

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
SAINT THOMAS HOSPITAL FOR
CALENDAR YEARS 2009 AND 2010**

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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.

Saint Thomas Hospital (the Hospital) is a 541 bed acute care facility located in Nashville Tennessee. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$261 million for 26,855 inpatient and 71,176 outpatient claims for services provided to beneficiaries during calendar years 2009 and 2010 (audit period).

Our audit covered \$28,592,688 in Medicare payments to the Hospital for 3,297 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 250 claims with payments totaling \$3,335,641. These 250 claims had dates of service in our audit period and consisted of 195 inpatient and 55 outpatient claims.

OBJECTIVE

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

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 206 of the 250 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 44 claims, resulting in overpayments of \$293,359 for the audit period. Specifically, 40 inpatient claims had billing errors resulting in overpayments of \$270,040, and 4 outpatient claims had billing errors resulting in overpayments of \$23,319. These errors occurred primarily because the Hospital did not have adequate internal controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,092,248 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$1,092,248 in estimated overpayments for the audit period claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare billing requirements.

SAINT THOMAS HOSPITAL COMMENTS

In written comments on our draft report, the Hospital did not agree with our first recommendation. In regard to our second recommendation, the Hospital discussed steps it had taken or planned to take to strengthen its internal controls to ensure compliance with Medicare billing requirements.

Incorrectly Billed as Inpatient

The Hospital agreed that 29 of 40 inpatient claims and all 4 outpatient claims were errors. The Hospital disagreed that it incorrectly billed the remaining 11 claims as inpatient. The Hospital also said that if these 11 claims were in error because they were billed for the wrong setting (inpatient versus outpatient), then we should only report the difference between the inpatient claim amount the Hospital actually received and the amount that the Hospital would have received had it billed the claim as outpatient.

Statistical Sampling

Statistical Sampling Versus Judgmental Sampling

The Hospital said that it was not informed, until towards the end of the audit process that the sample was statistical and the findings would be estimated. The Hospital also questioned our rationale for selecting a hospital for statistical sampling and estimation of the overpayment rather

than using judgmental sampling with no estimation. Additionally, the Hospital requested that we permit them to repay only those claims that were actually audited.

Sample Frame

The Hospital said that our sample frame included several claims that the Recovery Audit Contractors (RAC) had also reviewed. The Hospital believed that including RAC claims in our sample frame, especially claims that the Hospital had already repaid, would result in the Hospital repaying Medicare twice.

Although the Hospital did not agree with our sampling methodology, the Hospital said that it would make any final payment necessary as a result of our use of statistical sampling.

OFFICE OF INSPECTOR GENERAL RESPONSE

Incorrectly Billed As Inpatient

We do not have enough information to calculate the difference between the inpatient claim amount the Hospital actually received and the amount that the Hospital would have received had it billed the claim correctly as outpatient. At the time of our exit conference with the Hospital on March 26, 2013, the Hospital had not rebilled the 11 inpatient claims as outpatient. For us to calculate the difference the Hospital would have to rebill the claims as outpatient and the Medicare Administrative Contractor (MAC) would have to adjudicate the claims.

Statistical Sampling

Statistical Sampling Versus Judgmental Sampling

At our entrance conference on June 26, 2012, we informed the Hospital that we would use statistical sampling techniques to select claims for review. In addition, during the course of the audit, we discussed with a Hospital official our plans to “project” the sample results across the population.

In regard to the Hospital’s selection for audit, we choose hospitals for audit on the basis of data analysis, discussions with Medicare contractors, and previous OIG work. As this hospital compliance review initiative has matured, we have refined our audit methodologies. Some reviews use statistical sampling and estimation techniques to draw conclusions about a larger portion of a hospital’s claims while other reviews use judgmental sampling. Each hospital review is unique, and the sampling method used in each of these reviews will vary. For this reason, we review different risk areas at different hospitals and use both statistical and nonstatistical methods for selecting our samples. Our sampling and estimation techniques are statistically valid methodologies that the OIG has used successfully to identify overpayments. Therefore, we continue to recommend that the Hospital repay the full estimated amount.

