

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
VIA CHRISTI HOSPITAL
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.*



**Patrick J. Cogley
Regional Inspector General**

**July 2013
A-07-11-01099**

Office of Inspector General

<https://oig.hhs.gov/>

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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 permanent kidney 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. 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 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 sampled claims for inpatient and outpatient services.

Via Christi Hospital (the Hospital) is a 759-bed acute care hospital located in Wichita, Kansas. Medicare paid the Hospital approximately \$219 million for 21,840 inpatient and 47,374 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$1,518,679 in Medicare payments to the Hospital for 67 claims that we judgmentally sampled as potentially at risk for billing errors. These claims consisted of 66 inpatient claims and 1 outpatient claim with 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 sampled claims.

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 39 of the 67 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 28 claims, resulting in net overpayments totaling \$170,440 for CYs 2009 and 2010. Specifically, 27 inpatient claims had billing errors, resulting in net overpayments totaling \$164,364, and 1 outpatient claim had a billing error, resulting in an overpayment of \$6,076. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contain errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$170,440, consisting of \$164,364 in net overpayments for the 27 incorrectly billed inpatient claims and the overpayment of \$6,076 for the incorrectly billed outpatient claim, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with part of our first recommendation and described actions that it had taken to address our second recommendation.

The Hospital disagreed with our findings on 15 inpatient claims, consisting of \$89,800 in questioned costs, in which we stated that the Hospital should have billed the claims as outpatient or as outpatient with observation services. (In its written comments, the Hospital disagreed with 16 inpatient claims, but in subsequent communications, it clarified that it disagreed with only 15 of these claims.) To support that it correctly billed these claims as inpatient services, the Hospital provided radiology and laboratory reports that our medical review contractors did not review and results from an independent review performed by a physician advisory firm that the hospital engaged. Finally, the Hospital stated that our medical review contractors may not have correctly applied Medicare guidance.

For the remaining 13 incorrectly billed claims, the Hospital agreed with our findings and said that it had either already refunded or would refund a total of \$80,640.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid.

Regarding the radiology and laboratory reports that our independent medical review contractor did not review, we verified that the Hospital included results from these reports in the medical

records. Accordingly, we did not separately forward the additional reports to our contractor. Our contractor examined all of the medical records and documentation originally submitted (including results from the radiology and laboratory reports), and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements.

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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 permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

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

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

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

Hospital Claims at Risk for Incorrect Billing

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

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

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

- inpatient short stays,
- inpatient claims paid in excess of charges,
- inpatient claims billed with high severity level DRGs,
- inpatient psychiatric facility interrupted stays, and
- outpatient manufacturer credits for replaced medical devices.

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 sampled claims for inpatient and outpatient services.

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that “... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” In addition, sections 1815(a) and 1833(e) of the Act preclude 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.

Via Christi Hospital

Via Christi Hospital (the Hospital) is a 759-bed acute care hospital located in Wichita, Kansas.³ Medicare paid the Hospital approximately \$219 million for 21,840 inpatient and 47,374 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2009 and 2010 based on CMS’s National Claims History data.

³ The Hospital has more than one facility in Wichita. We reviewed the facility on St. Francis Street.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit covered \$1,518,679 in Medicare payments to the Hospital for 67 claims that we judgmentally sampled as potentially at risk for billing errors. These claims consisted of 66 inpatient claims and 1 outpatient claim with dates of service in CYs 2009 and 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. We evaluated compliance with selected billing requirements and used medical review on a sampled number of claims to determine whether the services were medically necessary.

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

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

We conducted our fieldwork at the Hospital during August 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 2009 and 2010;
- obtained information on known credits for replaced 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;
- judgmentally sampled 67 claims (66 inpatient and 1 outpatient) for detailed review;

- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been canceled 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;
- used an independent contractor to determine whether 24 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 on November 27, 2012.

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 39 of the 67 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 28 claims, resulting in net overpayments totaling \$170,440 for CYs 2009 and 2010. Specifically, 27 inpatient claims had billing errors, resulting in net overpayments totaling \$164,364, and 1 outpatient claim had a billing error, resulting in an overpayment of \$6,076. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contain errors. For the results of our review by risk area, see Appendix A.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 27 of the 66 sampled inpatient claims that we reviewed. These errors resulted in net overpayments totaling \$164,364.

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."

According to Chapter 1, section 10, of the CMS *Benefit Policy Manual*, factors that determine whether an inpatient admission is medically necessary include:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;
- the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- the availability of diagnostic procedures at the time when and at the location where the patient presents.

