



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



June 29, 2012

TO: Peter Budetti
Deputy Administrator and Director
Center for Program Integrity
Centers for Medicare & Medicaid Services

Deborah Taylor
Director and Chief Financial Officer
Office of Financial Management
Centers for Medicare & Medicaid Services

FROM: /Brian P. Ritchie/
Assistant Inspector General for the
Centers for Medicare & Medicaid Audits

SUBJECT: Medicare Compliance Reviews for Calendar Years 2009 and 2010: Palmetto General Hospital (A-04-11-07025) and West Florida Hospital (A-04-11-08010)

Attached, for your information are advance copies of two of our final reports for hospital compliance reviews. We will issue these reports to Palmetto General Hospital and West Florida Hospital within 5 business days.

These reports are part of a series of the Office of Inspector General's hospital compliance initiative, designed to review multiple issues concurrently at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through email at Lori.Pilcher@oig.hhs.gov.

Attachment

cc: Daniel Converse
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION IV
61 FORSYTH STREET, SW, SUITE 3T41
ATLANTA, GA 30303

July 5, 2012

Report Number: A-04-11-07025

Ms. Melissa L. Paper
Hospital Compliance and Privacy Officer
Palmetto General Hospital
2001 West 68th Street
Hialeah, FL 33016

Dear Ms. Paper:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Palmetto General Hospital for Calendar Years 2009 and 2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Denise R. Novak, Audit Manager, at (305) 536-5309, extension 10, or through email at Denise.Novak@oig.hhs.gov. Please refer to report number A-04-11-07025 in all correspondence.

Sincerely,

/Lori S. Pilcher/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 355
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
PALMETTO GENERAL HOSPITAL FOR
CALENDAR YEARS 2009 AND 2010**



Daniel R. Levinson
Inspector General

July 2012
A-04-11-07025

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the 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, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Palmetto General Hospital (the Hospital) is a 360-bed acute care hospital located in Hialeah, Florida. Medicare paid the Hospital approximately \$125 million for 17,957 inpatient and 23,119 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$4,236,548 in Medicare payments to the Hospital for 188 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2009 and 2010 and consisted of 170 inpatient and 18 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 173 of the 188 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare

billing requirements for the remaining 15 claims, resulting in overpayments totaling \$124,566 for CYs 2009 and 2010. Specifically, 14 inpatient claims had billing errors, resulting in overpayments totaling \$123,799, and 1 outpatient claim had a billing error, resulting in an overpayment of \$767. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$124,566 in overpayments and
- strengthen controls to ensure full compliance with Medicare billing requirements.

PALMETTO GENERAL HOSPITAL COMMENTS

In written comments on our draft report, the Hospital agreed with our findings and described actions that it planned to take in response to our recommendations. The Hospital's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.¹

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the 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. 106-113.² The OPPS was effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.³ All services and items within an APC group are comparable clinically and require comparable resources.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. At the time of our fieldwork, most, but not all, of the MACs were fully operational; for jurisdictions where the MACs were not fully operational, the fiscal intermediaries and carriers continued to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever was applicable.

² In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

³ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Hospital Payments at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. The types of payments to hospitals reviewed by this and related audits included payments for claims billed for:

- inpatient short stays,
- inpatient transfers,
- inpatient claims with payments greater than \$150,000,
- inpatient hospital-acquired conditions and “present on admission”⁴ indicator reporting,
- inpatient claims paid in excess of charges,
- inpatient psychiatric facility emergency department adjustments,
- inpatient psychiatric facility interrupted stays,
- inpatient claims billed with high severity level DRG codes,
- outpatient surgeries billed with units greater than one,
- outpatient manufacturer credits for replaced medical devices, and
- outpatient claims with payments greater than \$25,000.

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

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

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and services that “are not reasonable and necessary for 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

⁴ “Present on admission” refers to diagnoses that are present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are also considered present on admission. Acute care hospitals are required to complete the present on admission indicator field on the Medicare inpatient claim for every diagnosis billed.

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 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.

Palmetto General Hospital

Palmetto General Hospital (the Hospital) is a 360-bed acute care hospital located in Hialeah, Florida. Medicare paid the Hospital approximately \$125 million for 17,957 inpatient and 23,119 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit covered \$4,236,548 in Medicare payments to the Hospital for 188 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2009 and 2010 and consisted of 170 inpatient and 18 outpatient claims.