Sample Frame

We removed claims from our sample frame that were under review by the RAC prior to drawing our sample. However, because of timing differences between when these claims were removed and when we drew our sample, some claims included in both our sample frame and our sample were subsequently identified as being under RAC or Department of Justice (DOJ) review. Our inclusion of these RAC and DOJ claims in our sample did not increase the number of errors we identified or increase our overpayment estimate. We treated each of the RAC and DOJ claims in our sample as non-errors. By treating these claims as non-errors, we reduced the sample error rate that was statistically applied to the sampling frame.

We continue to recommend that the Hospital refund to the Medicare contractor \$1,092,248 in estimated overpayments during the audit period.

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INTRODUCTION

BACKGROUND

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

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

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.¹ The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.² All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

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

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

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

- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims paid in excess of charges,
- inpatient same-day discharges and readmissions,
- inpatient and outpatient manufacturer credits for replaced medical devices, and
- outpatient claims with payments greater than \$25,000.

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

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

Medicare Requirements for Hospital Claims and Payments

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

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

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

Saint Thomas Hospital

Saint Thomas Hospital (the Hospital) is a 541 bed acute care facility located in Nashville, Tennessee. According to CMS’s National Claims History data, Medicare paid the Hospital approximately \$261 million for 26,855 inpatient and 71,176 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010.

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 types of claims.

Scope

Our audit covered \$28,592,688 in Medicare payments to the Hospital for 3,297 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 250 claims with payments totaling \$3,335,641. These 250 claims had dates of service in our audit period and consisted of 195 inpatient and 55 outpatient claims.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 18 claims to medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

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

We conducted our fieldwork at the Hospital from June through September 2012.

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 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 analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 250 claims (195 inpatient and 55 outpatient) totaling \$3,335,641 for detailed review (Appendix A);

- reviewed available data from CMS’s Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital’s procedures for assigning DRG, HCPCS and admission status codes for Medicare claims;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- used CMS’s Medicare contractor medical review staff to determine whether 18 sampled claims met medical necessity requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample review to calculate the estimated Medicare overpayment to the Hospital (Appendix B); 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 206 of the 250 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 44 claims, resulting in overpayments of \$293,359 for the audit period. Specifically, 40 inpatient claims had billing errors resulting in overpayments of \$270,040, and 4 outpatient claims had billing errors resulting in overpayments of \$23,319. These errors occurred primarily because the Hospital did not have adequate internal controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,092,248 for the audit period. Please see Appendix A for our sample design and methodology and Appendix B for our sample results and estimates.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 40 of 195 randomly selected inpatient claims, which resulted in overpayments of \$270,040.

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 22 of 195 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 said that these overpayments occurred because of human errors in the billing process, including inappropriate decisions made by case management personnel.

As a result of these errors, the Hospital received overpayments of \$189,952.³

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

For 10 of 195 sampled claims, the Hospital submitted claims to Medicare with incorrect DRG codes. For example, one claim was submitted with a principal diagnosis code associated with a myocardial infarction but the medical records indicated that the principle diagnosis code should have been for supraventricular tachycardia. Changing the principle diagnosis code to the correct code caused the DRG to change. The Hospital attributed these coding errors to its staff’s misapplication of coding guidelines in the coding process.

As a result of these errors, the Hospital received overpayments of \$25,976.

Incorrect Reporting of Medical Device Credits

Federal regulations (42 CFR § 412.89) 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 cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

³ The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

The Manual, chapter 3, section 100.8, states that to bill correctly for a replacement device that was provided with a credit, the hospital must code its Medicare claims with a combination of condition code 49 or 50, along with value code “FD.”

For 6 of 195 sampled claims, the Hospital received a reportable medical device credit from the manufacturer for a replaced device, but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required.

For example, one claim included charges for the replacement of a malfunctioning heart device lead. The lead had originally been implanted in 2007 and was covered by the manufacturer’s warranty. Based on this coverage, the manufacturer reimbursed the Hospital \$3,600. However, the Hospital did not adjust its claim to reflect this credit.

The Hospital said that copies of credit memos or credit notifications from manufacturers were difficult to obtain, which made it difficult for the Hospital to follow up on credits. The Hospital also said that it did not perform audits of manufacturers’ credits as thoroughly or regularly as needed.

As a result of these errors, the Hospital received overpayments of \$44,400.

Incorrectly Billed as Separate Inpatient Stay

The Manual, chapter 3, section 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 2 of 195 sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital attributed these incorrect billings to human error.

As a result, the Hospital received overpayments of \$9,712.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 4 of 55 randomly selected outpatient claims, which resulted in overpayments of \$23,319.

