



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

October 20, 2011

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

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

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

**SUBJECT:** Medicare Compliance Review of St. John's Hospital for Calendar Years 2008 and 2009 (A-07-11-01098)

Attached, for your information, is an advance copy of our final report for one of our hospital compliance reviews. We will issue this report to St. John's Hospital within 5 business days.

This report is part of a series of the Office of Inspector General's hospital compliance initiative designed to concurrently review multiple issues at individual hospitals. This review of Medicare payments to hospitals examines selected claims for inpatient and outpatient services. The attached report is the sixth report issued in this initiative.

If you have any questions or comments about this report, please do not hesitate to call me at (410) 786-7104 or through email at [Brian.Ritchie@oig.hhs.gov](mailto:Brian.Ritchie@oig.hhs.gov) or your staff may contact Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591 or through email at [Patrick.Cogley@oig.hhs.gov](mailto:Patrick.Cogley@oig.hhs.gov). Please refer to report number A-07-11-01098.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region VII  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

October 25, 2011

Report Number: A-07-11-01098

Mr. Jay Guffey  
Chief Operating Officer  
St. John's Regional Health Center  
1235 East Cherokee Street  
Springfield, MO 65804

Dear Mr. Guffey:

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. John's Hospital for Calendar Years 2008 and 2009*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

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

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Chris Bresette, Audit Manager, at (816) 426-3591 or through email at [Chris.Bresette@oig.hhs.gov](mailto:Chris.Bresette@oig.hhs.gov). Please refer to report number A-07-11-01098 in all correspondence.

Sincerely,

/Patrick J. Cogley/  
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 12<sup>th</sup> Street, Room 235  
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
ST. JOHN'S HOSPITAL  
FOR CALENDAR YEARS  
2008 AND 2009**



Daniel R. Levinson  
Inspector General

October 2011  
A-07-11-01098

# *Office of Inspector General*

<http://oig.hhs.gov>

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

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

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# *Notices*

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

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## EXECUTIVE SUMMARY

### BACKGROUND

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

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for 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 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. The OPPS was effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification group to which the service is assigned.

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

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

St. John's Hospital (the Hospital) is an 866-bed acute care hospital with locations in Springfield and Joplin, Missouri. The Hospital was paid approximately \$308 million for 31,066 inpatient and 216,433 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2008 and 2009 based on CMS's National Claims History data.

Our audit covered \$4,374,647 in Medicare payments to the Hospital for 164 inpatient and 60 outpatient claims that we identified as potentially at risk for billing errors for CYs 2008 and 2009 (6 of these 224 claims involved replacement medical devices and had dates of service in CY 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 166 of the 224 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, of the 224 sampled claims, 58 claims had errors, resulting in net overpayments totaling \$420,410 for CYs 2008 through 2010. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand Medicare billing requirements.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$420,410, consisting of \$227,239 in overpayments for the 36 incorrectly billed inpatient claims and \$193,171 in overpayments for the 22 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital concurred with our findings. However, the Hospital indicated that overall net recovery would be lower after it worked with the Medicare contractor to re-bill eligible claims. The Hospital also described corrective actions that it planned to implement.

The Hospital's comments, in separate letters from the Springfield and Joplin facilities, are included in their entirety as Appendixes A and B, respectively.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

We agree that the Hospital could re-bill some of the claims and that the additional Medicare payments would offset the corresponding dollar effect of our findings. However, we are unable to determine the offset amount until the Medicare contractor has adjudicated the additional claims.

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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 who have been discharged from the hospital. 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.<sup>1</sup>

### **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 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>2</sup> The OPPS was effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.<sup>3</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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<sup>1</sup> Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or Medicare administrative contractor, whichever is applicable.

<sup>2</sup> In 2009, SCHIP was formally redesignated as the Children's Health Insurance Program.

<sup>3</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures.

