

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
BATON ROUGE GENERAL MEDICAL
CENTER
FOR CALENDAR YEARS
2009 AND 2010**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Patricia Wheeler
Regional Inspector General

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A-06-11-00065

Office of Inspector General

<http://oig.hhs.gov>

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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 inpatient hospital 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.

Baton Rouge General Medical Center (the Hospital) is a 544-bed hospital located on two campuses in Baton Rouge, Louisiana. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$156 million for 15,621 inpatient and 53,240 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010.

Our audit covered \$4,135,369 in Medicare payments to the Hospital for 152 inpatient and 21 outpatient claims that we identified as potentially at risk for billing errors. These 173 claims had dates of service in CYs 2009 and 2010.

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 125 of the 173 sampled inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare

billing requirements for the remaining 48 claims, resulting in overpayments totaling \$372,913 for CYs 2009 and 2010. Specifically, 44 inpatient claims had billing errors resulting in overpayments totaling \$360,600, and 4 outpatient claims had billing errors resulting in overpayments totaling \$12,313. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims, relied on physicians with varying levels of knowledge regarding level-of-care decisions, and did not fully understand the Medicare billing requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$372,913, consisting of \$360,600 in overpayments for the 44 incorrectly billed inpatient claims and \$12,313 in overpayments for the 4 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

BATON ROUGE GENERAL MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital concurred with most of our findings and recommendations and provided information regarding the corrective actions it has taken to address the compliance issues identified in our report. The Hospital did not fully agree with our finding that it incorrectly billed 39 claims involving inpatient stays that should have been billed as outpatient or outpatient with observation services. For 6 of the 39 claims, the Hospital stated that the attending physician ordered inpatient services and that the admissions were supported by the criteria used by care management staff.

With respect to the six claims discussed above, we continue to maintain that these claims should have been billed as outpatient or outpatient with observation services. A review by CMS's Medicare contractor confirmed our position. Therefore, we continue to recommend that the overpayments be refunded to the Medicare contractor.

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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 administrative contractors (MAC) 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 inpatient hospital 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. 106-113.¹ 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 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

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.

analysis techniques. Examples of the types of claims at risk for noncompliance included the following:

- inpatient short stays,
- inpatient claims paid in excess of charges,
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient hospital-acquired conditions and present-on-admission indicators,³
- inpatient manufacturer credits for replaced medical devices,
- outpatient claims with payments greater than \$25,000, and
- outpatient claims billed with modifier -59.

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

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 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.

³ “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 an emergency department visit, 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.

Baton Rouge General Medical Center

Baton Rouge General Medical Center (the Hospital) is a 544-bed hospital located in Baton Rouge, Louisiana. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$156 million for 15,621 inpatient and 53,240 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 claims.

Scope

Our audit covered \$4,135,369 in Medicare payments to the Hospital for 173 claims that we judgmentally selected as potentially at risk for billing errors (Appendix). These 173 claims had dates of service in CYs 2009 and 2010 and consisted of 152 inpatient and 21 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 subjected a limited number of claims to focused 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. Our review enabled 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 the Hospital submitted for Medicare reimbursement.

We performed our audit work from December 2011 to July 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers 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 173 claims (152 inpatient and 21 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation the Hospital provided 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;
- used CMS's Medicare contractor medical review staff to determine whether a limited number of sampled claims met medical necessity requirements;
- discussed with Hospital personnel the incorrectly billed claims and the internal controls applicable to each area of noncompliance with Medicare requirements to determine the underlying causes of noncompliance;
- 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 125 of the 173 sampled inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in overpayments totaling \$372,913 for CYs 2009 and 2010. Specifically, 44 inpatient claims had billing errors resulting in overpayments totaling \$360,600, and 4 outpatient claims had billing errors resulting in overpayments totaling \$12,313. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims, relied on physicians with varying levels of knowledge regarding level-of-care decisions, and did not fully understand the Medicare billing requirements. See the Appendix for a breakdown of billing errors by review category.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 44 of the 152 sampled inpatient claims. These errors resulted in overpayments totaling \$360,600.