Incorrect Reporting of Medical Device Credits

Federal regulations (42 CFR § 419.45) 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.

Billing Requirements for Medical Device Credits

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPSS. 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.

Prudent Buyer Principle

Pursuant to 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services ...” The CMS *Provider Reimbursement Manual*, part 1, section 2102.1, 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.

Section 2103.A of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties for medical devices. 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 Overpayments

For 2 of 55 sampled claims, the Hospital received a full credit for a replaced device but did not report the “FB” modifier and reduced charges on its claim (1 claim), or the Hospital did not obtain a credit for a replaced device that was available under the terms of the manufacturer’s warranty (1 claim). In the first instance, the Hospital received a credit for replacing a malfunctioning battery.

The Hospital said that copies of credit memos or credit notifications from manufacturers were difficult to obtain, which made it difficult for the Hospital to follow up on credits. The Hospital also said that it did not perform audits of manufacturers' credits as thoroughly or regularly as needed.

As a result of these errors, the Hospital received overpayments of \$22,190.

Incorrect Healthcare Common Procedure Coding System Codes

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, section 80.3.2.2, states: “[T]o be processed correctly and promptly, a bill must be completed accurately....”

For 2 of 55 sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes. In one instance, the Hospital billed using a HCPCS code for the removal of a heart device lead. However, the medical records showed that the lead was repaired but not removed. The Hospital cited human error as the cause of these errors.

As a result of these errors, the Hospital received overpayments of \$1,129.

OVERALL ESTIMATE OF OVERPAYMENTS

Based on our sample results, we estimated that the Hospital received overpayments of at least \$1,092,248 for the audit period. Our sample design and methodology are discussed in Appendix A and our sample results and estimates are discussed in Appendix B.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$1,092,248 in estimated overpayments for the audit period claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare billing requirements.

SAINT THOMAS HOSPITAL COMMENTS

In written comments on our draft report, the Hospital did not agree with our first recommendation. In regard to our second recommendation, the Hospital discussed steps it had taken or planned to take to strengthen its internal controls to ensure compliance with Medicare billing requirements.

Incorrectly Billed as Inpatient

The Hospital agreed that 29 of 40 inpatient claims and all 4 outpatient claims were errors. The Hospital disagreed that it incorrectly billed the remaining 11 claims as inpatient. The Hospital also said that if these 11 claims were in error because they were billed for the wrong setting (inpatient versus outpatient), then we should only report the difference between the inpatient claim amount the Hospital actually received and the amount that the Hospital would have received had it billed the claim as outpatient.

Statistical Sampling

Statistical Sampling Versus Judgmental Sampling

The Hospital said that it was not informed, until towards the end of the audit process that the sample was statistical and the findings would be estimated. The Hospital also questioned our rationale for selecting a hospital for statistical sampling and estimation of the overpayment rather than using judgmental sampling with no estimation. Additionally, the Hospital requested that we permit them to repay only those claims that were actually audited.

Sample Frame

The Hospital said that our sample frame included several claims that the Recovery Audit Contractors (RAC) had also reviewed. The Hospital believed that including RAC claims in our sample frame, especially claims that the Hospital had already repaid, would result in the Hospital repaying Medicare twice.

Although the Hospital did not agree with our sampling methodology, the Hospital said that it would make any final payment necessary as a result of our use of statistical sampling.

OFFICE OF INSPECTOR GENERAL RESPONSE

Incorrectly Billed As Inpatient

We do not have enough information to calculate the difference between the inpatient claim amount the Hospital actually received and the amount that the Hospital would have received had it billed the claim correctly as outpatient. At the time of our exit conference with the Hospital on March 26, 2013, the Hospital had not rebilled the 11 inpatient claims as outpatient. For us to calculate the difference the Hospital would have to rebill the claims as outpatient and the Medicare Administrative Contractor (MAC) would have to adjudicate the claims.

Statistical Sampling

Statistical Sampling Versus Judgmental Sampling

At our entrance conference on June 26, 2012, we informed the Hospital that we would use statistical sampling techniques to select claims for review. In addition, during the course of the

audit, we discussed with a Hospital official our plans to “project” the sample results across the population.