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

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

- inpatient zero- and 1-day stays (short stays),
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level DRGs,
- inpatient claims paid in excess of charges,
- inpatient manufacturer credits for medical devices,
- inpatient claims with payments greater than \$150,000,
- inpatient claims with blood clotting factor drugs,
- outpatient manufacturer credits for medical devices,
- outpatient claims paid in excess of charges, and
- outpatient claims with payments greater than \$25,000.

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

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

## **Medicare Requirements for Hospital Claims and Payments**

Section 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. In addition, pursuant to section 1862(a)(1)(A) of the Act, no Medicare payment may be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member.

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

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly. Chapter 3, section 10, of the Manual states that the hospital may bill only for services provided. In addition, chapter 23, section 20.3, of the Manual states: “Providers must use HCPCS codes ... for most outpatient services.”

## **St. John’s Hospital**

St. John’s Hospital (the Hospital) is an 866-bed acute care hospital with locations in Springfield and Joplin, Missouri. The Hospital was paid approximately \$308 million for 31,066 inpatient and 216,433 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2008 and 2009 based on CMS’s National Claims History data.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

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

### **Scope**

Our audit covered \$4,374,647 in Medicare payments to the Hospital for 164 inpatient and 60 outpatient claims that we identified as potentially at risk for billing errors. Of these 224 claims, 218 had dates of service in CYs 2008 and 2009. Six of the 224 claims (involving replacement medical devices) had dates of service in CY 2010.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. Our review was based on selected billing requirements and did not include a 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 allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

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

We conducted our fieldwork at the Hospital during March through June 2011.

## **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 2008 and 2009;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2008, 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 224 claims (164 inpatient and 60 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 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;
- discussed the incorrectly billed and/or coded 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 on June 9, 2011.

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 166 of the 224 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, of the 224 sampled claims, 58 claims had errors, resulting in net overpayments totaling \$420,410 for CYs 2008 through 2010. These

errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand Medicare billing requirements.

Of 164 sampled inpatient claims, 36 claims had billing errors, resulting in overpayments totaling \$227,239.

- For inpatient claims with short stays, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or as outpatient-with-observation services (14 errors). The Hospital also billed for inpatient stays that lacked a physician's signature to admit the patients to inpatient care (two errors). (These 16 errors totaled \$104,484 in overpayments).
- For inpatient claims with same-day discharge and readmissions, the Hospital billed Medicare separately for related discharges and readmissions within the same day (four errors). The hospital also billed Medicare for the second stay as an acute care claim that should have been billed as a rehabilitation claim (two errors). (These six errors totaled \$39,649 in overpayments).
- For inpatient claims billed with high severity level DRGs, the Hospital billed Medicare with an incorrectly coded DRG (one error resulting in a \$33,958 overpayment).
- For inpatient claims paid in excess of charges, the Hospital billed Medicare with incorrectly coded DRGs (four errors totaling \$25,765 in overpayments).
- For inpatient claims involving manufacturer credits for medical devices, the Hospital incorrectly billed Medicare when available credits should have been obtained from the manufacturer (two errors) and for a medical device after receiving a credit from the manufacturer (one error) (three errors totaling \$25,350 in overpayments).
- For inpatient claims paid in excess of \$150,000, the Hospital billed Medicare for units of service or supplies that were not supported by the medical records (five errors totaling \$12,176 in overpayments).
- For inpatient claims with blood clotting factor drugs, the Hospital billed Medicare with an incorrect revenue code, which resulted in the Hospital receiving an outlier payment instead of an add-on payment (one error resulting in a \$14,143 underpayment because the add-on payment had a higher reimbursement than the outlier payment).<sup>4</sup>

Of 60 sampled outpatient claims, 22 claims had billing or coding errors, resulting in overpayments totaling \$193,171.

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<sup>4</sup> Under IPPS, Medicare makes outlier payments to hospitals when exceptionally costly cases exceed established thresholds. Pursuant to the Manual, hospitals receive add-on payments for the costs of furnishing blood clotting factor drugs to certain Medicare beneficiaries.

