

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW  
OF RAPID CITY  
REGIONAL HOSPITAL  
FOR CALENDAR YEARS  
2010 AND 2011**

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Patrick J. Cogley  
Regional Inspector General

May 2013  
A-07-12-05033

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

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

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.

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

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

Rapid City Regional Hospital (the Hospital) has 368 beds and is located in Rapid City, South Dakota. Medicare paid the Hospital approximately \$161 million for 43,714 outpatient and 10,659 inpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$6,335,984 in Medicare payments to the Hospital for 132 outpatient and 119 inpatient claims that we identified as potentially at risk for billing errors for CYs 2010 and 2011.

### **OBJECTIVE**

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

## **SUMMARY OF FINDINGS**

The Hospital complied with Medicare billing requirements for 177 of the 251 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 74 claims, resulting in overpayments totaling \$256,789 for CYs 2010 and 2011. Specifically, 66 outpatient claims had billing errors, resulting in overpayments totaling \$187,984, and 8 inpatient claims had billing errors, resulting in overpayments totaling \$68,805. Overpayments occurred primarily because the Hospital's computerized pharmacy and charge systems were not programmed correctly for a drug. Overpayments also occurred because of human error and because the Hospital did not have adequate controls related to reporting manufacturer credits for replaced medical devices.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$256,789, consisting of \$187,984 in overpayments for the 66 incorrectly billed outpatient claims and \$68,805 in overpayments for the 8 incorrectly billed inpatient 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 and recommendations and stated that it had taken steps to strengthen controls to ensure full compliance with Medicare billing 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 and 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 Outpatient Prospective Payment System**

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

### **Hospital 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, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

### **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 the types of claims at risk for noncompliance included the following:

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

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

- outpatient claims billed for Lupron injections,
- outpatient claims with payments greater than \$25,000,
- outpatient claims billed with Doxorubicin Hydrochloride,
- outpatient claims billed with evaluation and management (E&M) services,
- outpatient claims billed with modifiers,
- inpatient claims billed with high severity level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims paid in excess of charges,
- inpatient short stays,
- inpatient claims with payments greater than \$150,000, and
- inpatient hospital-acquired conditions and present on admission indicator reporting.

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 outpatient and inpatient 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, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

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

## **Rapid City Regional Hospital**

Rapid City Regional Hospital (the Hospital) has 368 beds and is located in Rapid City, South Dakota. Medicare paid the Hospital approximately \$161 million for 43,714 outpatient and 10,659 inpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2010 and 2011 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 outpatient and inpatient services on selected claims.

#### **Scope**

Our audit covered \$6,335,984 in Medicare payments to the Hospital for 132 outpatient and 119 inpatient claims that we identified as potentially at risk for billing errors for CYs 2010 and 2011.

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

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

We conducted our fieldwork at the Hospital from July to October 2012.

#### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient and inpatient paid claim data from CMS's National Claims History file for CYs 2010 and 2011;

- obtained information on known credits for replaced medical devices from the device manufacturers for CYs 2010 and 2011;
- 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 251 claims (132 outpatient and 119 inpatient) 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
- shared the results of our review with Hospital officials on October 23, 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 177 of the 251 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 74 claims, resulting in overpayments totaling \$256,789 for CYs 2010 and 2011. Specifically, 66 outpatient claims had billing errors, resulting in overpayments totaling \$187,984, and 8 inpatient claims had billing errors, resulting in overpayments totaling \$68,805; see Appendix A. Overpayments occurred primarily because the Hospital's computerized pharmacy and charge systems were not programmed correctly for a drug. Overpayments also occurred because of human error and because the Hospital did not have adequate controls related to reporting manufacturer credits for replaced medical devices.

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

The Hospital incorrectly billed Medicare for 66 of the 132 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$187,984.

### **Incorrect Healthcare Common Procedure Coding System Code**

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” The Manual, chapter 17, section 90.2.A, states: “It is ... of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug ... that was used in the care of the patient.” If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 ....”