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 used medical review on a limited selection of sampled claims 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 allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

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

We conducted our fieldwork at the Hospital during September and October 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's National Claims History file for CYs 2009 and 2010;
- 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 188 claims (170 inpatient and 18 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 medical record documentation that the Hospital provided to support the sampled claims;
- requested that the Hospital conduct its own review of the selected sampled claims to determine whether the services were billed correctly;
- utilized Medicare contractor medical review staff to determine whether a limited selection of sampled claims met medical necessity requirements;
- 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 173 of the 188 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 15 claims, resulting in overpayments totaling \$124,566 for CYs 2009 and 2010. Specifically, 14 inpatient claims had billing errors, resulting in

overpayments totaling \$123,799, and 1 outpatient claim had a billing error, resulting in an overpayment of \$767. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 14 of 170 sampled inpatient claims. These errors resulted in overpayments totaling \$123,799.

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 5 of the 80 sampled claims for inpatient short stays, the Hospital incorrectly billed Medicare for inpatient claims that it should have billed as outpatient or outpatient with observation services. The Hospital attributed the incorrect admissions to human error when applying the inpatient admission criteria. As a result of these errors, the Hospital received overpayments totaling \$39,785.

Inpatient Transfers

Federal regulations (42 CFR § 412.4(c)) state that a discharge of a hospital inpatient is considered to be a transfer when the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to an inpatient rehabilitation facility. A hospital that transfers an inpatient under the above circumstance is paid a graduated per diem rate for each day of the patient’s stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 1 of the 14 sampled claims for inpatient transfers, the Hospital incorrectly billed Medicare for a patient discharge that it should have billed as a transfer. For this claim, it should have coded the discharge status as a transfer to an inpatient rehabilitation facility. Instead, it incorrectly coded the discharge status as if the patient had left against medical advice; thus the Hospital should have received the per diem payment instead of the full DRG. The Hospital stated that this incorrect billing occurred because of human error. As a result of this error, the Hospital received an overpayment of \$6,066.

Inpatient Hospital-Acquired Conditions and Present on Admission Indicator Reporting

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 one of the five sampled claims for inpatient hospital-acquired conditions and present on admission indicator reporting, the Hospital billed Medicare with an incorrect DRG code. The

Hospital stated that this error occurred because of human error. As a result of this error, the Hospital received an overpayment of \$3,398.

Inpatient Claims Paid in Excess of Charges

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

For 3 of the 20 sampled inpatient claims paid in excess of charges, the Hospital billed Medicare with incorrect DRG codes. For one claim, the Hospital coded and billed for a procedure that was cancelled. For the other two claims, the Hospital billed Medicare based on a DRG code that was supported by the physician’s written diagnosis in the patient’s medical records. However, after further review, the patient’s clinical documentation did not support the physician’s written diagnosis. These errors occurred because of human error, and the Hospital’s coders relied on the physician’s written diagnosis within the patient’s medical records. As a result of these errors, the Hospital received overpayments totaling \$20,775.

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 4 of the 40 sampled inpatient claims billed with high severity level DRG codes, the Hospital billed Medicare with incorrect DRG codes. For one claim, the coder coded a particular diagnosis that was later ruled out upon discharge. For the other three claims, the Hospital billed Medicare based on a DRG code that was supported by the physician’s written diagnosis in the patient’s medical records. However, after further review, the patient’s clinical documentation did not support the physician’s written diagnosis. These errors occurred because the coder did not re-review the patient’s account when the discharge summary became available, and the coder relied on the physician’s written diagnosis within the patient’s medical records. As a result, the Hospital received overpayments totaling \$53,775.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 1 of 18 sampled outpatient claims, which resulted in an overpayment totaling \$767.

Outpatient Surgeries With Billed Units Greater Than One

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 20.4, of the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For the only sampled outpatient claim for outpatient surgeries with billed units greater than one, the Hospital submitted the claim to Medicare with an incorrect number of surgical units of service performed. The Hospital stated that the incorrect units were billed due to human error. As a result of this error, the Hospital received an overpayment totaling \$767.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$124,566 in overpayments and
- strengthen controls to ensure full compliance with Medicare billing requirements.

PALMETTO GENERAL HOSPITAL COMMENTS

In written comments on our draft report, the Hospital agreed with our findings and described actions that it planned to take in response to our recommendations. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX



2001 West 68th Street
Hialeah, FL 33016
Tel 305.823.5000

May 23, 2012

Lori S. Pilcher
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Dear Ms. Pilcher:

Palmetto General Hospital ("Hospital") has received the draft report provided by the United States Department of Health and Human Services, Office of Inspector General ("OIG") entitled *Medicare Compliance Review of Palmetto General Hospital for Calendar Years 2009 and 2010* ("OIG Medicare Compliance Review"). The Hospital is in general agreement with the stated findings and appreciates this opportunity to respond to the OIG Medicare Compliance Review.