- For outpatient claims involving manufacturer credits for medical devices, the Hospital received full credit for a replaced device but did not report either the correct modifier or the reduced charges on its claim (12 errors). The Hospital also did not obtain credits for replaced devices that were available under the terms of the manufacturers' warranties (5 errors). (These 17 errors totaled \$100,327 in overpayments).
- For outpatient claims paid in excess of charges, the Hospital submitted claims to Medicare with incorrect HCPCS codes and incorrect units of service (four errors totaling \$81,303 in overpayments).
- For outpatient claims paid in excess of \$25,000, the Hospital submitted a claim to Medicare with an incorrect modifier (one error resulting in an \$11,541 overpayment).

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

The Hospital incorrectly billed Medicare for 36 of 164 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$227,239.

### **Inpatient Short Stays**

Section 1862(a)(1)(A) of the Act states that no Medicare payment may be made for items or services that "... are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member." Section 1814(a)(3) of the Act states that payment for services furnished an individual may be made only to providers of services that are eligible and only if "... with respect to inpatient hospital services, which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment ...."

For 16 out of 65 sampled claims with short stays, the Hospital incorrectly billed Medicare Part A for inpatient short stays. For 14 claims, the Hospital incorrectly billed Medicare for beneficiary stays that should have been billed as outpatient or as outpatient-with-observation services. For two claims, the Hospital billed for inpatient stays that lacked a physician's signature to admit the patients to inpatient care. The Hospital stated that the 14 patient admission errors occurred because the hospital staff did not have a full understanding of the patient class criteria, and/or because coders may not have seen the physicians' orders referring to the outpatient status in the medical records. The Hospital attributed the missing signatures on the physician orders to admit the beneficiaries for inpatient care to human error. As a result of these 16 errors, the Hospital received overpayments totaling \$104,484.<sup>5</sup>

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<sup>5</sup> The Hospital indicated that there may have been some allowable Part B costs for the associated denied Part A services.

## **Inpatient Same-Day Discharges and Readmissions**

The Manual, chapter 3, section 40.2.5, states:

When a patient is discharged 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 six out of seven sampled claims, the Hospital incorrectly billed Medicare for same-day discharges and readmissions. For four of the claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. For the remaining two claims, the Hospital billed Medicare for the second stay as an acute care claim that should have been billed as a rehabilitation claim. The Hospital stated that the four related acute care inpatient errors occurred due to miscommunication between the utilization management department and the business office. The Hospital also stated that the two acute care claims that should have been billed as rehabilitation claims occurred because the hospital staff did not have a full understanding of how to enter patient class criteria into a newly implemented claims processing system. As a result of these six errors, the Hospital received overpayments totaling \$39,649.

## **Inpatient Claims Billed With High Severity Level Diagnosis Related Groups**

Section 1862(a)(1)(A) of the Act states that no Medicare payment may be made for items or services that "... are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member." The Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For 1 out of 31 sampled claims billed with high severity level DRGs, the Hospital billed Medicare with an incorrectly coded DRG. The Hospital stated that this error occurred because the claim included an unusual coding error that was not identified during the Hospital's quality review process. As a result of this error, the Hospital received an overpayment of \$33,958.

## **Inpatient Claims Paid in Excess of Charges**

Section 1862(a)(1)(A) of the Act states that no Medicare payment may be made for items or services that "... are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member." In addition, the Manual, chapter 3, section 10, states that the hospital may bill only for services provided, and chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

For 4 out of 34 sampled claims, the Hospital billed Medicare with incorrectly coded DRGs. The Hospital stated that these errors occurred because the claims included unusual coding errors that were not identified during the Hospital's quality review process. As a result of these errors, the Hospital received overpayments totaling \$25,765.

## **Inpatient Manufacturer Credits for Medical Devices**

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.

### *Prudent Buyer Principle*

Pursuant to 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services ...” CMS’s *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 of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. 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 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.