The Food and Drug Administration (FDA) identifies and reports drug products with a universally used unique, three-segment number called the national drug code (NDC). Each quarter, CMS provides Medicare contractors with an updated listing that cross-references the NDC to the drug name, billing units, and HCPCS code.

Lupron is a drug commonly used to treat hormone-dependent cancers. The FDA approved Lupron for the treatment of disorders relating to the uterus and for the treatment of prostatic cancer. According to the NDCs in effect during our audit period, Lupron was available for the treatment of: (1) disorders relating to the uterus, in doses of 3.75 mg once a month or 11.25 mg once every 3 months, and was linked to HCPCS code J1950; and (2) prostatic cancer, in doses of 7.5 mg once a month, 22.5 mg once every 3 months, or 30 mg once every 4 months, and was linked to HCPCS code J9217.

For 61 out of 132 sampled claims, the Hospital incorrectly submitted claims using the HCPCS code J1950 instead of the correct HCPCS code (J9217) and billed with either 8 or 6 service units when the correct amount should have been 4 or 3, respectively. The Hospital stated that these errors occurred because the incorrect HCPCS code was in the pharmacy dictionary and the chargemaster.<sup>3</sup> As a result of these errors, the Hospital received overpayments totaling \$161,740.

### **Incorrect Revenue Center Code**

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 1 out of 132 sampled claims, the Hospital submitted the claim with an incorrect revenue center code 636 (which denotes the administration or prescription of one or more drugs requiring

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<sup>3</sup> A hospital’s chargemaster contains data on every chargeable item or procedure that the hospital offers.

detailed coding) when revenue center 250 (“pharmacy general”) should have been used on the claim. Because the claim included the incorrect revenue center code, Medicare made an unallowable separate payment for a medication. The Hospital attributed this issue to an isolated incident caused by a manual clerical error. As a result of this error, the Hospital received an overpayment of \$19,988.

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

Federal regulations (42 CFR § 419.45) require a reduction in the OPSS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device.

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, 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.

For 2 out of 132 sampled claims, the Hospital received a full credit for a replaced medical device but did not report the “FB” modifier and reduced charges on its claims. These overpayments occurred because the Hospital did not have adequate controls to report the appropriate modifier and reduced charges to accurately reflect credits it had received from manufacturers. As a result of these errors, the Hospital received overpayments totaling \$5,816.

### **Incorrect Number of Units for Doxorubicin Hydrochloride**

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.” The Manual, chapter 17, section 90.2.A, states: “It is ... of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug ... that was used in the care of the patient.” If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 ....”

For 1 out of 132 sampled claims, the Hospital incorrectly submitted a claim to Medicare with an incorrect number of units for Doxorubicin Hydrochloride.<sup>4</sup> For this claim, rather than billing seven units of Doxorubicin Hydrochloride, the Hospital billed eight units.

The Hospital attributed this issue to an isolated clerical error. As a result of this error, the Hospital received an overpayment of \$383.

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<sup>4</sup> This drug is used in the chemotherapy treatment of a wide range of cancers.

## **Incorrectly Billed Evaluation and Management Service**

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

For 1 out of 132 sampled claims, the Hospital incorrectly billed Medicare for an E&M service (a dressing change) that was not above and beyond the usual postoperative work associated with the procedure. The dressing change was a routine postoperative service and required minimal intervention from nursing staff. The Hospital attributed this issue to an error in coding this service on the part of nursing staff. As a result of this error, the Hospital received an overpayment of \$57.

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

The Hospital incorrectly billed Medicare for 8 of the 119 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$68,805.

### **Incorrect Diagnosis-Related Group Codes**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that "... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 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 3 out of 119 sampled claims, the Hospital submitted the claim to Medicare with incorrectly coded DRG codes. Each of the three claims had an incorrect diagnosis code, which resulted in the incorrect DRG codes. The Hospital attributed the incorrect coding to human error. As a result of these errors, the Hospital received overpayments totaling \$39,655.

