

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
HEARTLAND REGIONAL  
MEDICAL CENTER FOR CALENDAR  
YEARS 2010 AND 2011**

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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*Heartland Regional Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of approximately \$282,000 over 2 years.*

### WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Heartland Regional Medical Center (Heartland) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient 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. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Heartland is a 328-bed acute care hospital located in St. Joseph, Missouri. Medicare paid Heartland approximately \$231 million for 17,934 inpatient and 303,627 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$2,886,744 in Medicare payments to Heartland for 194 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 131 inpatient and 63 outpatient claims, with dates of service in CYs 2010 and 2011 (audit period).

### WHAT WE FOUND

Heartland complied with Medicare billing requirements for 128 of the 194 inpatient and outpatient claims we reviewed. However, Heartland did not fully comply with Medicare billing requirements for the remaining 66 claims, resulting in net overpayments of \$281,997 for the audit period. Specifically, 42 inpatient claims had billing errors, resulting in overpayments of \$270,037, and 24 outpatient claims had billing errors, resulting in net overpayments of \$11,960.

These errors occurred primarily because Heartland did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

## **WHAT WE RECOMMEND**

We recommend that Heartland:

- refund to the Medicare contractor \$281,997, consisting of \$270,037 in overpayments for 42 incorrectly billed inpatient claims and \$11,960 in net overpayments for 24 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, Heartland concurred in part with our first recommendation and described actions that it had taken to address our second recommendation.

Heartland disagreed with our findings on 40 inpatient claims, consisting of \$260,787 in questioned costs, in which we found that Heartland should have billed the claims as outpatient or outpatient with observation services. Heartland stated that we (that is, our medical review contractor) "... based their review on the time the [physician's] order was placed in the computer." Heartland also stated that our medical review contractor did not consider individual factors related to the ability to safely care for these patients in an outpatient setting and that we "... did not give sufficient weight to the possibility of adverse events and scarcity of resources in a rural setting."

For the remaining 26 claims, Heartland concurred with our findings and said that it had either refunded or would refund a total of \$21,210.

After reviewing Heartland's comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether the 40 inpatient claims that the Hospital disagreed with met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether Heartland billed the inpatient claims according to Medicare requirements. Based on the contractor's conclusions, we determined, and continue to believe, that the 40 inpatient claims should have been billed as outpatient or outpatient with observation services.

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## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

### **OBJECTIVE**

Our objective was to determine whether Heartland Regional Medical Center (Heartland) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### **BACKGROUND**

#### **The Medicare Program**

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

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

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

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). 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), which 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>1</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient same-day discharges and readmissions,
- inpatient transfers,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient and outpatient claims paid in excess of charges,
- outpatient claims billed before and during inpatient stays,
- outpatient claims billed with modifiers,
- outpatient claims billed for Doxorubicin Hydrochloride,
- outpatient claims billed for surgeries with units greater than one, and
- outpatient claims billed for Lupron injections.

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

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

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” (the Social Security Act (the Act), § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

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<sup>1</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

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

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

## **Heartland Regional Medical Center**

Heartland is a 328-bed acute care hospital located in St. Joseph, Missouri. Medicare paid Heartland approximately \$231 million for 17,934 inpatient and 303,627 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

## **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$2,886,744 in Medicare payments to Heartland for 194 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 131 inpatient and 63 outpatient claims with dates of service in CYs 2010 and 2011 (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 46 claims to focused medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Heartland for Medicare reimbursement.

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.

See Appendix A for the details of our scope and methodology.

## **FINDINGS**

Heartland complied with Medicare billing requirements for 128 of the 194 inpatient and outpatient claims we reviewed. However, Heartland did not fully comply with Medicare billing requirements for the remaining 66 claims, resulting in net overpayments of \$281,997 for the audit period. Specifically, 42 inpatient claims had billing errors, resulting in overpayments of \$270,037, and 24 outpatient claims had billing errors, resulting in net overpayments of \$11,960. These errors occurred primarily because Heartland did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

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

Heartland incorrectly billed Medicare for 42 of 131 selected inpatient claims, which resulted in overpayments of \$270,037.