### *Billing Requirements for Medical Device Credits*

The Manual, chapter 3, section 100.8, states: “To correctly bill for a replacement device that was provided with a credit ... hospitals must use the combination of condition code 49 or 50, along with value code FD.”

For 3 out of 18 sampled claims,<sup>6</sup> the Hospital incorrectly billed Medicare for inpatient claims involving credits that were available from manufacturers for replaced medical devices. For two claims, the Hospital incorrectly billed Medicare for replaced medical devices because it did not attempt to obtain available credits from the manufacturer. For an additional claim, the Hospital incorrectly billed Medicare for a medical device after receiving a credit from the manufacturer. The Hospital stated that these errors occurred because of a lack of understanding of Medicare requirements regarding the refunding of credits for medical devices. As a result of these three errors, the Hospital received an overpayment of \$25,350.

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<sup>6</sup> One claim in error was from the St. John’s Hospital facility located in Joplin, Missouri.

## **Inpatient Claims With Payments Greater Than \$150,000**

Section 1862(a)(1)(A) of the Act states that no Medicare payment may be made for items or services that "... are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member." The Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately." Also, chapter 3, section 10, states: "The hospital may bill only for services provided ...."

For five out of five sampled claims, the Hospital billed Medicare for units of service or supplies that were not supported by the medical records. As a result, the Hospital incorrectly included charges for these items in cost outlier computations, thus creating the overpayments. The Hospital attributed these overpayments to human error and to the fact that its quality review process did not include 100 percent of the charges. As a result of these five errors, the Hospital received overpayments totaling \$12,176.

## **Inpatient Claims With Blood Clotting Factor Drugs**

The Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately." Additionally, chapter 3, section 20.7.3(A), states that hospitals receive an add-on payment for the costs of furnishing blood clotting factor drugs to certain Medicare beneficiaries and that the provider must use revenue code 636 (drugs requiring detail coding) so that the clotting factor charges are not included in the cost outlier computations.

For one out of four sampled claims, the Hospital billed Medicare with an incorrect revenue code. Specifically, the Hospital used revenue code 250 (pharmacy) instead of revenue code 636 (drugs requiring detail coding), which caused the clotting factor charges to be included in the claim's cost outlier computation. However, the Hospital should have received an add-on payment for providing this blood-clotting factor drug. The add-on payment had a higher reimbursement than the outlier payment. The Hospital stated that this error occurred because its computer software was programmed incorrectly and because of human error. As a result of this error, the Hospital received an underpayment of \$14,143.

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

The Hospital incorrectly billed Medicare for 22 of 60 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$193,171.

## **Outpatient Manufacturer Credits for Medical Devices**

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.

### *Prudent Buyer Principle*

Pursuant to 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services ....” CMS’s *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 of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. 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 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.

### *Billing Requirements for Medical Device Credits*

CMS guidance in Transmittal 1103, dated November 3, 2006, and in the Manual explains 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 to file for reduced charges on a claim that includes a procedure code for the insertion of a replacement device in cases when the provider has incurred no cost, or has received full credit, for the replaced device.

For 17 out of 45 sampled claims,<sup>7</sup> the Hospital incorrectly billed Medicare for outpatient claims involving credits that were available from manufacturers for replaced medical devices. For 12 claims, the Hospital received full credit for a replaced device but did not report either the “FB” modifier or the reduced charges on its claim. For five claims, the Hospital did not obtain credits for replaced devices that were available under the terms of the manufacturers’ warranties. The Hospital stated that these errors occurred because of a lack of understanding of Medicare requirements regarding the refunding of credits for medical devices. As a result of these 17 errors, the Hospital received an overpayment of \$100,327.

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<sup>7</sup> Ten claims in error were from the St. John’s Hospital facility located in Joplin, Missouri.