As the OIG Medicare Compliance Review indicates, the OIG originally selected for review certain inpatient and outpatient claims submitted by the Hospital for dates of service within calendar years 2009 and 2010, ultimately covering eleven (11) audit areas. In total, 188 claims were reviewed, consisting of 170 inpatient claims and 18 outpatient claims. The Hospital understands that the claims were selected as a judgmentally focused (non-statistically significant) sample because such claims were potentially at risk for billing errors. Prior to the audit, the Hospital received \$4,236,548.05 in Medicare payments for the 188 claims reviewed. Based on the claim review, the OIG auditors concluded that 15 of the 188 claims reviewed require claim corrections, that when re-processed, will cause the Hospital to have received \$124,566.00 in overpayments, resulting in a payment error rate of 2.94%.

OIG Findings, Recommendations & Hospital Responses

Inpatient Short Stays

OIG Findings and Recommendations:

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 5 of the 80 sampled claims for inpatient short stays, the Hospital incorrectly billed Medicare for inpatient claims that it should have billed as outpatient or outpatient with observation services. The Hospital attributed the incorrect admissions to a human error when applying the inpatient admission criteria. As a result of these errors, the Hospital received overpayments totaling \$39,785.00.

Hospital Response:

At the time the services were rendered, the Hospital had the following controls in place:

1. The Hospital Case Managers use McKesson InterQual® clinical criteria to help determine if the patient is appropriate for inpatient or outpatient. InterQual® is an evidence based clinical criteria set that evaluates the severity of the patient’s illness along with the treatment plan to help determine the appropriate level of care based on the patient’s clinical needs. When there is a lack of concordance between the criteria met and the level of care ordered by the physician, the Case Manager submits the case to the Physician Advisor for a Secondary Physician Review.
2. Secondary Physician Review – the Physician Advisor reviews cases and follows up with the attending physician to discuss the medical reasons for the patient status and level of care when what has been ordered by the attending physician does not meet InterQual® criteria.
3. InterQual® Education-This mandatory training is required for all RN Case Managers upon hire and annually, thereafter. The education process is not considered to be complete until the Case Manager passes a final competency exam.
4. Medical Necessity Report -The Hospital has a process in place to pull a report of cases with InterQual admission reviews that are “not met” or “not complete” on a daily basis prior to billing. The report process includes a review by the Hospital Director of Case Management and the Physician Advisor to confirm whether the patient met criteria for Outpatient Observation or Inpatient admission.
5. Physician Education-The Director of Case Management provided education to the Hospital’s physician staff regarding patient status and CMS regulations.

During 2011, prior to this OIG Medicare Compliance Review, the Hospital had conducted an internal assessment of the Hospital case management processes. The 2011 Hospital internal assessment reflected opportunities to further strengthen the Hospital case management processes. As a result, the following controls (2, 3 & 4 above) were enhanced and implemented during 2011, prior to the OIG Medicare Compliance Review:

1. Secondary Physician Review – the Hospital established a standard process and policy in the fall of 2010 to manage and monitor the cases that are referred for Secondary Physician Review.
2. InterQual® Education – in addition to continuing mandatory education requirements, the Hospital developed comprehensive Inter-Rater-Reliability (IRR) review processes to include an assessment of each RN Case Manager performing InterQual® reviews. The focus of the IRR review process is to assess case management staffs’ ability to apply the InterQual® criteria accurately and consistently. The Hospital Director of Case Management is responsible to follow-up with a corrective action plan, based on the review findings. Targeted case manager education is provided, with corrective action assigned.
3. Medical Necessity Report – the process for patient status determination was documented via a standard policy in the Fall of 2010. The report criteria was reviewed and updated in March

2011, to further align the policy and process steps. The criteria is reviewed and updated annually, with the next release due March 2013.

4. **Physician Education**-Due to physician turnover and changing regulations, a process was instituted to educate new physicians on applicable requirements regarding patient status and CMS regulations.

A review of the five claims (5/80) found to be in error, as identified by the OIG Medicare Compliance Review, reflected the following:

1. The historical documentation for one (1) of the cases reflected that the patient did not meet InterQual® inpatient criteria admission review. This case was timely sent to secondary physician review and upheld; however, the patient was subsequently discharged, prior to any additional Condition Code 44 steps being taken. The case manager did not communicate this information to the Hospital's Billing Department.
2. The historical documentation for four (4) of the cases reflected that the patients met InterQual® inpatient criteria admission review; therefore, they were not sent for Secondary Physician review. After analyzing the four (4) admission reviews, the error was determined to be attributable to case manager user error in applying the criteria at the time reviews were completed.

Based on the previously implemented process controls, the Hospital has determined the only remaining corrective action is to review the findings of the OIG Medicare Compliance Review at the next Hospital Utilization Management Committee, at the next Case Management Staff Meeting and with the Hospital Physician Advisor. The Hospital Physician Advisor will follow-up with individual physicians, as needed.

