

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

*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**

**March 2014
A-07-12-05036**

Office of Inspector General

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

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:

Office of Audit Services

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.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://oig.hhs.gov/>

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

Bryan Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$255,000 over more than 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 (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Bryan Medical Center (the Hospital) 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.

The Hospital is a 672-bed acute care hospital located in Lincoln, Nebraska. Medicare paid the Hospital approximately \$205 million for 16,375 inpatient and 57,598 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$3,208,464 in Medicare payments to the Hospital for 142 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 108 inpatient and 34 outpatient claims. Of the 142 claims, 126 claims had dates of service in CYs 2010 or 2011, and 16 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CYs 2009 or 2012.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 112 of the 142 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 30 claims, resulting in net overpayments of \$254,514 for CYs 2010 and 2011 (14 claims) and CYs 2009 and 2012 (16 claims). Specifically, 27 inpatient

claims had billing errors, resulting in overpayments of \$206,120, and 3 outpatient claims had billing errors, resulting in net overpayments of \$48,394. These errors occurred primarily because the Hospital 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 the Hospital:

- refund to the Medicare contractor \$254,514, consisting of \$206,120 in overpayments for 27 incorrectly billed inpatient claims and \$48,394 in net overpayments for 3 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital agreed with most of our findings and said that it had filed adjustments for the claims related to the findings with which it agreed.

The Hospital disagreed with our findings on nine inpatient claims, with \$64,966 in associated questioned costs, in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services. The Hospital described its process for internal review of medical necessity and stated that during our fieldwork, it had engaged the services of an outside company to perform secondary physician medical review of these nine claims. The Hospital added that its outside company reviewed the opinions of the OIG's third-party medical evaluator (our independent medical review contractor) as well as the complete medical records for the nine claims. The Hospital said that its outside company's reviewers determined that all nine claims met the criteria for inpatient admission but that for one of them, "... the case was not as strong" as it was for the other eight. The Hospital stated that it was in the process of cancelling that one claim but planned to appeal the other eight claims.

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

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
The Medicare Program	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System	1
Hospital Claims at Risk for Incorrect Billing	2
Medicare Requirements for Hospital Claims and Payments	2
Bryan Medical Center	3
How We Conducted This Review	3
FINDINGS	3
Billing Errors Associated With Inpatient Claims	4
Incorrectly Billed Diagnosis-Related Group Codes	4
Incorrectly Billed as Inpatient	4
Manufacturer Credits for Replaced Medical Devices Not Reported	5
Incorrectly Billed as Separate Inpatient Stays	5
Billing Errors Associated With Outpatient Claims	5
Manufacturer Credits for Replaced Medical Devices Not Reported	5
Incorrectly Billed Number of Units	6
RECOMMENDATIONS	6
AUDITEE COMMENTS	6
OFFICE OF INSPECTOR GENERAL RESPONSE	7
APPENDIXES	
A: Audit Scope and Methodology	8
B: Results of Review by Risk Area	10
C: Auditee Comments	11

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 Bryan Medical Center (the Hospital) 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, for hospital outpatient services. 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.¹ 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 and outpatient claims paid in excess of charges,
- inpatient claims billed with high severity level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient same-day discharges and readmissions,
- inpatient claims with payments greater than \$150,000,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- outpatient claims with payments greater than \$25,000, and
- outpatient claims billed with modifier -74.

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)).

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.

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

100-04, chapter 1, § 80.3.2.2). In addition, the Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Bryan Medical Center

The Hospital is a 672-bed acute care hospital located in Lincoln, Nebraska. Medicare paid the Hospital approximately \$205 million for 16,375 inpatient and 57,598 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 \$3,208,464 in Medicare payments to the Hospital for 142 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 108 inpatient and 34 outpatient claims. Of the 142 claims, 126 claims had dates of service in CYs 2010 or 2011, and 16 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CYs 2009 or 2012.² We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 13 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 the Hospital 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

The Hospital complied with Medicare billing requirements for 112 of the 142 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 30 claims, resulting in net overpayments of \$254,514 for CYs 2010 and 2011 (14 claims) and CYs 2009 and 2012 (16 claims). Specifically, 27 inpatient claims had billing errors, resulting in overpayments of \$206,120, and 3 outpatient claims had billing errors, resulting in net overpayments of \$48,394. These errors occurred primarily because the Hospital 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.

² We selected these 16 claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 27 of 108 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$206,120.

Incorrectly Billed Diagnosis-Related Group Codes

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)).

For 7 out of 108 selected claims, the Hospital billed Medicare for incorrect DRG codes that, specifically, were not supported in the medical records. The Hospital attributed these overpayments to human error. As a result of these errors, the Hospital received overpayments of \$92,503.

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, 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.