The *Benefit Policy Manual* also states that admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital.

For 21 of 66 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or as outpatient with observation services. For example, in one case, our medical reviewer said that "the services ordered were of the intensity that could have been safely provided at the observation level."

These errors occurred because the Hospital did not have adequate controls to ensure that it billed Medicare correctly. As a result of these errors, the Hospital received overpayments totaling \$110,700.⁴

Incorrect Diagnosis-Related Groups

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that "... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Chapter 1, section 80.3.2.2, of the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For 6 of 66 sampled inpatient claims, the Hospital submitted claims to Medicare with incorrect DRGs. In one case, the Hospital used the DRG for cardiac defibrillator implant without cardiac

⁴ The Hospital may 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 before we prepared our report for issuance.

catheter with major complication/comorbidity rather than using the DRG for cardiac defibrillator implant without cardiac catheter without major complication/comorbidity.

- For five of the six claims, the Hospital identified the errors. For these claims, the Hospital attributed the incorrect DRGs to human error in coding diagnosis codes and procedure codes for highly complex medical cases with interrelated disease processes, and to conflicting clinical information.
- For the remaining claim, our medical reviewer determined that the medical record did not support the submission or reimbursement of the DRG.

As a result of these errors, the Hospital received net overpayments totaling \$53,664.

BILLING ERRORS ASSOCIATED WITH AN OUTPATIENT CLAIM INVOLVING A MANUFACTURER CREDIT FOR A REPLACED MEDICAL DEVICE 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, section 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPSS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier -FB and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.

For the one sampled outpatient claim, the Hospital received full credit for a replaced medical device but did not report the -FB modifier and reduced charges on its claim. The Hospital stated that this error occurred because it did not have adequate controls to report the appropriate modifiers and charges to reflect credits received from manufacturers. As a result of this error, the Hospital received an overpayment of \$6,076.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$170,440, consisting of \$164,364 in net overpayments for the 27 incorrectly billed inpatient claims and the overpayment of \$6,076 for the incorrectly billed outpatient claim, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with part of our first recommendation and described actions that it had taken to address our second recommendation.

The Hospital disagreed with our findings on 15 inpatient claims, consisting of \$89,800 in questioned costs, in which we stated that the Hospital should have billed the claims as outpatient or as outpatient with observation services.⁵ To support that it correctly billed these claims as inpatient services, the Hospital provided radiology and laboratory reports that our medical review contractors did not review. The Hospital asserted that information from some of these reports supported the physicians' admission decisions. The Hospital added that a physician advisory firm, which the Hospital engaged to perform an independent review, concluded that the 15 claims met applicable Medicare inpatient admission criteria. The Hospital also stated that our medical review contractor "... may have denied claims solely because the patient did not stay for twenty-four (24) hours post admission, instead of focusing on the patient's medical condition and needs at the time of the admission...."

For the remaining 13 incorrectly billed claims, the Hospital agreed with our findings and said that it had either already refunded or would refund a total of \$80,640.

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.

Regarding the radiology and laboratory reports that our independent medical review contractor did not review, we verified that the Hospital included results from these reports in the medical records. Our contractor advised that it would not change its conclusions by separately reviewing the radiology and laboratory reports. Accordingly, we did not separately forward the additional reports to our contractor.

Our independent medical review contractor did not deny claims solely because the beneficiary did not stay for 24 hours after admission. Instead, our contractor examined all of the medical records and documentation originally submitted (including results from the radiology and laboratory reports), and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements.

⁵ In its written comments (Appendix B, page 2), the Hospital disagreed with 16 inpatient claims, but in subsequent communications, it clarified that it disagreed with only 15 of these claims.

APPENDIXES

APPENDIX A: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Under / Over-payments	Value of Net Over-payments
Inpatient				
Short Stays	22	\$104,170	20	\$91,182
Claims Paid in Excess of Charges	5	118,308	2	37,453
Claims Billed With High Severity Level Diagnosis-Related Group Codes	31	1,198,233	5	35,729
Psychiatric Facility Interrupted Stays	8	89,325	0	0
Inpatient Totals	66	\$1,510,036	27	\$164,364
Outpatient				
Manufacturer Credits for Replaced Medical Devices	1	8,643	1	6,076
Outpatient Totals	1	\$8,643	1	\$6,076
Inpatient and Outpatient Totals	67	\$1,518,679	28	\$170,440

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 Via Christi Hospital. 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: AUDITEE COMMENTS