Inpatient Transfers

OIG Findings and Recommendations:

Federal regulations (42 CFR § 412.4(c)) state that a discharge of a hospital inpatient is considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to an inpatient rehabilitation facility. A hospital that transfers an inpatient under the above circumstance is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 1 of the 14 sampled claims for inpatient transfers, the Hospital incorrectly billed Medicare for a patient discharge that it should have billed as a transfer. For this claim, it should have coded the discharge status as a transfer to an inpatient rehabilitation facility. Instead, it incorrectly coded the discharge status as if the patient had left against medical advice; thus the Hospital should have received the per diem payment instead of the full DRG. The Hospital stated that this incorrect billing occurred because of human error. As a result of this error, the Hospital received an overpayment of \$6,066.00.

Hospital Response:

The Hospital maintains a policy requiring the completion of a post-acute services form that is completed by the Hospital staff responsible for discharge planning. The Hospital Coding Department then uses this form to assign the appropriate discharge disposition code. Additionally, the Hospital has system checks and processes to stop and manually evaluate claims that are subject to the Same Day Readmission & Three Day Payment Window Rules.

The Hospital, like many of its peers, maintains distinct medical records based on actual patient encounters. When billing rules, such as the Same Day Readmission & Three Day Payment Window Rules, dictate that a combined claim be submitted, the Hospital will continue to maintain separate medical records for each encounter, each with its own distinct coding abstract. Any combining of claims for billing purposes is done directly at the claim level by the Hospital's Billing Office.

The claim, identified by the OIG Compliance Review to be in error, was reviewed and is reflective of services rendered to a patient that was admitted to the Hospital and, days later, left Against Medical Advice (AMA). The patient subsequently returned to the Hospital on the same day (within an hour) and was re-admitted. The second admission resulted in the patient being discharged to a sub-acute rehabilitation facility. Each of the admissions were coded with the appropriate Discharge Disposition Codes; however, when the two separate claims were manually combined, due to the Same Day Readmission & Three Day Payment Window Rules, the claim reflected the AMA Discharge Disposition Code (07) instead of reflecting the second/final the sub-acute rehabilitation facility Discharge Disposition Code(62).

There is a control in place that requires the Hospital Health Information Management Department (HIM) to review the two accounts to see if they should be combined. This includes checking to see if the discharge disposition code needs to be changed. The Hospital provides a combined coding summary sheet with correct ICD-9, DRG and disposition codes to the Billing Office. Keying is done directly from this coding summary sheet, by the biller, at the time the claims are combined. This final, manual step failed to occur for this claim.

Additionally, it is our understanding that CMS has a safeguard in place via a Common Working File (CWF) edit. The Hospital is notified by the FI/MAC that a claim conflict exists and is subject to the Post-acute Care Transfer rule (40.2.4.C in the Medicare Claims Processing manual), in the event the Hospital is either unaware of post-acute services or has made an error and billed incorrectly. In these cases, the FI/MAC automatically cancels the initial claim and reprocesses with the appropriate discharge disposition code, recouping any payment variance, with no action required by the Hospital. The Hospital is unclear why the FI that was processing the Hospital's claims at that time (Wisconsin Physician Services), did not identify this as an overpayment and reprocess this claim automatically.

Based on the previously implemented process controls, the Hospital has determined the only remaining corrective action is to re-educate the billing staff regarding the manual process of combining claims.

Outpatient Claims with Payments Greater Than \$25,000

OIG Findings and Recommendations:

10 claims sampled and reviewed. No errors identified.

Hospital Response:

Adequate controls in place.

Inpatient Claims with Payments Greater Than \$150,000

OIG Findings and Recommendations:

6 claims sampled and reviewed. No errors identified.

Hospital Response:

Adequate controls in place.

Inpatient Hospital Acquired Conditions and Present on Admission Indicator Reporting

OIG Findings and Recommendations:

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 one of the five sampled claims for inpatient hospital-acquired conditions and present on admission indicator reporting, the Hospital billed Medicare with an incorrect DRG code. The Hospital stated that this error occurred because of human error. As a result of this error, the Hospital received an overpayment of \$3,398.

Hospital Response:

The Hospital notes that the error identified by the OIG Medicare Compliance Review was unrelated to Hospital Acquired Conditions (HAC), therefore the Hospital will forego any discussion of the Hospital’s HAC controls. Instead, given that the OIG and the Hospital are in agreement that the error was the result of an incorrect DRG assignment, the Hospital is providing coding key controls and corrective action taken.

The Hospital coding compliance program is based on the “seven elements of an effective compliance program” that was published in the *OIG Compliance Program Guidance for Hospitals* on February 23, 1998, together with the *OIG Supplemental Compliance Program Guidance for Hospitals* that was published on January 31, 2005. The Hospital’s policies, procedures and processes address each of the

seven elements, with specific focus on "Education and Training" and "Auditing and Monitoring." Policies, procedures and processes are reviewed annually and revised as needed. Newly hired coders receive six hours of coding compliance orientation training; part of this includes a review of the official coding guidelines involving the correct selection of principal and secondary diagnoses. Once a coder satisfies all orientation requirements, he/she is then monitored for coding quality.