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

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. The Manual, chapter 3, section 100.8, states that to correctly bill 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."

For 3 out of 119 sampled claims, the Hospital received a reportable medical device credit from a manufacturer for a replaced device but did not adjust its inpatient claims with the appropriate condition and value codes to reduce payment as required. These overpayments occurred because the Hospital did not have adequate controls to report the appropriate condition and value codes to

accurately reflect credits it had received from manufacturers. As a result of these errors, the Hospital received overpayments totaling \$18,831.

### **Lack of Physician Orders**

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." Section 1814(a)(3) of the Act states that payment for services furnished to 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 ...." Federal regulations (42 CFR § 424.13(a)) state that "Medicare Part A pays for inpatient hospital services ... only if a physician certifies and recertifies," among other things, the reasons for continued hospitalization.

For 2 out of 119 sampled claims, the Hospital incorrectly billed Medicare Part A for inpatient short stays (that is, Hospital admissions in which the length of stay was 1 day or less) that did not have valid physician orders to admit the beneficiaries for inpatient care. The Hospital attributed this issue to a miscommunication between nursing staff and patient financial services staff. As a result of these errors, the Hospital received overpayments totaling \$10,319.

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$256,789, consisting of \$187,984 in overpayments for the 66 incorrectly billed outpatient claims and \$68,805 in overpayments for the 8 incorrectly billed inpatient 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 and recommendations and stated that it had taken steps to strengthen controls to ensure full compliance with Medicare billing requirements.

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

# **APPENDIXES**

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

| <b>Risk Area</b>  | <b>Selected Claims</b> | <b>Value of Selected Claims</b> | <b>Claims With Over-payments</b> | <b>Value of Over-payments</b> |
|---|------------------------|---------------------------------|----------------------------------|-------------------------------|
| <b>Outpatient</b>   |                        |                                 |                                  |                               |
| Lupron  | 61                     | \$214,332                       | 61                               | \$161,740                     |
| Claims paid in Excess of \$25,000   | 31                     | \$925,688                       | 1                                | \$19,988                      |
| Manufacturer Credits for Replaced Medical Devices                         | 3                      | \$33,512                        | 2                                | \$5,816                       |
| Claims Billed for Doxorubicin Hydrochloride                               | 10                     | \$120,572                       | 1                                | \$383                         |
| Claims Billed With Modifier 25  | 25                     | \$157,225                       | 1                                | \$57                          |
| Claims Billed With Modifier 74  | 2                      | \$3,514                         | 0                                | \$0                           |
| <b>Outpatient Totals</b>  | <b>132</b>             | <b>\$1,454,843</b>              | <b>66</b>                        | <b>\$187,984</b>              |
|   |                        |                                 |                                  |                               |
| <b>Inpatient</b>  |                        |                                 |                                  |                               |
| Claims Billed With High Severity Level Diagnosis-Related Group Codes      | 49                     | \$1,471,705                     | 2                                | \$22,656                      |
| Manufacturer Credits for Replaced Medical Devices                         | 4                      | \$90,293                        | 3                                | \$18,831                      |
| Claims Paid in Excess of Charges  | 13                     | \$427,355                       | 1                                | \$16,999                      |
| Short Stays   | 34                     | \$185,758                       | 2                                | \$10,319                      |
| Claims Paid in Excess of \$150,000  | 9                      | \$1,995,572                     | 0                                | \$0                           |
| Hospital Acquired Conditions and Present on Admission Indicator Reporting | 10                     | \$710,458                       | 0                                | \$0                           |
| <b>Inpatient Totals</b>   | <b>119</b>             | <b>\$4,881,141</b>              | <b>8</b>                         | <b>\$68,805</b>               |
|   |                        |                                 |                                  |                               |
| <b>Outpatient and Inpatient Totals</b>                                    | <b>251</b>             | <b>\$6,335,984</b>              | <b>74</b>                        | <b>\$256,789</b>              |