VIA CERTIFIED MAIL

March 13, 2013

Office of Inspector General
Office of Audit Services, Region VII
Attn: Mr. Patrick Cogley
601 East 12th Street, Room 0429
Kansas City, MO 64106



...because your life matters

Doctors

Hospitals

Senior Villages

Health Services

Re: Draft Audit Report A-07-11-01099

Dear Mr. Cogley:

We are responding to your letter dated January 23, 2013 regarding the U.S. Department of Health and Human Services, Office of Inspector General ("OIG") draft report entitled *Medicare Compliance Review of Via Christi Hospital for Calendar Years 2009 and 2010 (A-07-11-01099)* ("Draft Report"). Please note that Via Christi Hospitals Wichita, Inc. ("Via Christi") has 759 operational hospital beds, 32,463 inpatient and 90,983 outpatient Medicare claims, respectively, for the two-year period subject to the Draft Report; and received total Medicare reimbursement of over \$368 million for those claims.

During the above referenced Compliance Review at Via Christi, the OIG reviewed sixty-six (66) inpatient claims and one (1) outpatient claim as potentially at risk for billing errors. In the Draft Report, the OIG suggests that twenty-eight (28) of the sixty-seven (67) claims reviewed did not comply with Medicare billing requirements. Specifically, the OIG allegedly found that Via Christi:

- Incorrectly billed Medicare for twenty-one (21) inpatient stays that Via Christi should have billed as outpatient claims or as outpatient claims with observation services;
- Submitted six (6) inpatient claims with incorrect Diagnosis Related Groups ("DRGs"); and
- Incorrectly billed Medicare for a single replacement medical device received from a manufacturer.

As a result of these errors, the OIG recommended that Via Christi refund \$170,440 to the Medicare contractor and strengthen controls to ensure full compliance with Medicare requirements.

Via Christi agrees and disagrees, in part, with the OIG's findings. Via Christi agrees with the OIG's findings that Via Christi inadvertently coded six (6) claims with incorrect DRGs and that by mistake it billed Medicare for a single replacement medical device. Via Christi already refunded the appropriate program amounts related to these claims.

Via Christi also agrees that it inadvertently billed Medicare for five (5) inpatient stays that it should have billed as outpatient claims or as outpatient claims with observation services. Via

Via Christi Health, Inc.

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Christi is in the process of determining the proper overpayment amounts related to such claims and will refund those amounts accordingly.

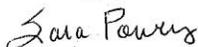
Conversely, Via Christi disagrees with the OIG's findings that Via Christi should have billed the remaining sixteen (16) inpatient stays as outpatient claims or as outpatient claims with observation services. Via Christi recently provided the OIG with additional information to support these inpatient claims. In particular, it came to Via Christi's attention that certain radiology and laboratory reports for these cases were not originally included in the records, some of which provided important information supporting physician admission decisions. Via Christi provided copies of the relevant radiology and laboratory records to the OIG on January 4, 2013. Via Christi also engaged a national physician advisory firm to perform an independent review by qualified physicians of the claims in question. Via Christi forwarded to the OIG the results of the independent review on January 4, 2013, which concluded that the sixteen (16) remaining cases all met applicable Medicare inpatient admission criteria. Finally, Via Christi understands that the OIG's reviewers may have denied claims solely because the patient did not stay for twenty-four (24) hours post admission, instead of focusing on the patient's medical condition and needs at the time of the admission consistent with applicable Medicare guidance.

Via Christi has implemented comprehensive remedial measures to address the errors identified in the Draft Report. For example, Via Christi established a detailed verification process to ensure replacement device credits are properly obtained from the manufacturer and promptly reported. To address the identified DRG coding errors, Via Christi provided extensive education to inpatient coding staff that detailed medical record documentation requirements, applicable coding guidelines, and correct DRG assignment. Likewise, Via Christi also provided extensive education to staff, residents and physicians regarding proper patient status. To further address any inpatient status errors, Via Christi also hired an external physician advisory firm to provide physician review of complex cases when additional support for status determination is needed. Based on all of these efforts, we believe that Via Christi adequately addressed the billing issues identified as part of this Compliance Review.

Finally, please note that Via Christi maintains a proactive Corporate Responsibility Program ("CRP") with rigorous auditing and monitoring functions to ensure the accuracy of our Medicare claims and compliance with all program regulations and billing requirements. If any errors are detected through these CRP functions, Via Christi promptly refunds any identified overpayments to the appropriate payers.

If you have any questions regarding this matter, please feel free to contact me at (316) 858-4978.

Sincerely,



Sara Powers
Interim Vice President, Corporate Responsibility
Via Christi Health