Incorrectly Billed as Inpatient Services

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 39 of 152 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Pinnacle Business Solutions, the Hospital’s MAC, reviewed 7 of the 39 claims and agreed that they were incorrectly billed because the documentation did not support that an inpatient admission was medically necessary and reasonable. The Hospital attributed the errors to its Care Management staff, which did not review the claims until after the patients were discharged, and to its reliance on physicians with varying levels of knowledge regarding level-of-care decisions. As a result of these errors, the Hospital received overpayments totaling \$334,973.⁴

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 on a single claim.

For 5 of the 152 sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that its process for same-day readmissions did not follow Medicare policy. Billing staff reviewed only diagnosis code information rather than conducting clinical assessments of the reasons for the two stays. As a result of these errors, the Hospital received overpayments totaling \$25,627.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 4 of the 21 sampled outpatient claims. These errors resulted in overpayments totaling \$12,313.

⁴ The Hospital may be able to bill Medicare Part B for some services related to some of these incorrect Medicare Part A claims. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

Incorrect Number of Units

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. Additionally, 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 1 of the 21 sampled claims, the Hospital submitted the claim to Medicare with the incorrect number of units of a drug administered. The Hospital attributed this error to a human error by the pharmacy staff that the billing staff failed to recognize while finalizing the claims for submission. As a result of this error, the Hospital received an overpayment of \$10,666.

Incorrectly Billed as Separate Services or Procedure Not Performed

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 23, section 20.9.1.1(B), states: “The ‘-59’ modifier is used to indicate a distinct procedural service ... this may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).”

The Manual, chapter 4, section 20.6.4(C), states that planned procedures that are not started may not be claimed.

For 3 of the 21 sampled claims, the Hospital incorrectly billed Medicare separately for services that were not distinct from one another (2 errors) or for a planned procedure that was not started (1 error). The Hospital stated that these errors occurred primarily because of human error, staff oversights, and ambiguous coding guidance issued by the American Medical Association. As a result of these errors, the Hospital received overpayments totaling \$1,647.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$372,913, consisting of \$360,600 in overpayments for the 44 incorrectly billed inpatient claims and \$12,313 in overpayments for the 4 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

BATON ROUGE GENERAL MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital concurred with most of our findings and recommendations and provided information regarding the corrective actions it has taken to

address the compliance issues identified in our report. The Hospital did not fully agree with our finding that it incorrectly billed 39 claims involving inpatient stays that should have been billed as outpatient or outpatient with observation services. For 6 of the 39 claims, the Hospital stated that the attending physician ordered inpatient services and that the admissions were supported by the criteria used by care management staff.

In addition, the Hospital provided a clarification on the guidance reported in the “Incorrectly Billed as Separate Services or Procedure Not Performed” section. The Hospital’s comments are included in their entirety as Appendix B.

With respect to the six claims discussed above, we continue to maintain that these claims should have been billed as outpatient or outpatient with observation services. A review by CMS’s Medicare contractor confirmed our position. Therefore, we continue to recommend that the overpayments be refunded to the Medicare contractor. Additionally, based on the Hospital’s clarification on the guidance, we revised that finding.

APPENDIXES

APPENDIX A: RISK AREAS REVIEWED AND BILLING ERRORS

Risk Area	Sampled Claims	Value Of Sampled Claims	Claims With Over-payments	Value Of Over-payments
Inpatient short stays	56	\$404,381	33	\$227,358
Inpatient claims paid in excess of charges	28	679,749	6	107,615
Inpatient same-day discharges and readmissions	13	291,041	5	25,627
Inpatient claims billed with high-severity-level diagnosis-related group codes	26	407,360	0	0
Inpatient hospital-acquired conditions and present-on-admission indicators	24	2,114,901	0	0
Inpatient manufacturer credits for replaced medical devices	5	50,440	0	0
Inpatient Total	152	\$3,947,872	44	\$360,600
Outpatient claims with payments greater than \$25,000	4	\$177,419	1	\$10,666
Outpatient claims billed with modifier -59	17	10,079	3	1,647
Outpatient Total	21	\$187,498	4	\$12,313
Inpatient and Outpatient Total	173	\$4,135,369	48	\$372,913