## **Outpatient Claims Paid in Excess of Charges**

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: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, section 20.4, states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For four out of five sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes and incorrect units of service. The hospital stated that these errors occurred because of human error and because of confusion regarding the Medicare requirements for charging compounded drugs.<sup>8</sup> As a result of these four errors, the Hospital received overpayments totaling \$81,303.<sup>9</sup>

## **Outpatient Claims With Payments Greater Than \$25,000**

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

For one out of four sampled claims, the Hospital submitted the claim to Medicare with an incorrect modifier. The Hospital stated that this error occurred because it did not select the claim as part of its quality review process. As a result of this error, the Hospital received an overpayment totaling \$11,541.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$420,410, consisting of \$227,239 in overpayments for the 36 incorrectly billed inpatient claims and \$193,171 in overpayments for the 22 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital concurred with our findings. However, the Hospital identified 23 claims that we have classified as findings for which it could submit new claims for either Medicare Part A (rehabilitation) services or Medicare Part B services.

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<sup>8</sup> Compounded drugs are created by combining two or more prescription or nonprescription drug products and repackaging them into a new capsule or other dosage form.

<sup>9</sup> The majority of these total overpayments for outpatient claims paid in excess of charges were due to one claim (\$79,448).

According to the hospital, the additional payments for these eligible claims would lower the overall net recovery. The Hospital stated that it would work with the Medicare contractor to re-bill these eligible claims.

The Hospital also described corrective actions that it planned to implement.

The Hospital's comments, in separate letters from the Springfield and Joplin facilities, are included in their entirety as Appendixes A and B, respectively.

#### **OFFICE OF INSPECTOR GENERAL RESPONSE**

We agree that the Hospital could re-bill some of the claims and that the additional Medicare payments would offset the corresponding dollar effect of our findings. However, we are unable to determine the offset amount until the Medicare contractor has adjudicated the additional claims.

# **APPENDIXES**

## APPENDIX A: AUDITEE COMMENTS (SPRINGFIELD, MISSOURI, FACILITY)



ST. JOHN'S

ST. JOHN'S HEALTH SYSTEM

1235 EAST CHEROKEE STREET ■ SPRINGFIELD, MISSOURI 65804-2263  
417-820-2000 PH

August 4, 2011

Douglas Kelly, CPA, RN  
Senior Auditor, Region VII  
HHS/OIG/Office of Audit Services  
601 East 12th Street, Room 429  
Kansas City, MO, 64106

Dear Mr. Kelly:

St. John's Regional Health Center, Springfield and St. John's Regional Medical Center, Joplin is in receipt of the draft report provided by the Department of Health & Human Services, Office of Inspector General (OIG) entitled, "St. John's Medicare Compliance."

The OIG originally selected for review certain inpatient and outpatient claims submitted by St. John's Springfield and St. John's Joplin for dates of service from January 1, 2008 through December 31, 2009, covering nine audit areas. The types of payments to hospitals reviewed by this and related audits included payments for claims billed for:

- inpatient zero- and 1-day stays (short stays),
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level diagnosis related groups,
- inpatient claims paid in excess of charges,
- inpatient manufacturer credits for medical devices,
- inpatient claims with payments greater than \$150,000,
- inpatient claims with blood clotting factor drugs,
- outpatient manufacturer credits for medical devices,
- outpatient claims paid in excess of charges, and
- outpatient claims with payments greater than \$25,000.

It is our understanding that the selection of the records was not by a random sampling methodology, but was based on "focused audit criteria" covering areas identified on OIG reviews at other hospitals and is a new approach for OIG audits. It is also our understanding that the results will not be extrapolated to the total claim population for 2008 and 2009.