In regard to the Hospital’s selection for audit, we choose hospitals for audit on the basis of data analysis, discussions with Medicare contractors, and previous OIG work. As this hospital compliance review initiative has matured, we have refined our audit methodologies. Some reviews use statistical sampling and estimation techniques to draw conclusions about a larger portion of a hospital’s claims while other reviews use judgmental sampling. Each hospital review is unique, and the sampling method used in each of these reviews will vary. For this reason, we review different risk areas at different hospitals and use both statistical and nonstatistical methods for selecting our samples. Our sampling and estimation techniques are statistically valid methodologies that the OIG has used successfully to identify overpayments. Therefore, we continue to recommend that the Hospital repay the full estimated amount.

Sample Frame

We removed claims from our sample frame that were under review by the RAC prior to drawing our sample. However, because of timing differences between when these claims were removed and when we drew our sample, some claims included in both our sample frame and our sample were subsequently identified as being under RAC or Department of Justice (DOJ) review. Our inclusion of these RAC and DOJ claims in our sample did not increase the number of errors we identified or increase our overpayment estimate. We treated each of the RAC and DOJ claims in our sample as non-errors. By treating these claims as non-errors, we reduced the sample error rate that was statistically applied to the sampling frame.

We continue to recommend that the Hospital refund to the Medicare contractor \$1,092,248 in estimated overpayments during the audit period.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population contained inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during the audit period.

SAMPLING FRAME

Medicare paid the Hospital \$260,747,957 for 26,855 inpatient and 71,176 outpatient claims for services provided to beneficiaries during the audit period based on CMS's National Claims History (NCH) data.

We downloaded a database of claims from the NCH database totaling \$155,711,635 for 13,193 inpatient and 22,791 outpatient claims in 30 high risk areas. From these 30 areas, we selected 6 consisting of 11,612 claims totaling \$124,744,004, for further review.

We then removed the following:

- \$0 paid claims,
- claims under review by the Recovery Audit Contractor, and
- claims duplicated within individual high risk categories.

We assigned each claim that appeared in multiple high risk categories to just one category based on the following hierarchy: Manufacturer Credits for Replaced Medical Devices, Inpatient Short Stays, and Inpatient Claims Paid in Excess of Charges. This resulting database contained 3,297 unique Medicare claims in 6 high risk categories totaling \$28,592,688 from which our sample was drawn.

Medicare High Risk Area	Number of Claims	Amount of Payments
1. Inpatient Short Stays	1,707	\$11,510,539
2. Inpatient Claims Paid in Excess of Charges	369	3,335,775
3. Outpatient Claims with Payments Greater Than \$25,000	98	2,628,766
4. Inpatient Claims Billed with High-Severity-Level Diagnosis-Related Group Codes	1,043	9,691,709
5. Inpatient Same-Day Discharges and Readmissions	4	34,518
6. Inpatient and Outpatient Manufacturer Credits for Replaced Medical Devices	76	1,391,381
Total	3,297	\$28,592,688

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into six strata based on the Medicare risk category.

SAMPLE SIZE

We selected 250 claims for review as follows:

Stratum	Medicare High Risk Area	Claims in Sample Frame	Claims in Sample
1	Inpatient Short Stays	1,707	50
2	Inpatient Claims Paid in Excess of Charges	369	40
3	Outpatient Claims With Payments Greater Than \$25,000	98	30
4	Inpatient Claims Billed With High-Severity-Level Diagnosis-Related Group Codes	1,043	50
5	Inpatient Same Day Discharges and Readmissions	4	4
6	Inpatient and Outpatient Manufacturer Credits for Replaced Medical Devices	76	76
	TOTAL	3,297	250

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata one through four. After generating the random numbers for these strata, we selected the corresponding frame items. We selected all claims in strata five and six.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments paid to the Hospital during the audit period.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	1,707	\$11,510,539	50	\$325,141	9	\$56,050
2	369	3,335,775	40	358,353	12	86,240
3	98	2,628,766	30	803,289	1	565
4	1,043	9,691,709	50	422,959	4	14,945
5	4	34,518	4	34,518	1	3,624
6	76	1,391,381	76	1,391,381	17	131,935
Total	3,297	\$28,592,688	250	\$3,335,641	44	\$293,359

Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	\$2,844,665
Lower limit	1,092,248 ⁴
Upper limit	4,612,592

⁴ In accordance with OAS policy, we did not use the results from strata 3 and 4 in calculating the estimated overpayments. Instead, we added the actual overpayments from strata 3 and 4 (\$15,510) to the lower limit (\$1,076,738), which resulted in an adjusted lower limit of \$1,092,248.

