

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF  
ST. JOSEPH REGIONAL HEALTH 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](mailto:Public.Affairs@oig.hhs.gov).*



Patricia Wheeler  
Regional Inspector General

August 2013  
A-06-12-00029

# *Office of Inspector General*

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



OFFICE OF AUDIT SERVICES, REGION VI  
1100 COMMERCE STREET, ROOM 632  
DALLAS, TX 75242

August 27, 2013

Report Number: A-06-12-00029

Mr. Barry Hudgin  
Senior Vice President, General Counsel, Chief Compliance Officer  
St. Joseph Regional Health Center  
3231 Central Park West, Suite 106  
Toledo, OH 43617

Dear Mr. Hudgin:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of St. Joseph Regional Health Center 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 <https://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414, or contact Matt Moore, Audit Manager, at (214) 767-9203 or through email at [Matt.Moore@oig.hhs.gov](mailto:Matt.Moore@oig.hhs.gov). Please refer to report number A-06-12-00029 in all correspondence.

Sincerely,

/Patricia Wheeler/  
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

## **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 data 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.

St. Joseph Regional Health Center (the Hospital), located in Bryan, Texas, is a 310-bed health care center and the anchor facility for the St. Joseph Health System. Medicare paid the Hospital approximately \$159 million for 15,045 inpatient and 99,363 outpatient claims for services provided to beneficiaries during calendar years 2009 and 2010 (audit period) based on CMS's National Claims History data.

Our audit covered \$2,376,966 in Medicare payments to the Hospital for 242 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 193 inpatient and 49 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 110 of the 242 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 132 claims, resulting in overpayments of \$638,960 for the audit period. Specifically, 117 inpatient claims had billing errors, resulting in overpayments of \$608,180, and 15 outpatient claims had billing errors, resulting in overpayments of \$30,780. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$638,960, consisting of \$608,180 in overpayments for 117 incorrectly billed inpatient claims and \$30,780 in overpayments for 15 incorrectly billed outpatient claims, and
- strengthen its controls to ensure full compliance with Medicare requirements.

## **ST. JOSEPH REGIONAL HEALTH CENTER COMMENTS**

In written comments on our draft report, the Hospital agreed with part of our first recommendation and did not address our second recommendation. The Hospital agreed that it did not fully comply with Medicare requirements for all the risk areas we questioned except inpatient short stays. Although the Hospital agreed with the recommended denial of the four inpatient claims that were billed with high-severity-level DRG codes, it disagreed with the value of the overpayment. In addition, the Hospital disagreed with our findings on all 79 inpatient short-stay claims and stated that “the physician determination and criteria for admission are fully supported by the medical record and that there is a demonstrated medical necessity for each claim submission.” The Hospital added that it intends to seek redetermination and appeal the claims at issue in the Short Stay risk area.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the Hospital’s comments, we maintain that our findings and recommendations are valid. We maintain that our overpayment calculation is correct for the four inpatient claims that were billed with high-severity-level DRG codes. For inpatient short stays, we used an independent medical review contractor to determine whether specified claims met medical necessity requirements. The contractor examined all of the medical records and documentation originally submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractor’s conclusions, we determined that 79 claims should have been billed as outpatient or outpatient with observation services.

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# INTRODUCTION

## BACKGROUND

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

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

### **Hospital Inpatient Prospective Payment System**

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

### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>1</sup> The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.<sup>2</sup> All services and items within an APC group are comparable clinically and require comparable resources.

### **Hospital Claims at Risk for Incorrect Billing**

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

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<sup>1</sup> In 2009, SCHIP was formally redesignated as the Children's Health Insurance Program.

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

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient transfers,
- inpatient psychiatric facility emergency department adjustments, and
- outpatient claims billed with evaluation and management (E&M) services.