I am writing to you on behalf of St. John's Regional Health Center, located in Springfield, Missouri ("St. John's Springfield"). St. John's Springfield is a subsidiary of St. John's Health System, Inc., also based in Springfield, and is part of the Sisters of Mercy Health System, St. Louis, Missouri ("Mercy"). St. John's Regional Medical Center is located in Joplin, Missouri ("St. John's Joplin") and until November 1, 2009, was part of Catholic Health Initiatives ("CHI") based in Denver, Colorado. St. John's Joplin became a part of Mercy after November 1, 2009. Therefore, the St. John's Joplin response will not be included with my response and will be provided separately.<sup>1</sup>

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The Nation's #1 Integrated Health System

A member of the Sisters of Mercy Health System

Our responses to the OIG's recommendations are set forth below:

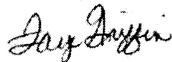
1. St. John's Springfield concurs with the OIG findings where 181 claim reviews resulted in 47 claims with errors that caused overpayments totaling \$329,576.10 for CYs 2008 through 2009 which includes \$121,287 for Outpatient claims and \$208,239 for Inpatient claims.
2. St. John's Springfield will work with our Medicare contractor to appropriately reconcile these accounts. We will re-bill eligible claims to Medicare Part B and/or Part A Rehabilitation after the original claims identified in the audit are adjusted as directed by the Medicare contractor. We will also request eligible credits from device manufacturers. This will consist of 23 claims and approximate reimbursement back to St. John's Springfield in the amount of \$122,609.82. This will result in an over-all estimated net recovery to Medicare from St. John's Springfield of \$234,856.28.
3. St. John's Springfield continues to further strengthen our Compliance Programs and internal controls to be compliant with Medicare Billing requirements:
  - a. St. John's Springfield continues to provide coding education and audits for our coders as well as continuing compliance education for co-workers.
    - i. Mini Compliance Academy (4 days) covering the Seven Elements of Compliance.
    - ii. AHIMA webcast FY11 CMS IPPS Update
    - iii. AHIMA webcast FY11 ICD9 Update
    - iv. AAPC 2011 OPPI Rule Update
    - v. Annual Education Update – we implemented MyEducation which is a new tool that will track required education as well as individual education records. This will be used for annual Privacy and Compliance Education.
    - vi. Presentation to St. John's Management Forum – Department Managers' Role in Compliance
  - b. In January 2009, St. John's Springfield implemented its new electronic health record and billing system. Some of the errors identified on the OIG audit were software issues that we had already resolved or were in the process of being resolved prior to the OIG audit. St. John's has implemented additional internal controls to identify and monitor these types of errors, i.e., improved edit criteria and more detailed reports.
  - c. St. John's Springfield continues to refine internal processes and controls surrounding the case management process that impacts the appropriate patient classification to inpatient or outpatient.
    - i. A monitoring report was developed to check the accuracy of patient class of patients transferred between nursing units.
    - ii. Software adjustment was made to the electronic ordering process for patient class changes.
  - d. St. John's Springfield is working closely with vendors and involved hospital departments to improve the process for appropriate billing and refunds of device warranty credits.

- i. Assigned an analyst to coordinate the device warranty/re-bill process between departments.
- ii. Implemented a device data collection form to obtain complete information from the vendors.
- iii. Implemented a work queue in our billing system for follow-up and reconciliation with department procedure logs to track device returns and refunds.

Thank you for the opportunity to respond to the audit findings. St. John's Springfield appreciates the professionalism demonstrated by the OIG Audit Staff throughout this audit. We will proceed with the claims adjustments described above to resolve this matter.

Please contact me if you have any questions or we need to do anything in addition to the action items described above to close this matter.

Sincerely,



Faye Griffin, RHIA, CHC  
Corporate Compliance Officer  
St. John's Regional Health Center  
Springfield, Missouri 65804  
[faye.griffin@mercy.net](mailto:faye.griffin@mercy.net)

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<sup>1</sup> St. John's Joplin claims review consisted of 43 total claims which resulted in 11 claims with errors that caused overpayments of \$90,884.48.

