Regional Inspector General**

**March 2013  
A-03-12-06107**

# *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. 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 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 techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Somerset Hospital (the Hospital) is a 150-bed hospital located in Somerset, Pennsylvania. Medicare paid the Hospital approximately \$27.6 million for 3,260 inpatient and 63,666 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 through 2011 based on CMS's National Claims History data.

Our audit covered \$594,645 in Medicare payments to the Hospital for 126 claims that we judgmentally selected as potentially at risk for billing errors. These 126 claims consisted of 86 inpatient and 40 outpatient claims.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

### **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 48 of the 126 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 78 claims, resulting in overpayments totaling \$313,443 for CYs 2009 through 2011. Specifically, 38 inpatient claims had billing errors, resulting in overpayments totaling \$115,866, and 40 outpatient claims had billing errors, resulting in overpayments totaling \$197,577. 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 contain errors.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$313,443, consisting of \$115,866 in overpayments for 38 incorrectly billed inpatient claims and \$197,577 in overpayments for 40 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **SOMERSET 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 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.<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 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.<sup>2</sup> 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:

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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.

- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient psychiatric facility (IPF) emergency department adjustments, and
- outpatient dental 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, 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.

### **Somerset Hospital**

Somerset Hospital (the Hospital) is a 150-bed hospital located in Somerset, Pennsylvania. Medicare paid the Hospital approximately \$27.6 million for 3,260 inpatient and 63,666 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 through 2011 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 \$594,645 in Medicare payments to the Hospital for 126 claims that we judgmentally selected as potentially at risk for billing errors. These 126 claims had dates of service in CYs 2009 through 2011 and consisted of 86 inpatient and 40 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.

Our fieldwork included contacting the Hospital in Somerset, Pennsylvania during July through December 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 CYs 2009 through 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 126 claims (86 inpatient and 40 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 medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for 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 48 of the 126 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 78 claims, resulting in overpayments totaling \$313,443 for CYs 2009 through 2011. Specifically, 38 inpatient claims had billing errors, resulting in overpayments totaling \$115,866, and 40 outpatient claims had billing errors, resulting in overpayments totaling \$197,577. 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 contain errors. For a detailed list of the risk areas that we reviewed and associated billing errors, see the Appendix.

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

The Hospital incorrectly billed Medicare for 38 of the 86 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$115,866.

#### **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 26 of the 86 sampled 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 stated that the errors occurred because the medical records did not clearly identify the patient’s inpatient or outpatient status or document the level of care needed, and case management reviews were inadequate. As a result of these errors, the Hospital received overpayments totaling \$106,637.<sup>3</sup>

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<sup>3</sup> The Hospital may be able to bill Medicare Part B for some services related to some of these incorrect Medicare Part A claims. 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.

## **Incorrect Diagnosis-Related Groups**

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 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately ....”

For 3 of the 86 sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that the errors occurred because of weak and inconsistent medical record documentation, and because billing staff did not obtain clarification from the physician when necessary. As a result of these errors, the Hospital received overpayments totaling \$8,405.

## **Incorrect Source-of-Admission Code**

CMS increases the Federal per diem rate for the first day of a Medicare beneficiary’s IPF stay to account for the facility’s costs associated with maintaining a qualifying emergency department (42 CFR § 412.424). The Manual, chapter 3, section 190.6.4, states that CMS makes this additional payment regardless of whether the beneficiary used emergency department services. However, the IPF should not receive the additional payment if the beneficiary was discharged to the IPF from the acute-care section of the same hospital.

The Manual, chapter 3, section 190.6.4.1, states that source-of-admission code “D” is reported by an IPF to identify patients who have been transferred to the IPF from the same hospital. The IPF’s proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 9 of the 86 sampled claims, the Hospital incorrectly coded the source of admission for beneficiaries who were admitted to the IPF upon discharge from the Hospital’s acute-care section. The Hospital stated that the errors occurred because its patient registration staff had not been educated on the appropriate use of source-of-admission code “D.” As a result of these errors, the Hospital received overpayments totaling \$824.

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

The Hospital incorrectly billed Medicare for all 40 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$197,577.

### **Noncovered Dental Services**

Section 1862(a)(12) of the Act states: “no payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth ....”

For all 40 sampled claims, the Hospital incorrectly billed Medicare for the treatment or removal of teeth. The Hospital stated that the errors occurred because billing staff incorrectly used bill type 131, instead of bill type 130 with condition code 21, for dental claims. In addition, when

the Hospital took corrective action in November 2010 as the result of a prior OIG audit, it did not correct claims paid prior to that date and did not include four dental HCPCS codes in the edit. As a result of these errors, the Hospital received overpayments totaling \$197,577.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$313,443, consisting of \$115,866 in overpayments for 38 incorrectly billed inpatient claims and \$197,577 in overpayments for 40 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **SOMERSET 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 or planned to take to address them. The Hospital's comments are included in their entirety as Appendix B.