For the purpose 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, § 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, § 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, § 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

### **St. Joseph Regional Health Center**

St. Joseph Regional Health Center (the Hospital), located in Bryan, Texas, is a 310-bed health care center and the anchor facility for the St. Joseph Health System. Medicare paid the Hospital approximately \$159 million for 15,045 inpatient and 99,363 outpatient claims for services provided to beneficiaries during calendar years 2009 and 2010 (audit period) 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 \$2,376,966 in Medicare payments to the Hospital for 242 claims that we judgmentally selected as potentially at risk for billing errors. These 242 claims consisted of 193 inpatient and 49 outpatient claims and had dates of service during the audit period.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 100 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. 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 from April 2012 through March 2013.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 242 claims (193 inpatient and 49 outpatient) for detailed review;

- reviewed available data from CMS’s Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the medical record documentation provided by the Hospital to support the selected claims;
- used an independent contractor to determine whether 100 selected 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 objectives.

## **FINDINGS AND RECOMMENDATIONS**

The Hospital complied with Medicare billing requirements for 110 of the 242 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 132 claims, resulting in overpayments of \$638,960 for the audit period. Specifically, 117 inpatient claims had billing errors, resulting in overpayments of \$608,180, and 15 outpatient claims had billing errors, resulting in overpayments of \$30,780. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors. For a detailed list of the risk areas that we reviewed and associated billing errors, see Appendix A.

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

The Hospital incorrectly billed Medicare for 117 of the 193 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$608,180.

## **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 79 of the 193 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Hospital officials stated that the errors occurred because (1) care management processes were not fully effective during our audit period, (2) a second-level physician-review solution<sup>3</sup> was not in place for most of the audit period, and (3) human error related to the data entry process and determining whether claims should be billed as inpatient or outpatient. As a result of these errors, the Hospital received overpayments of \$505,644.<sup>4</sup>

## **Incorrectly Billed as Separate Inpatient Stays**

The Manual, chapter 3, § 40.2.5, states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 14 of the 193 selected inpatient claims, the Hospital incorrectly billed Medicare separately for related discharges and readmissions in the same day. Hospital officials stated that these errors occurred because the admission report failed to include inpatient same-day discharges and readmissions and because of human error in identifying and addressing the principal error. As a result of these errors, the Hospital received overpayments of \$41,199.

## **Incorrectly Billed 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.” In addition, the Manual, chapter 1, § 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

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<sup>3</sup> A second-level physician review provides medical-necessity compliance through physician advisors who are trained in Medicare/Medicaid rules and regulations on observation and inpatient status.

<sup>4</sup> 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 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.

For 4 of the 193 selected inpatient claims, the Hospital submitted claims to Medicare with incorrect DRG codes. Hospital officials stated that these errors occurred because of human error and the coding staff's failure to recognize and appropriately code using the National Coding Guidelines. As a result of these errors, the Hospital received overpayments of \$24,765.

### **Manufacturer Credits for Replaced Medical Devices Not Reported**

Federal regulations (42 CFR § 412.89) require reductions in 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. The Manual, chapter 3, § 100.8, states that to correctly bill for a replacement device that was provided with a credit, hospitals must use the combination of condition code 49 or 50 (which identifies the replacement device and nature of the replacement) and value code "FD" (which identifies the amount of the credit or cost reduction received by the hospital for the replaced device).

For 4 of the 193 selected inpatient claims, the Hospital received reportable medical device credits from manufacturers for replaced medical devices but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required. Hospital officials stated that these errors occurred because there was no reliable reconciliation process to identify and track manufacturer warranty credits. As a result of these errors, the Hospital received overpayments of \$19,250.

### **Incorrect Discharge Status Code**

Federal regulations (42 CFR § 412.4(b)) state that the discharge of a hospital inpatient is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge. The discharge of a hospital inpatient is also considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to a skilled nursing facility (SNF) or to home under a written plan of care for home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstances 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 6 of the 193 selected inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers. For these claims, the Hospital should have coded the discharge status either as a transfer to an SNF or to home under a written plan of care for the provision of home health services and received the per diem payment instead of the full DRG payment. Hospital officials stated that these errors occurred because there was a lack of follow up on the beneficiary's postacute care status. As a result of these errors, the Hospital received overpayments of \$16,564.