## APPENDIX B: AUDITEE COMMENTS (JOPLIN, MISSOURI, FACILITY)



**ST. JOHN'S  
REGIONAL MEDICAL CENTER**

2727 McCLELLAND BOULEVARD ■ JOPLIN, MISSOURI 64804-1694  
417-781-2727 ph.

August 4, 2011

Douglas Kelly, CPA, RN  
Senior Auditor, Region VII  
HHS/OIG/Office of Audit Services  
601 East 12th Street, Room 429  
Kansas City, MO, 64106

Dear Mr. Kelly:

St. John's Regional Medical Center, Joplin, and St. John's Regional Health Center, Springfield, have received the draft report provided by the Department of Health & Human Services, Office of Inspector General (OIG), entitled, "Medicare Compliance Review of Saint John's Hospital for Calendar Years 2008 and 2009" dated July 2011 (Report Number: A-07-11-01098).

The majority of the claims reviewed were those of St. John's Regional Health Center, located in Springfield, Missouri ("St. John's Springfield"). St. John's Springfield is a subsidiary of St. John's Health System, Inc., also based in Springfield, and is part of the Sisters of Mercy Health System, St. Louis, Missouri ("Mercy").

I am writing to you on behalf of St. John's Regional Medical Center located in Joplin, Missouri ("St. John's Joplin"), which until November 1, 2009, was part of Catholic Health Initiatives ("CHI") based in Denver, Colorado. St. John's Joplin became a part of Mercy after November 1, 2009. Therefore, the St. John's Springfield response will not be included with my response and will be provided separately.

While the OIG's report focuses on several audit areas that were largely related to the St. John's Springfield location, this response is limited to the reviews conducted on claims for the St. John's Joplin location only. Specifically, the types of payments reviewed by this audit for Joplin included payments for claims billed for:

- inpatient manufacturer credits for medical devices,
- outpatient manufacturer credits for medical devices.

It is our understanding that the selection of the records was not by a random sampling methodology, but was based on "focused audit criteria" covering areas identified on OIG reviews at other hospitals and is a new approach for OIG audits. It is also our understanding that the results will not be extrapolated to the total claim population for 2008 and 2009.

Our responses to the OIG's recommendations are set forth below:

1. St. John's Joplin concurs with the OIG findings that of the 40 claims reviewed, 11 had errors that caused overpayments totaling \$90,884.48 for CYs 2008 and 2009.

2. St. John's Joplin will work with our Medicare contractor to appropriately reconcile these accounts in accordance with the audit findings.
3. St. John's Joplin continues to work on process improvements to further strengthen our Compliance Program and internal controls to be compliant with Medicare Billing requirements:
  - a. St. John's Joplin continues to provide coding education and audits for our coders as well as continuing compliance education for co-workers:
    - i. Mini Compliance Academy (4 days) covering the Seven Elements of Compliance;
    - ii. AHIMA webcast FY11 CMS IPPS Update;
    - iii. AHIMA webcast FY11 ICD9 Update;
    - iv. AAPC 2011 OPPTS Rule Update;
    - v. Annual Education Update – we recently implemented MyEducation which is a new tool that will track required education as well as individual education records.
  - b. St. John's Joplin implemented its new electronic health record and billing system at the beginning of May 2011, just prior to the tornado that struck Joplin, and we are committed to enhancing our internal controls for tracking and reports regarding device refunds and credits.
  - c. St. John's Joplin is working closely with vendors and involved hospital departments to improve the process for appropriate billing and refunds of device warranty credits by:
    - i. Assigning an analyst to coordinate the device warranty/re-bill process between departments.
    - ii. Implementing a device data collection form to obtain complete information from the vendors.
    - iii. Implementing a work queue in our billing system for follow-up and reconciliation with department procedure logs to track device returns and refunds.

Thank you for the opportunity to respond to your findings. St. John's Joplin appreciates the professionalism demonstrated by the OIG Audit Staff throughout this audit. We will proceed with the claims adjustments described above to resolve this matter.

Please contact me if you have any questions, or if we need to do anything in addition to the action items described above to close this matter.

Sincerely,



Michael Wardlow, RN, BSN, BSEd.  
Compliance Manager  
St. John's Regional Medical Center  
Joplin, Missouri 64804  
[michael.wardlow@mercy.net](mailto:michael.wardlow@mercy.net)