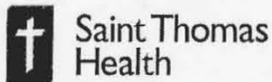
APPENDIX C: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Short Stays	50	\$325,141	9	\$56,050
Claims Paid in Excess of Charges	40	358,353	12	86,240
Claims Billed with High-Severity-Level Diagnosis-Related Group Codes	50	422,959	4	14,945
Same-Day Discharges and Readmissions	4	34,518	1	3,624
Manufacturer Credits for Replaced Medical Devices	51	1,031,617	14	109,181
Inpatient Totals	195	\$2,172,588	40	\$270,040
Outpatient				
Claims With Payments Greater Than \$25,000	30	\$803,289	1	\$565
Manufacturer Credits for Replaced Medical Devices	25	359,764	3	22,754
Outpatient Totals	55	\$1,163,053	4	\$23,319
Inpatient and Outpatient Totals	250	\$3,335,641	44	\$293,359

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 Saint Thomas. 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.

OIG Note: Subsequent to the issuance of our draft report to Saint Thomas, we determined that our sample of 250 claims consisted of 195 inpatient and 55 outpatient claims rather than the 204 and 46, respectively, we reported in the draft report.

APPENDIX D: SAINT THOMAS HOSPITAL COMMENTS



April 3, 2013

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

RE: Medicare Compliance Review of Saint Thomas Hospital for Calendar Years 2009 and 2010 (Report Number A-04-12-03071)

Dear Ms. Pilcher:

We are in receipt of the U. S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled *Medicare Compliance Review of Saint Thomas Hospital for Calendar Years 2009 and 2010*. We appreciate the opportunity to respond to the draft report.

Saint Thomas Hospital ("STH") is committed to providing quality care to our patients. In addition, we are good corporate citizens and it is our intent and focus to ensure that we appropriately and accurately bill all payors, in particular our governmental payors. We strive to stay abreast of billing guidelines and have implemented many measures to self-audit our processes and claims. To this end, STH values the feedback provided by the draft report and has taken it seriously.

The OIG audit covered \$3,335,641 in Medicare payments to STH for 250 claims (204 inpatient and 46 outpatient claims) audited. Towards the end of the audit process, we were informed for the first time that the sample was statistical and would result in extrapolation of the audit findings. As a result of the detail review, the OIG identified 40 inpatient claims with billing errors resulting in overpayment of \$270,040 and 4 outpatient claims with billing errors resulting in overpayments of \$23,319. The 44 claims with billing errors resulted in a total of \$293,359 in overpayments for CYs 2009 and 2010. The OIG subsequently applied the error rate to the population and estimated that the Hospital received overpayments totaling \$1,092,248 for CYs 2009 and 2010.

STH would like to comment on the application of the "statistical" vs. "judgmental" sampling methodology that was utilized for this audit. In reviewing the Medicare Compliance Reviews audit reports the OIG has issued in the past two years, all of them were based on a "judgmental" sampling methodology. In some cases, it was noted that some hospitals had no extrapolation even though their overpayment audit results appeared to exceed those of STH. STH respectfully questions the rationale for selecting a hospital for the "statistical" vs. "judgmental" sampling methodology, particularly so far in to this present hospital compliance audit initiative. Those facilities that had the "judgmental" sampling methodology

applied only had to refund the overpayments for the claims actually reviewed as part of the audit. This seems reasonable especially when the process of determining "medical necessity" for inpatients is a "complex decision making process" and sometimes "gray" at best. Indeed, billing reviews conducted over the past two years by the Recovery Audit Contractor on behalf of the Center for Medicare and Medicaid Services (CMS) have proven that many claims cited as being inappropriate for inpatient status have been subsequently appealed and reversed through the appeal process. The American Hospital Association has reported that 61% of medical necessity denials were for 1 day stays where the care was provided in the wrong setting. Of those cases appealed, 72% of the appeals are being reversed in the provider favor. This further substantiates the difficulty in applying the "complex medical decision" process to appropriate setting. We therefore request that you reconsider the application of the "statistical" sampling methodology in this case and permit us to reimburse only those claims that were actually audited, as has been the case with all of your previously published hospital Medicare compliance reviews.