# **APPENDIXES**

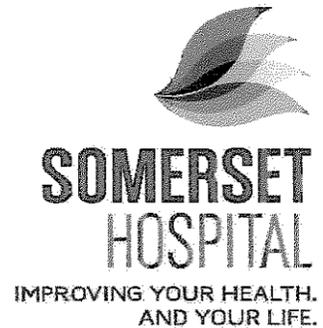
**APPENDIX A: RISK AREAS REVIEWED AND BILLING ERRORS**

<b>Risk Area</b>	<b>Sampled Claims</b>	<b>Value Of Sampled Claims</b>	<b>Claims With Overpayments</b>	<b>Value Of Overpayments</b>
Inpatient short stays	53	\$193,780	23	\$83,893
Inpatient claims billed with high severity level diagnosis-related group codes	24	175,217	6 <sup>1</sup>	31,149
Inpatient psychiatric facility emergency department adjustments	9	28,071	9	824
<b>Inpatient Totals</b>	<b>86</b>	<b>\$397,068</b>	<b>38</b>	<b>\$115,866</b>
Outpatient dental services	40	\$197,577	40	\$197,577
<b>Outpatient Totals</b>	<b>40</b>	<b>\$197,577</b>	<b>40</b>	<b>\$197,577</b>
<b>Inpatient and Outpatient Totals</b>	<b>126</b>	<b>\$594,645</b>	<b>78</b>	<b>\$313,443</b>

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<sup>1</sup> Three of the six claims with overpayments in the high severity-level diagnosis-related group codes category were incorrectly billed as inpatient.

**APPENDIX B: SOMERSET HOSPITAL COMMENTS**



February 8, 2013

Mr. Stephen Virbitsky  
Regional Inspector General for Audit Services  
Office of Inspector General  
Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, PA 19106

RE: Report Number: A-03-12-06107

Dear Mr. Virbitsky:

I am in receipt of the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled Medicare Compliance Review of Somerset Hospital for Calendar Years 2009 through 2011, dated January 16, 2013, and am hereby providing the Hospital's written response and comments requested therein. As stated during our exit conference, we are in general agreement with the OIG's audit findings and recommendations, and have already submitted corrected billings and initiated various corrective actions, as further explained below:

**1. Inpatient claims incorrectly billed as inpatient services**

We agree that 26 of the 86 sampled claims should have been billed as outpatient or outpatient with observation services. Claim cancellations have been submitted for these 26 claims, and our Medicare Administrative Contractor (MAC) has already retracted the full amount of the identified overpayments.

In response to these findings, we have already begun working with our medical staff in an effort to more clearly and accurately identify patient status designations, and have undertaken various training and education initiatives with our case management staff in an effort to improve their review processes and patient status determinations. Lastly, we have initiated a pre-billing review of all short-stay admissions and outpatient observation patients in order to ensure the accuracy of our future billings to Medicare.

**2. Inpatient claims with incorrect DRGs**

We agree that three of the 86 sampled claims were billed with incorrect coding assignments and were paid at incorrect DRG rates. Corrected claims have been submitted for these three occurrences, and have already been processed and re-adjudicated by our MAC, thus effectively fulfilling our refund obligation for the identified overpayments.

ADDRESS	PHONE	WEB
225 South Center Avenue	(814) 443 5000	www.somersethospital.com
Somerset, PA 15501-2088	(814) 443 4937	info@somersethospital.com
	FAX	EMAIL

In response to these findings, we have apprised our coding staff of the three identified errors, and have undertaken various training and education initiatives related to the querying of physicians in response to inconsistencies and deficiencies in medical record documentation. Although we regret the fact that these three coding errors occurred, we continue to have a high degree of confidence in our coding staff.

**3. Inpatient claims with incorrect source-of-admission codes**

We agree that nine of the 86 sampled claims were reported with incorrect source-of-admission codes for patients who were admitted to our IPF directly from our acute care service. The identified refunds have already been retracted by our MAC following the hospital's submission of corrected claims.

In response to these findings, we have educated our registration staff on the appropriate use of source-of-admission code "D", and have implemented a pre-billing review of IPF claims intended to confirm the accuracy of future source-of-admission code assignments.

**4. Outpatient claims for non-covered dental services**

We agree that all 40 of the sampled claims involved noncovered dental services, and were therefore incorrectly billed to and paid by Medicare. As you may know, we had conducted a review of these claims prior to the initiation of the OIG's audit, and had apprised the OIG staff of our review findings. With the OIG's concurrence, we also initiated full refunds of all of the identified overpayments via the submission of claim cancellations to the hospital's MAC.

In response to these findings, we have already educated and re-educated our billing staff regarding the correct bill type and condition code to be reported for outpatient surgery cases involving noncovered dental services. We have also initiated a pre-billing review of all dental surgery cases in order to confirm the accuracy of the bill type and condition code reported on future claim submissions to Medicare.

Please know that Somerset Hospital is committed to complying with the various rules and regulations under which we must operate, and will continue to strive to ensure the accuracy of our future billings to Medicare and all other payers and patients. We will also ensure that the corrective measures outlined above are effective in preventing the re-occurrence of the respective identified errors, and will monitor the effectiveness of these measures on an ongoing basis.

Thank you for the opportunity to respond to your report, and for the courtesy and professionalism extended to us throughout the audit. Please contact me at your convenience with any questions regarding the above comments, or if any of my colleagues or I can be of any assistance to you.

Sincerely,



Ronald M. Park  
Chief Executive Officer