Notice: The table above illustrates the results of our review by risk area. In it, we have organized outpatient and inpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the 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**



**REGIONAL HEALTH**

P.O. Box 6000 Rapid City, SD 57709

April 4, 2013

Mr. Patrick J. Cogley  
Regional Inspector General  
Office of Audit Services, Region VII  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

Re: Report Number: A-07-12-05033

Dear Mr. Cogley,

This letter provides comments on behalf of Rapid City Regional Hospital to the draft report entitled "Medicare Compliance Review of Rapid City Regional Hospital for Calendar Years 2010 and 2011". Rapid City Regional Hospital appreciates the opportunity to respond to the Draft Report.

As noted in the Draft Report, the Office of Inspector General (the "OIG") reviewed \$6,335,983 in Medicare payments to the Hospital for 132 outpatient and 119 inpatient claims. The Hospital concurs with the OIG's findings that 177 of the 251 outpatient and inpatient claims fully complied with Medicare billing and 74 claims did not comply with Medicare billing. The Hospital concurs with the OIG finding that the billing errors resulted in overpayments totaling \$256,789 for CYs 2010 and 2011. The OIG's recommendations and the corrective action taken are set forth as follows:

*"The OIG recommends that the Hospital refund to the Medicare contractor \$256,789, consisting of \$187,984 in overpayments for the 66 incorrectly billed outpatient claims and \$68,805 in overpayments for the 8 incorrectly billed inpatient claims."*

Rapid City Regional Hospital concurs with this recommendation and refunded the total amount of \$256,789 by submitting corrected claims to Noridian.

*"The OIG recommends that the Hospital strengthen controls to ensure full compliance with the Medicare requirements."*

Rapid City Regional Hospital concurs with this recommendation and implemented the follow corrective actions:

1. The Hospital corrected the pharmacy dictionary and the Chargemaster system to use the correct HCPS code J9217 while the OIG was on site. The \$161,470 overpayment was refunded.
2. A baclofen drug claim was submitted with an incorrect revenue code. The Hospital determined this issue to be an isolated incident caused by a manual clerical error. Internal education was provided and the \$19,988 overpayment was refunded.
3. The Hospital incorrectly submitted two outpatient and three inpatient claims for replaced medical devices without the required FB modifier to indicate no-cost and reduced cost devices under OPPS. The Hospital implemented adequate controls to report the appropriate modifier and reduced charges to accurately reflect credit had received from manufacturers. The \$5,816 outpatient and \$18,831 inpatient overpayments were refunded.
4. A single claim for Doxorubicin Hydrochloride was submitted for eight units rather than seven units. The Hospital determined this issue to be an isolated incident caused by a clerical error. Internal education was provided and the \$383 overpayment was refunded.
5. A single claim for a postoperative dressing change was erroneously coded. The Hospital determined this issue to be an error in coding by nursing staff. Internal education was provided and the \$57 overpayment was refunded.
6. Three inpatient claims were submitted with incorrect DRG codes. The Hospital attributed the incorrect coding to human error. Internal education was provided and the \$39,655 overpayment was refunded.
7. Two claims were submitted incorrectly as inpatient Medicare Part A short stay claims without valid physician orders to admit the patients for inpatient care. The Hospital attributed the issue to a miscommunication between nursing staff and patient financial services staff. Internal education was provided and the \$10,319 overpayment was refunded.

Rapid City Regional Hospital reviewed the claims errors and implemented changes, various processes and education to prevent these errors from occurring in the future. We will continue to educate our staff and conduct monitoring and auditing activities to strengthen controls and ensure full compliance with Medicare billing requirements.

Please contact me if you need any additional information.

Sincerely,



Michael G. Diedrich  
Interim Vice President of Corporate Responsibility