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

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

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

For 10 of the 193 selected inpatient claims, the Hospital incorrectly coded the source of admission for beneficiaries who were admitted to the IPF upon discharge from the Hospital's acute care section. Hospital officials stated that these errors occurred because of human error and failure to train staff on the use of source-of-admission code "D." As a result of these errors, the Hospital received overpayments of \$758.

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

The Hospital incorrectly billed Medicare for 15 of the 49 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$30,780.

### **Manufacturer Credits for Replaced Medical Devices Not Reported**

Federal regulations (42 CFR § 419.45) require a reduction in the OPSS 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.

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 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" (which identifies that the replaced device was provided without cost to the provider or full credit was received for the replaced device) 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.

For 6 of the 49 selected outpatient claims, the Hospital received manufacturer credits for replaced devices but did not report the "FB" modifier and reduced charges on its claims. Hospital officials stated that these errors occurred because there was no reliable reconciliation process to identify and track manufacturer warranty credits. As a result of these errors, the Hospital received overpayments of \$29,535.

## **Incorrectly Billed Evaluation and Management Services**

The Manual, chapter 12, § 30.6.6(B), states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure.

For 7 of the 49 selected outpatient claims, the Hospital incorrectly billed Medicare for E&M services that were not separately identifiable from the usual postoperative work of the procedure. The services should have been included in the cost of the procedure. Hospital officials stated that these errors occurred because of a lack of regular audits of outpatient claims to validate whether the appropriate modifier was appended when outpatient procedures were provided. As a result of these errors, the Hospital received overpayments of \$1,173.

## **Insufficiently Documented Services**

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.

For 2 of the 49 selected outpatient claims, the Hospital incorrectly billed Medicare for services that were not supported by the medical records. Hospital officials stated that these errors occurred because of human error and a failure to bill appropriately. As a result of these errors, the Hospital received overpayments of \$72.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$638,960, consisting of \$608,180 in overpayments for 117 incorrectly billed inpatient claims and \$30,780 in overpayments for 15 incorrectly billed outpatient claims, and
- strengthen its controls to ensure full compliance with Medicare requirements.

## **ST. JOSEPH REGIONAL HEALTH CENTER COMMENTS**

In written comments on our draft report, the Hospital agreed with part of our first recommendation and did not address our second recommendation. The Hospital agreed that it did not fully comply with Medicare requirements for all the risk areas we questioned except inpatient short stays. Although the Hospital agreed with the recommended denial of the four inpatient claims that were billed with high-severity-level DRG codes, it disagreed with the value of the overpayment. In addition, the Hospital disagreed with our findings on all 79 inpatient short-stay claims and stated that “the physician determination and criteria for admission are fully supported by the medical record and that there is a demonstrated medical necessity for each claim submission.” The Hospital added that it intends to seek redetermination and appeal the claims at issue in the Short Stay risk area.

The Hospital's comments are included in their entirety as Appendix B.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We maintain that our overpayment calculation is correct for the four inpatient claims that were billed with high-severity-level DRG codes. For inpatient short stays, we used an independent medical review contractor to determine whether specified claims met medical necessity requirements. The contractor examined all of the medical records and documentation originally submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractor's conclusions, we determined that 79 claims should have been billed as outpatient or outpatient with observation services.