Assuming for the sake of argument that extrapolation is appropriate here, we would also like to comment on the payment calculation methodology used for the claims that were found in error due to the wrong setting (inpatient vs. outpatient). For those claims, the total reimbursement amount was reflected as an overpayment error when in fact this is not accurate. The overpayment error should be reflective of the "actual overpayment" amount (net, not gross). The overpayment calculation for DRG errors is reflected as the "actual overpayment" (difference between the correct DRG and the wrong DRG reimbursement). CMS has most recently issued a ruling (1455-NR) which allows hospital who have an inpatient denial to submit a Part B inpatient claim for more than just ancillary services. This ruling provides significant relief to hospitals who in the past could only receive reimbursement for ancillary services. This audit should similarly reflect reimbursement for medically necessary services provided. Some Administrative Law Judges have agreed to the extent that Part A denial is upheld, the hospital is entitled to full Part B payment reimbursement. The audit reflects \$189,952 in overpayments because medically necessary services were performed in an inpatient setting. The audit payment calculation methodology should accurately reflect the actual overpayment (inpatient DRG – outpatient APC). In doing so, the hospital is compensated for medically necessary services provided to the Medicare Beneficiary. We would like to request that you apply the rebill payment methodology as described in the recently issued MLN Matters Number: MM8185 "**CMS Administrator's Ruling: Part A to Part B Rebilling of Denial Hospital Inpatient Claims**". In doing so, the accurate overpayment amount will be reflected in the extrapolation process and the report.

The draft audit report indicated that Recovery Audit Contractor (RAC) cases were excluded from the frame. We requested the frame file to confirm that RAC cases had been excluded. The use of extrapolation while there is such extensive RAC activity could result in the hospital repaying Medicare twice. Based on our review, we identified several RAC cases that are included in the frame file. I have cited two examples of the type of cases included in the frame and the impact to STH:

- Short Stay Case that was reviewed and **approved** by the RAC, no repayment required; extrapolation error rate was applied against this case as part of the frame;
- Short Stay Case was reviewed and **denied** by the RAC, repayment to CMS has occurred, STH is appealing the case. In this case, we have already repaid the Medicare Program and the extrapolation is being applied against this case which results in "double payment".

We would request that the OIG re-evaluate the frame file to ensure that all cases that have been requested by the RAC are removed as indicated in the draft report.

We have taken great effort to review the details of the audit findings and provide the following response:

Billing Errors Associated With Inpatient Claims

Incorrectly Billed as Inpatient

The OIG auditor's findings indicate that STH incorrectly billed 24 of 204 sampled claims to Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. As a result, STH received overpayments totaling \$189,952.

STH concurs that 13 claims were in error but we respectfully disagree that 11 claims were incorrectly billed as inpatients. The 11 claims are sample cases 25, 28, 33, 34, 65, 78, 87, 88, 125, 134, and 180; these claims represent approximately \$70,572 in reimbursement.

CMS policy states that the physician is responsible for a patient's care at the hospital. The physician is also responsible for deciding whether the patient should be admitted as an inpatient. The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history, current medical needs, and the type of facilities available to inpatients and to outpatients, the hospital bylaws and admission policies and the relative appropriateness of treatment in each setting. To assist and support the physician in this complex decision making process, the hospital utilizes nationally accepted screening criteria, evidence based practices, clinical judgment and advisement from those who have expertise in this area. It is our position that we exercised due diligence in supporting and assisting the physician in his/her final decision to admit the patient as an inpatient in the eleven claims noted above.

Because we adamantly believe that we provided the appropriate services in the best interest of our patients and in compliance with Medicare's policy, we will take these claims through the appeal process available to us. At such time that we receive a final opinion regarding our appeal, we will request through the CMS/Medicare Audit Contractor that the OIG re-evaluate the overpayment calculation for any reversed opinions.

Incorrect Diagnosis-Related Groups

The OIG auditor's findings indicate that STH incorrectly billed 10 of 204 sampled claims to Medicare with incorrect DRG codes. As a result, STH received overpayments totaling \$25,976.

STH concurs that 10 claims were in error.

Incorrect Reporting of Medical Device Credits

The OIG auditor's findings indicate that STH incorrectly billed 6 of 204 sampled claims where STH received a reportable medical device credit from the manufacturer for a replaced device and failed to adjust the inpatient claims with the proper condition code and value codes to reduce payment as required by Medicare. As a result, the Hospital received overpayments totaling \$ 44,400.