General Health System

December 3, 2012

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: Report Number A-06-11-00065

Dear Ms. Wheeler:

I am writing in response to the request for comments on the draft report noted above dated November 5, 2012. Baton Rouge General appreciates the opportunity to respond to the draft report.

Inpatient Claim Errors

Incorrectly billed as inpatient Services

The report states that 39 of 152 sampled claims were found to have been incorrectly billed as inpatient Part A claims that should have been billed as outpatient or outpatient with observation services. We concur with 33 of the 39 findings. The remaining six claims we found to be properly ordered and in compliance with utilization policies and relevant Interqual criteria. We have previously sent corrected claims to resolve all the agreed errors but we will continue to defend the remaining six to ensure we retain appropriate reimbursement. The attending physician in these six cases in their medical judgment ordered inpatient services and according to the Interqual criteria used by care management to assess this decision it was found to be supported. We do not feel it is appropriate to second guess the decision after the fact based on the hindsight that there were no adverse care outcomes while an inpatient.

In regards to those that we concur were billed in error, a number of corrective actions have taken place over time. In 2011, a number of training events were held to educate various departments about the importance of correct level of care decisions. In January 2012, the hospital engaged the use of an independent physician consulting service for review of level of care decisions. The Compliance Department has started its own review into short stay level of care decisions in July 2012. The audit is ongoing, but early indications are showing a risk factor in the knowledge of care managers in the proper use of the criteria tools. As we discover more evidence as to specific root causes of failures we will work with the Director of Care Management on corrective actions.

Incorrectly Billed as Separate Stay

We concur that 5 of the 152 sampled claims were incorrectly billed as a separate stay when the patient was discharged and readmitted on the same day. Our processes were using the guidelines applicable to

A Community of Caring 

assessing related claims for outpatient services billed in the 72 hour window surrounding inpatient stays rather than the guidelines found in the same day readmission regulation. We have changed the billing process to involve coding personnel to apply medical judgment whether the stays are indeed related.

Outpatient Claims

Incorrect Number of Units

We concur that one outpatient drug claim was found to have the incorrect units. It was likely a data set up error or data entry error not discovered by edits. A set of J-code specific edits were implemented in early 2010 after other OIG audits to prevent large dollar billing errors on high risk drugs. This claim was processed before that change was made.

Incorrectly Billed as Separate Service or Service not Performed

We concur that there were 3 errors noted in the testing of claims using modifier 59. These cases have been used as a training tool in our ongoing quality monitoring process for our coders. Please note that it is not "Medicare guidance" we mentioned in our initial audit response as ambiguous but rather coding guidance issued by the American Medical Association (AMA) for a particular procedure.

Overall Recommendations

The report recommends that we refund to the Medicare Contractor \$372,913, consisting of \$360,600 for inpatient errors and \$12,313 for outpatient errors. We have already submitted corrections on all agreed upon errors, however as noted above we disagree with findings on 6 claims totaling \$58,841.

The report recommends strengthening controls to ensure full compliance with Medicare requirements. Our corrective actions have been indicated previously. Education and monitoring are ongoing as issues are discovered both internally and by monitoring industry developments.

Baton Rouge General Medical Center strives to meet all compliance expectations. We have taken corrective actions to address the issues noted in the report. We appreciate the opportunity to respond to the report. I can be reached at 225-237-1588 for any questions.

Sincerely,



Kendall B. Miller
Compliance Officer
Baton Rouge General Medical Center