# **APPENDIXES**

**APPENDIX A: RESULTS OF REVIEW BY RISK AREA**

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Over-payments</b>	<b>Value of Over-payments</b>
<b>Inpatient</b>				
Short Stays	101	\$659,441	79	\$505,644
Same-Day Discharges and Readmissions	24	258,179	14	41,199
Claims Billed With High-Severity-Level Diagnosis-Related Group Codes	31	574,404	4	24,765
Manufacturer Credits for Replaced Medical Devices	18	402,498	4	19,250
Transfers	9	56,416	6	16,564
Psychiatric Facility Emergency Department Adjustments	10	38,092	10	758
<b>Inpatient Totals</b>	<b>193</b>	<b>\$1,989,030</b>	<b>117</b>	<b>\$608,180</b>
<b>Outpatient</b>				
Manufacturer Credits for Replaced Medical Devices	21	\$370,287	6	\$29,535
Claims Billed With Evaluation and Management Services	28	17,649	9	1,245
<b>Outpatient Totals</b>	<b>49</b>	<b>\$387,936</b>	<b>15</b>	<b>\$30,780</b>
<b>Inpatient and Outpatient Totals</b>	<b>242</b>	<b>\$2,376,966</b>	<b>132</b>	<b>\$638,960</b>

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 St. Joseph Regional Health Center. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

## APPENDIX B: ST. JOSEPH REGIONAL HEALTH CENTER COMMENTS



**St. Joseph Health System**

2801 Franciscan Drive  
Bryan, Texas 77802

July 24, 2013

Report Number: A-06-12-00029

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

VIA USPS

Dear Ms. Wheeler,

St. Joseph Regional Health Center ("St. Joseph") is in receipt of your Office's draft report entitled *Medicare Compliance Review of St. Joseph Regional Health Center for Calendar Years 2009 and 2010*. St. Joseph is fully committed to complying with governing standards and regulations concerning federal health care programs and appreciates the opportunity to provide written comment on the draft report.

The draft report reviewed 242 selected claims (193 inpatient and 49 outpatient) from calendar years 2009 and 2010 submitted by St. Joseph to Medicare. The audit was divided into eight (8) risk areas including six (6) inpatient risk areas and two (2) outpatient risk areas. St. Joseph concurs with the draft report's recommendation that the denials in the two (2) outpatient risk areas of fifteen (15) of the forty-nine (49) selected outpatient claims were appropriate. St. Joseph also concurs that in five of the six inpatient risk areas the draft report's recommended denials of thirty-eight (38) claims out of ninety-two (92) selected claims were appropriate. In the case of one inpatient area, Claims Billed With High-Severity-Level DRG Codes, while agreeing with the recommended denial of four (4) claims, St. Joseph disagrees with the stated value of the overpayments. By St. Joseph's calculation, the value of the four (4) overpayments is Twenty Thousand Five Hundred Twenty One Dollars and Ninety Seven Cents (\$20,521.97).

St. Joseph respectfully disagrees, however, with the audit finding with regard to the Short Stay risk area of the inpatient claims. The audit selected one hundred and one (101) Short Stay claims and the draft report recommends repayment in seventy-nine (79) of the one hundred and one (101) claims at a dollar value of Five Hundred and Five Thousand Six Hundred Forty Four Dollars (\$505,644). St. Joseph respectfully disagrees with the audit finding and recommendation and proffers that for each Short Stay claim, the physician determination and criteria for admission are fully supported by the medical record and that there is a demonstrated medical necessity for each claim submission. A review of the draft report in the Short Stay risk area shows egregious denials despite strong evidence of medical necessity and points to significant information being missed by the reviewer in numerous circumstances. Significantly, in a recent history of appeals proceeding to the Administrative Law Judge level prepared by the Inspector General of Health and Human Services, an overwhelming seventy-two percent (72%) of findings in the hospital inpatient area have been returned by the Administrative Law Judges in favor of the provider and against the recommendation of Medicare's contracted reviewer. The prospects in favor of an Administrative Law Judge overturning the draft report's recommendation in this inpatient area and ruling for St. Joseph are very strong. With regard to the Short Stay risk area which contains the largest number of denied claims and the largest dollar volume at issue, St. Joseph intends to seek redetermination and appeal the claims at issue.

We do appreciate the opportunity to review your report and draft. Please do not hesitate to contact me if you have any further questions or require additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Barry F. Hudgin".

Barry F. Hudgin  
General Counsel and Chief Compliance Officer

[www.st-joseph.org](http://www.st-joseph.org)

*A Ministry of Sylvania Franciscan Health*