### **Incorrectly Billed as Inpatient**

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" (the Act, § 1862(a)(1)(A)).

According to chapter 1, § 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 "[a]dmissions 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 40 of the 131 selected inpatient claims, Heartland incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. Our independent medical reviewer determined that inpatient admission was not medically necessary for these beneficiaries. For example, in one case, the medical reviewer stated, "[t]he services planned at the time of admission ... were of the intensity that could have been safely provided at the observation level."

These errors occurred because Heartland did not have effective controls to ensure that it billed Medicare correctly. As a result of these errors, Heartland received overpayments of \$260,787.<sup>2</sup>

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<sup>2</sup> Heartland may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor prior to the issuance of our report.

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

Federal regulations 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 (42 CFR § 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, the hospital must code its Medicare claims with a combination of condition code 49 or 50, along with value code “FD” (chapter 3, § 100.8).

For 2 of the 131 selected inpatient claims, Heartland received a reportable medical device credit from a manufacturer but did not adjust its claims with the proper condition and value codes to reduce payments as required. Heartland stated that these overpayments occurred due to inadequate controls. As a result of these errors, Heartland received overpayments of \$9,250.

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

Heartland incorrectly billed Medicare for 24 of 63 selected outpatient claims, which resulted in net overpayments of \$11,960.

### **Incorrectly Billed as Outpatient**

Federal regulations state: “The prospective payment system provides a payment amount for inpatient operating costs, including.... Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary’s admission to the hospital and during the 3 calendar days [72 hours] immediately preceding the date of the beneficiary’s admission to the hospital...” (42 CFR § 412.2(c)(5)). The Manual states that Medicare Part A covers certain items and nonphysician services furnished to inpatients; consequently, the IPPS rate covers these services (chapter 3, § 10.4).

For 9 of the 63 selected outpatient claims, Heartland incorrectly billed Medicare Part B for outpatient services provided within 72 hours before or during inpatient stays. These services should have been included on Heartland’s inpatient (Part A) claims to Medicare. Heartland stated that these overpayments occurred due to inadequate controls. As a result of these errors, Heartland received overpayments of \$5,061.

### **Manufacturer Credit for a Replaced Medical Device Not Reported**

Federal regulations 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 (42 CFR § 419.45). 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.<sup>3</sup>

For 1 of the 63 selected outpatient claims, Heartland received a manufacturer credit for a replaced device but did not report the “FB” modifier and reduced charges on its claim. Heartland stated that this overpayment occurred due to inadequate controls. As a result of this error, Heartland received an overpayment of \$4,347.

### **Incorrectly Billed Healthcare Common Procedure Coding System Codes or Number of Units**

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). In addition, the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed” (chapter 4, § 20.4).

For 14 of the 63 selected outpatient claims, Heartland submitted claims to Medicare with unsupported HCPCS codes (10 claims), incorrect HCPCS codes (3 claims), or with an incorrect number of units (1 claim). Heartland stated that these errors occurred due to human error. As a result of these errors, Heartland received net overpayments of \$2,552.

### **RECOMMENDATIONS**

We recommend that Heartland:

- refund to the Medicare contractor \$281,997, consisting of \$270,037 in overpayments for 42 incorrectly billed inpatient claims and \$11,960 in net overpayments for 24 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

### **AUDITEE COMMENTS**

In written comments on our draft report, Heartland concurred in part with our first recommendation. Heartland also described actions that it had taken to address our second recommendation and stated that it would continue to use the results of this audit as guidelines for further process improvement and strengthening of its controls.

Heartland disagreed with our findings on 40 inpatient claims, consisting of \$260,787 in questioned costs, in which we found that Heartland should have billed the claims as outpatient or outpatient with observation services. Heartland stated that we (that is, our medical review

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<sup>3</sup> CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPI (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

contractor) "... based their review on the time the [physician's] order was placed in the computer." Heartland noted that there was a lag in time for information from a physician to appear in a patient's chart.