In 2010, the Hospital replaced an external coding compliance software system with an internally developed Coding Compliance rules software system that is significantly more sophisticated and better meets the Hospital's rigorous compliance and general business needs. For example, the Hospital has existing rules to identify accounts where the actual length of stay is less than the Medicare 25th percentile length of stay for the DRG assigned, identify accounts where a solitary MCC/CC has been assigned, as well as many other rules to identify potential overpayments. Cases flagged for a potential variance must be re-reviewed prior to billing. This process occurs daily.

On a quarterly basis, each coder's cumulative DRG change rate, based on the results of the Coding Compliance rules software system record reviews, is reported to the Hospital Compliance Committee. Coders not meeting established quality indicators are placed on a corrective action plan. On a semi-annual basis, the Hospital conducts audits of Medicare inpatient and outpatient surgery cases. Our policies and procedures prescribe specific follow up when quality standards are not achieved.

The Hospital also provides ample educational opportunities to the coders in the form of live workshops and distance learning opportunities. At the conclusion of each semi-annual audit, the coders attend a detailed exit conference, and all findings are reviewed in detail with the appropriate coder.

Finally, based on an article in the March 2008 Journal of AHIMA, "Collecting Root Cause to Improve Coding Quality Measurement," the Hospital seeks to identify the root cause of each coding variance identified, in an attempt to prevent the error from recurring. In the article, AHIMA identified five broad categories that contribute to coding variance. For each of these areas, the Hospital identified positive action steps that will mitigate risk and result in Effective Coding and Documentation.

For the case identified by the OIG Medicare Compliance Review, Alzheimer's was initially selected as the principal diagnosis; however, a clarification was available in the medical record to rule out Alzheimer's. This identified coding error was found to be coder oversight. After the OIG reviewed this case, the Hospital agreed that the diagnosis of Alzheimer's was not supported and should not have been selected as the principal diagnosis, which resulted in an incorrect DRG assignment.

Following all coding audits, the Hospital investigates every identified coding variance and uses the results to communicate the positive action step(s) to be taken to improve coding effectiveness. Based on a review of the root causes of the coding error on this identified account, the Hospital identified the opportunities for improvement are "*apply in-depth clinical knowledge insightfully*" and "*review records diligently.*" The findings were discussed with the coder, who expressed an understanding of the root causes of the error and will be more diligent in following effective coding processes in the future.

The Hospital has an excellent coding accuracy overall, as measured by the Hospital's semi-annual coding compliance audits. The Hospital calculates two rates on each audit:

1. The first is a DRG coding error rate, which is calculated as accounts with DRG errors divided by the number of accounts audited.
2. The second is a Net Financial Error Rate, which is calculated by dividing as the estimated overpayment dollar amount divided by total payments of the audited sample.

The most recent Hospital semi-annual coding audit was completed in December 2011. The audit produced a DRG Coding Error Rate of 1.96%, with a Net Financial Error Rate of 0.00%; the lone DRG error identified on the December 2011 coding audit was an underpayment that had passed timely filing.

Inpatient Claims Paid in Excess of Charges

OIG Findings and Recommendations:

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 20 sampled inpatient claims paid in excess of charges, the Hospital billed Medicare with incorrect DRG codes. For one claim, the Hospital coded and billed for a procedure that was cancelled. For the other two claims, the Hospital billed Medicare based on a DRG code that was supported by the physician's written diagnosis in the patient's medical records. However, after further review, the patient's clinical documentation did not support the physician's written diagnosis. These errors occurred because of human error, and the Hospital's coders relied on the physician's written diagnosis within the patient's medical records. As a result of these errors, the Hospital received overpayments totaling \$20,775.

Hospital Response:

The Hospital coding compliance program is based on the "seven elements of an effective compliance program" that was published in the *OIG Compliance Program Guidance for Hospitals* on February 23, 1998, together with the *OIG Supplemental Compliance Program Guidance for Hospitals* that was published on January 31, 2005. The Hospital's policies, procedures and processes address each of the seven elements, with specific focus on "Education and Training" and "Auditing and Monitoring."

The Hospital's response in the section above, entitled *Inpatient Hospital Acquired Conditions and Present on Admission Indicator Reporting*, details the extensive coding compliance program that the Hospital has in place. In addition to the previously stated coding compliance program and coding key controls, the Hospital has a policy that allows coders to code without waiting for a completed discharge summary; however, the Hospital policy requires that the chart be re-reviewed by a coder once the summary is available. Additionally, one of the Hospital's key billing controls is that the only way for the Hospital Billing Office to change a DRG or add/delete a procedure on a claim is via an "HIM DRG Rebill Log". This log is generated by the Hospital HIM Department and routed to the Billing Office for processing.