STH concurs that the 6 claims were billed in error.

Incorrect Billed as Separate Inpatient Stay

The OIG auditor's findings indicate that STH incorrectly billed 2 of 204 sampled claims to Medicare separately for related discharges and readmissions within the same day. As a result, the Hospital received overpayments totaling \$9,712.

STH concurs that the 2 claims were billed in error.

Billing Errors Associated With Outpatient Claims

Incorrect Reporting of Medical Device Credits

The OIG auditor's findings indicate that STH incorrectly billed 2 of 46 sampled claims where STH received a reportable medical device for full credit from the manufacturer for a replaced device and failed to adjust the outpatient claims with the proper modifier to reduce payment or STH failed to pursue the credit that was due as required by Medicare guidance. As a result, the Hospital received overpayments totaling \$22,190.

STH concurs that the 2 claims were billed in error.

Incorrect Healthcare Common Procedure Coding System Codes

The OIG auditor's findings indicate that STH incorrectly billed 2 of 46 sampled claims where STH submitted to Medicare incorrect HCPCS codes. As a result, the Hospital received overpayments totaling \$1,129.

STH concurs that the 2 claims were billed in error.

Response to Recommendations made by the OIG to STH:

- **Refund to the Medicare contractor \$1,092,248 in estimated overpayments for CYs 2009 and 2010 claims that it incorrectly billed and**

STH acknowledges the methodology used to estimate the overpayment of \$1,092,298 based on the statistical sampling methodology, however we do not concur with this methodology. As previously discussed we believe that it is not appropriate to extrapolate for the following reasons:

- Due to the complexity in determining appropriate setting and the significant reversal rate for appeals of previously denied inpatient claims, extrapolation compounds an error rate that is questionable;
- The use of extrapolation disadvantages STH as no other hospital with a published OIG audit report related to this initiative received this type of treatment even if their audit results were more unfavorable than ours;
- The error rate calculated does not accurately reflect the overpayment amount (overpayment calculation reflects total reimbursement for inpatient stay not the net overpayment as was done in the DRG changes).

We will however make any final payment necessary as a result of this process.

- **Strengthen controls to ensure full compliance with Medicare billing requirements.**

STH concurs that there is an opportunity to strengthen controls to ensure compliance with Medicare billing requirements. We do not believe though that it is reasonable to expect "full –

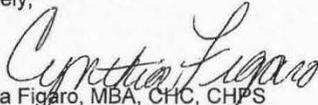
100%* compliance with Medicare billing requirements in all instances. However, STH is committed to strive to this objective and have implemented the following corrective action plans:

- To ensure accurate claims regarding credits of medical devices, the policy and procedure has gone through extensive revision, assignment to an STH Associate who has increased knowledge in the area of replacing devices, cooperation with vendors to receive medical device credit reports on a monthly basis, and the Compliance Department will conduct periodic audits to confirm billing accuracy.
- To ensure accurate coding of claims, STH has reviewed the audit results to identify any trends in errors as to type and individual making error. STH will continue to perform quarterly audits as necessary in the assignment of DRGs and selection of CDM codes. The audit process includes education to the coder, rebill of claims in error, and focused review follow-up, when warranted.
- To ensure accurate selection of patient setting (outpatient vs. inpatient), Case Managers will be audited on a routine basis to ensure proficiency in evaluating cases for medical necessity. The audit process includes education of the associate, rebill of claims in error, and focused review follow-up, when warranted.

STH takes compliance responsibilities and obligations very seriously. We have re-evaluated our current processes and procedures where we have made billing errors. We have taken steps to strengthen internal controls, increase the amount of auditing to better scrutinize our claims, and to re-educate staff where there are opportunities for improved accuracy. We are grateful for the constructive feedback this audit process has provided us to meet our goal as a good corporate citizen.

We look forward to receiving your response to the items discussed in our Exit Conference and in this communication. We would like the opportunity to review any revisions made to the audit report and shall prepare a response to the final audit report. Please feel free to contact me if you have questions about our efforts or if additional information is needed.

Sincerely,



Cynthia Figaro, MBA, CHC, CHPS
Corporate Responsibility Officer
Saint Thomas Health

cc: Dawn Rudolph, President and Chief Executive Officer
Pam Hess, Chief Financial Officer