Heartland also stated that our medical review contractor did not consider individual factors related to the ability to safely care for these patients in an outpatient setting and that we "... did not give sufficient weight to the possibility of adverse events and scarcity of resources in a rural setting." In this regard, Heartland stated that "[i]t was the professional judgment of three physicians ... that care for these patients could not safely be provided in any less restrictive environment, and that inpatient care was medically necessary and appropriate, and was anticipated to be necessary for greater than 24 hours." In addition, Heartland noted that "[c]ontrols have been improved since 2010 to include dedicated [emergency department] managers who are present in the facility rather than on-call for weekends."

For the remaining 26 claims, Heartland concurred with our findings and said that it had either refunded or would refund a total of \$21,210.

Heartland's comments are included in their entirety as Appendix C.

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

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

Our independent medical review contractor did not base its determinations solely upon the information that was available when the physician's order was placed in the computer. Instead, our contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether Heartland billed the inpatient claims according to Medicare requirements.

With respect to Heartland's comments that our medical review contractor did not consider factors related to the setting where the services were performed, our contractor advised us that the scarcity of resources in a rural setting did not impact its medical determination regarding the reasonableness of inpatient status versus the status as outpatient or outpatient with observation services. To this point, we note that although observation services are performed in an outpatient setting, these services are conducted in the hospital, thereby using the same resources.

Based on the contractor's conclusions, we determined, and continue to believe, that the 40 inpatient claims should have been billed as outpatient or outpatient with observation services.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered \$2,886,744 in Medicare payments to Heartland for 194 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 131 inpatient and 63 outpatient claims with dates of service in CYs 2010 and 2011 (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 46 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of Heartland'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 CMS's 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 Heartland for Medicare reimbursement.

We conducted our fieldwork at Heartland in August 2012 and April 2013.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Heartland'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 medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 194 claims (131 inpatient and 63 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;
- reviewed the itemized bills and medical record documentation provided by Heartland to support the selected claims;

- requested that Heartland conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed Heartland's procedures for submitting Medicare claims;
- submitted Heartland's medical records for 46 claims to an independent medical review contractor to determine whether the claims met medical necessity requirements;
- discussed the incorrectly billed claims with Heartland officials 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 Heartland officials on August 26, 2013.

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.

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

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Under / Over-payments</b>	<b>Value of Net Over-payments</b>
<b>Inpatient</b>				
Short Stays	44	\$306,502	40	\$260,787
Manufacturer Credits for Replaced Medical Devices	3	85,579	2	9,250
Claims Billed With High Severity Level Diagnosis-Related Group Codes	39	1,543,537	0	0
Claims Paid in Excess of Charges	35	721,626	0	0
Same-Day Discharges and Readmissions	8	80,962	0	0
Transfers	2	28,591	0	0
<b>Inpatient Totals</b>	<b>131</b>	<b>\$2,766,797</b>	<b>42</b>	<b>\$270,037</b>
<b>Outpatient</b>				
Claims Billed Before and During Inpatient Stays	18	\$35,008	9	\$5,061
Manufacturer Credits for Replaced Medical Devices	1	6,537	1	4,347
Claims Billed With Modifiers	32	35,137	14	2,552
Claims Paid in Excess of Charges	5	22,781	0	0
Claims Billed for Doxorubicin Hydrochloride	5	14,412	0	0
Claims Billed for Surgeries With Units Greater Than One	1	4,839	0	0
Claims Billed for Lupron Injections	1	1,233	0	0
<b>Outpatient Totals</b>	<b>63</b>	<b>\$119,947</b>	<b>24</b>	<b>\$11,960</b>
<b>Inpatient and Outpatient Totals</b>	<b>194</b>	<b>\$2,886,744</b>	<b>66</b>	<b>\$281,997</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 Heartland. 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.