Following all coding audits, the Hospital investigates every identified coding variance to communicate the positive action step(s) to be taken to improve coding effectiveness. Based on a review of the root causes of the coding errors on these 3 identified accounts, the Hospital identified the opportunities for improvements for Case 1 are *“review record diligently”* and *“communicate collaboratively”* and the opportunity for improvement for Cases 2 and 3 is to *“Document Reliably.”*

Case 1 of 3 involved the coding and billing of a procedure that was cancelled. At the time of the initial review, the documentation was unclear as to whether the surgery was cancelled, but upon re-review the Hospital Coding Department identified that the procedure had been cancelled. This was a coder oversight that a more diligent review of the record would have prevented. Hospital staff identified the error prior to the OIG Medicare Compliance Review, but failed to submit the required HIM DRG Rebill Log to the Hospital Billing Office for correction and rebill. This was the result of a miscommunication between the Hospital HIM Department and the Billing Office. The proper rebilling procedures were reiterated to the entire Hospital coding team.

Both Case 2 and 3 were short stays with limited documentation. Case 2, from a coding perspective, the coder was able to support a code for GI bleed based on the physician’s entry of “Upper GI Bleed” in the progress note. This case was coded correctly according to AHA/NCHS coding guidelines, as it was the documented condition that appears to be the reason chiefly responsible for the admission. The patient left AMA before the complete workup and additional documentation could be completed. The Hospital Chief Medical Officer for this facility reviewed the case and believed that from a clinical perspective, the patient likely did not have a GI bleed.

Case 3 is a similar situation. The physician clearly documented COPD, CHF and acute and chronic respiratory failure. The ICD-9-CM Official Guidelines for Coding and Reporting, Section II. C. states that when two or more diagnosis equally meet the criteria for principal diagnosis, either/any of the diagnoses may be listed first. Additionally in the Guidelines, section III. C. states that the diagnoses still to be ruled out may be coded as if they are confirmed. The physician documented “?CHF, ?COPD” therefore the coder believed she was appropriate in selecting CHF as the principal diagnosis. However, again when the Hospital Chief Medical Officer reviewed Case 3, he agreed that the patient did not have CHF and was in agreement with acute and chronic respiratory failure as the principal diagnosis.

Both Case 2 and 3 are examples of physicians documenting an unreliable diagnosis.

In 2008, AHIMA issued a practice brief on physician queries and clinical documentation entitled “Managing an Effective Query Process” (Journal of AHIMA 79, no.10 (October 2008): 83-88). In it they stated:

According to the Centers for Medicare and Medicaid Services and the Joint Commission, providers are expected to provide **legible, complete, clear, consistent, precise, and reliable** documentation of the patient’s health history, present illness, and course of treatment. This includes observations, evidence of medical decision-making in determining a diagnosis, and treatment plan, as well as the outcomes of all tests, procedures, and treatments. This documentation should be as complete and specific as possible, including information such as the

level of severity, specificity of anatomical sites involved, and etiologies of symptoms. (emphasis added)

The AHIMA Query practice brief goes on to state that a query is appropriate when a coder believes that the documentation fails to meet the criteria of legible, complete, clear, consistent and/or precise; however, the guidelines are clear that a coder cannot make a determination as to whether a physician's diagnostic statement is reliable or not. Additionally the brief states that a query is not appropriate in this situation:

Codes assigned to clinical data should be clearly and consistently supported by provider documentation. Providers often make clinical diagnoses that may not appear to be consistent with test results. For example, the provider may make a clinical determination that the patient has pneumonia when the results of the chest x-ray may be negative. **Queries should not be used to question a provider's clinical judgment**, but rather to clarify documentation when it fails to meet any of the five criteria listed above—legibility, completeness, clarity, consistency, or precision.

A query may not be appropriate simply because the clinical information or clinical picture does not appear to support the documentation of a condition or procedure (e.g., documentation of acute respiratory failure in a patient whose laboratory findings do not appear to support this diagnosis). In situations where the provider's documented diagnosis does not appear to be supported by clinical findings, a healthcare entity's policies can provide guidance on a process for addressing the issue without querying the attending physician.

Based on the information available in the record at the time of coding and following Official coding guidelines, the Hospital coders believed Case 2 and 3 were coded correctly and that all Hospital key controls were being followed. Coders do not have the clinical training to question a physician's diagnostic statement.

We believe the primary course of action with respect to addressing unreliable documentation is to continue to raise the coder's awareness about identifying unreliable documentation and establish a more formal escalation process, which will be discussed below.

To summarize, we do not believe these are coding errors but more specifically improvement opportunities regarding physician documentation.

Based on this OIG Medicare Compliance Review and an article in the January 2012 *Briefings on Coding Compliance Strategies* entitled, "Scrutinize Documentation in 2012 and Beyond" it is evident that our coding controls and processes to validate the DRG assigned do not necessarily validate that the clinical documentation is reliable.

CMS stated in the updated RAC Statement of Work released September 1, 2011:

“Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.”

The Hospital plans to educate all coders on this important issue at our upcoming live workshops. The Hospital’s coding professionals will be instructed to consider the following questions, consistent with their coding skills, as stated by the January 2012 article:

- “Does documentation support the diagnosis? For example, does documentation clearly include the patient’s status, responsiveness to treatment over time or any relevant laboratory results that help establish the validity of the diagnoses?”
- Is the diagnosis mentioned more than once?
- Does nursing documentation support physician documentation of the diagnoses?”

For accounts that may not meet these criteria, Hospital coders will be instructed to escalate the case to a clinician, prior to releasing the claim. This may include a referral to a non-physician clinician such as a case manager, or a physician; such as a physician advisor or the chief of the medical staff. The coder may always refer a case to his/her designated Coding Compliance Director who may confer with the applicable Chief Medical Officer. Additionally, the Chief Medical Officer for this facility will develop an education session, targeted at this facility’s physicians, with a focus on the reliability of documentation.

Finally, the Hospital will add a rule to the Hospital Coding Compliance software system to flag all Medicare inpatient accounts, where the expected DRG payment is in excess of charges, for a secondary review. The Coding Department will validate the coding and documentation of these flagged accounts, prior to billing.

Inpatient Claims with High Severity Level Diagnosis –Related Group Codes (MCC/CC)

OIG Findings and Recommendations:

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 4 of the 40 sampled inpatient claims billed with high severity level diagnosis-related group codes, the Hospital billed Medicare with incorrect DRG codes. For one claim, the coder coded a particular diagnosis that was later ruled out upon discharge. For the other three claims, the Hospital billed Medicare based on a DRG code that was supported by the physician’s written diagnosis in the patient’s medical records. However, after further review, the patient’s clinical documentation did not support the physician’s documented diagnosis. These errors occurred because the coder did not re-review the patient’s account when the discharge summary became available, and the coder relied on the physician’s written diagnosis within the patient’s medical records. As a result, the Hospital received overpayments totaling \$53,775.

Hospital Response:

As previously stated above, the Hospital coding compliance program is based on the “seven elements of an effective compliance program” that was published in the *OIG Compliance Program Guidance for Hospitals* on February 23, 1998, together with the *OIG Supplemental Compliance Program Guidance for Hospitals* that was published on January 31, 2005. The Hospital’s policies, procedures and processes address each of the seven elements, with specific focus on “Education and Training” and “Auditing and Monitoring.”

The Hospital’s response, in the sections above, entitled *Inpatient Hospital Acquired Conditions and Present on Admission Indicator Reporting* and *Inpatient Claims Paid in Excess of Charges* details the extensive coding compliance program that the Hospital has in place.

Following all coding audits, the Hospital investigates every identified coding variance to communicate the positive action step(s) to be taken to improve coding effectiveness. Based on a review of the root causes of the coding errors for these 4 identified accounts, the Hospital identified the opportunities for improvements for Case 1 are to “*Re-review Discharge Summary Thoroughly*” and the opportunity for improvement for Cases 2, 3 and 4 is to “*Document Reliably*.”

For Case 1, the coder coded pneumonia based on information available at the time of coding. The Hospital policy allows coders to code the account prior to the discharge summary being available. However, the policy requires that the account must be re-reviewed when the discharge summary becomes available. The Hospital has a procedure that outlines the steps required to ensure compliance. The HIM Director has reiterated the requirements for discharge summary review and the importance of doing so with each Hospital coder. The Hospital performs audits for evidence of adherence to the Discharge Summary Re-routing procedure during the semi-annual coding audits.

For Case 2, 3 and 4, the physicians documented “acute renal failure” and the coders believed they were appropriate in concluding that acute renal failure was an established diagnosis and appropriate to report. However, when the Hospital Chief Medical Officer reviewed the three cases, he agreed that these patients did not have acute renal failure. These are examples of physicians documenting an unreliable diagnosis.

The ICD-9-CM Official Guidelines for Coding and Reporting, Section III state the following:

The UHDDS item #11-b defines Other Diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.”

In addition, the AHIMA issued a practice brief on physician queries and clinical documentation entitled “Managing an Effective Query Process” (*Journal of AHIMA* 79, no.10 (October 2008): 83-88) in 2008. Excerpts from the brief were detailed in the Hospital’s response in the section above, entitled *Inpatient Claims Paid in Excess of Charges* and the excerpts are applicable to these cases, as well.

Based on the information available in the record at the time of coding and following AHA/NCHS Official coding guidelines, the coders believed they had coded the cases correctly and that all Hospital key

controls were being followed. Coders do not have the clinical training to question a physician's diagnostic statement.

We believe the primary course of action with respect to addressing unreliable documentation is to continue to raise coders' awareness about identifying unreliable documentation and establish a more formal escalation process.

Based on this OIG Medicare Compliance Review and an article in the January 2012 *Briefings on Coding Compliance Strategies* entitled, "Scrutinize Documentation in 2012 and Beyond" it is evident that our controls and processes in the Coding Department to validate the DRG assigned do not necessarily validate that the clinical documentation is reliable.

CMS stated in the updated RAC Statement of Work released September 1, 2011:

"Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials."

The Hospital plans to educate all Hospital coders on this important issue at our upcoming live workshops in May/June 2012. The Hospital's coding professionals will be instructed to consider the following questions, consistent with their coding skills, as stated by the January 2012 article:

- "Does documentation support the diagnosis? For example, does documentation clearly include the patient's status, responsiveness to treatment over time or any relevant laboratory results that help establish the validity of the diagnoses?"
- Is the diagnosis mentioned more than once?
- Does nursing documentation support physician documentation of the diagnoses?"

For accounts that may not meet these criteria, Hospital coders will be instructed to escalate the case to a clinician, prior to releasing the claim. This may include a referral to a non-physician clinician such as a case manager, or a physician such as a Physician Advisor or the Chief of the Medical Staff. The coder may always refer a case to his/her designated Coding Compliance Director who may confer with the Hospital Chief Medical Officer. In addition, the Hospital has provided education in the Hospital's monthly physician newsletter, focused on the appropriate documentation of acute renal failure.

Inpatient Psychiatric Facility Interrupted Stays

OIG Findings and Recommendations:

4 claims sampled and reviewed. No errors identified.

Hospital Response:

Adequate controls in place.

Outpatient Surgeries Billed with Units Greater than One

OIG Findings and Recommendations:

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 20.4, of the Manual states: "The definition of service units... is the number of times the service or procedure being reported was performed."

For the only sampled outpatient claim for outpatient surgeries with billed units greater than one, the Hospital submitted the claim to Medicare with an incorrect number of surgical units of service performed. The Hospital stated that the incorrect units were billed due to human error. As a result of this error, the Hospital received an overpayment totaling \$767.

Hospital Response:

The Hospital's patient accounting system has automated programming that is in place that converts the surgical charged units of service to a surgical unit of "1". In May 2010, prior to the OIG Medicare Review, it was determined that this key control was safeguarding claims that required no other manual review or correction to claims. In the event that a manual correction was needed on a claim, it was expected that all corrections would be performed manually by the biller. An internal assessment of our processes identified an opportunity to further enhance our clean claim edit process that would further ensure appropriate payment. Effective May 2010, a second safeguard was implemented within our billing editor software that suspends all claims with surgical units greater than "1" and returns the claim to the biller for re-review. These accounts are then clinically reviewed to ensure that the units billed are reflected appropriately on the claim, prior to submission.

The claim identified by the OIG to be in error, reflects a date of service of February 2009 and was returned for review of two edits. First, the claim was manually reviewed for the correct surgical date and then should have been manually reviewed for multiple surgical units. The surgical date was corrected and the claim was inadvertently "cleared" for billing, without review of the multiple surgical units. Once cleared, the claim was loaded to the billing editor software system and released for claim submission. This incorrect claim submission was due to a manual biller error. If this claim were to present today, the initial patient accounting safeguard would stop the claim for manual review and in the event that the manual correction of surgical units greater than "1" was overlooked, the claim would stop again in the claim editor software and be returned to the biller to correct.

Based on these previously enhanced and now established controls, the Hospital believes that no additional corrective action is indicated.

Inpatient Psychiatric Facility Emergency Department Adjustments

OIG Findings and Recommendations:

1 claim sampled and reviewed. No error identified.

Hospital Response:

Adequate controls in place.

Outpatient Manufacture Credits for Medical Devices

OIG Findings and Recommendations:

7 claims sampled and reviewed. No errors identified.

Hospital Response:

Adequate controls in place.

The OIG and the Hospital have agreed that the OIG will reprocess the 14 incorrectly billed inpatient claims and 1 incorrectly billed outpatient claim, which will result in a recoupment of the identified overpayment of \$124,566.00.

Again, thank you for the opportunity to respond to the OIG Medicare Compliance Review findings and we appreciate the professionalism demonstrated by the OIG audit team throughout this process.

Please do not hesitate to contact me if you have any further questions or require any additional information.

Sincerely,



Melissa L. Paper, JD, MPA, CHC
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Palmetto General Hospital