For 9 out of 108 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays. Our medical reviewer determined that the medical records did not support the medical necessity of the billed claims. The Hospital stated that these errors occurred because of differences of medical judgment in the application and interpretation of inpatient admission criteria. As a result of these errors, the Hospital received overpayments of \$64,966.³

³ The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than 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 device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code “FD” (chapter 3, § 100.8).

For 8 out of 108 selected claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate condition and value codes to reduce payment as required. (Of the eight claims, two had dates of service in CY 2009, two had dates of service in CY 2010, three had dates of service in CY 2011, and one had a date of service in CY 2012.) These overpayments occurred because the Hospital staff reporting these codes did not have a clear understanding of when the codes were to be used. As a result of these errors, the Hospital received overpayments of \$30,861.

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states:

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

For 3 out of 108 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital stated that staff members making the determinations as to whether the readmission was related to the discharge did not have a clear understanding of the rules. As a result of these errors, the Hospital received overpayments of \$17,790.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 3 of 34 selected outpatient claims that we reviewed. These errors resulted in net overpayments of \$48,394.

Manufacturer Credits for Replaced Medical Devices 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.⁴

For 2 out of 34 selected claims, the Hospital received full credit for replaced medical devices but did not report the “FB” modifier and reduced charges on its claims. (Of the two claims, one had a date of service in CY 2011 and one had a date of service in CY 2012.) These overpayments occurred because the Hospital staff reporting these codes did not have a clear understanding of when the codes were to be used. As a result of these errors, the Hospital received overpayments of \$41,671.

Incorrectly Billed Number of Units

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 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). The Manual also 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” (chapter 17, § 90.2.A). If the provider is billing for a drug, according to 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....” (chapter 17, § 70).

For 1 out of 34 selected claims, the Hospital submitted the claim to Medicare with an incorrect number of units for a medication. The Hospital attributed this overpayment to a coding error in the pharmacy charging system. As a result of this error, the Hospital received an overpayment of \$6,723.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$254,514, consisting of \$206,120 in overpayments for 27 incorrectly billed inpatient claims and \$48,394 in net overpayments for 3 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 agreed with most of our findings and said that it had filed adjustments for the claims related to the findings with which it agreed.

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

The Hospital disagreed with our findings on nine inpatient claims, with \$64,966 in associated questioned costs, in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services. The Hospital described its process for internal review of medical necessity and stated that it used "... nationally recognized Interqual Criteria to screen admissions for medical necessity. For patients whose condition does not meet the Interqual Criteria screen for inpatient admission, the Care Management nurse refers the case to an outside company ... for secondary physician medical review.... This expert secondary physician review ensures the correct admission status is identified."

The Hospital added that its outside company reviewed the opinions of the OIG's third party medical evaluator (our independent medical review contractor) as well as the complete medical records for the nine claims. The Hospital said that its outside company's reviewers determined that all nine claims met the criteria for inpatient admission but that for one of them, "... the case was not as strong" as it was for the other eight. The Hospital stated that it was in the process of cancelling that one claim but planned to appeal the other eight claims.

The Hospital's comments appear in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

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

We acknowledge that the Hospital had a process in place for internal review of medical necessity but note that the Interqual Criteria to which the Hospital referred is a screening tool only and, as such, can contribute to the process whereby physicians make decisions as to inpatient admission. We based our findings on the nine inpatient claims with which the Hospital disagreed not on any deficiencies in the *process*, but rather, on the admissions *decisions* themselves. In this context, we used an independent medical review contractor to determine whether these nine inpatient claims met medical necessity requirements. The contractor examined all of the medical records and documentation that the Hospital's outside company used to make its determination that the nine claims met the criteria for inpatient admission and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$3,208,464 in Medicare payments to the Hospital for 142 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 108 inpatient and 34 outpatient claims. Of the 142 claims, 126 claims had dates of service in CYs 2010 or 2011, and 16 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CYs 2009 or 2012 (see footnote 2).

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 13 claims to focused medical review to determine whether the services were medically necessary.

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

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

We conducted our fieldwork at the Hospital from October 2012 to September 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2010 and 2011;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2009 through 2012;
- 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 142 claims (108 inpatient and 34 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 the Hospital to support the selected claims;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- used an independent medical review contractor to determine whether 13 selected claims met medical necessity requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Hospital officials on September 3, 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

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Short Stays	13	\$87,992	9	\$64,966
Claims Paid in Excess of Charges	19	425,947	3	46,868
Claims Billed With High Severity Level Diagnosis-Related Group Codes	51	1,652,805	4	45,635
Manufacturer Credits for Replaced Medical Devices	16	306,070	8	30,861
Same-Day Discharges and Readmissions	6	61,781	3	17,790
Claims With Payments Greater Than \$150,000	2	339,131	0	0
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	1	29,576	0	0
Inpatient Totals	108	\$2,903,302	27	\$206,120
Outpatient				
Manufacturer Credits for Replaced Medical Devices	29	\$233,995	2	\$41,671
Claims Paid in Excess of Charges	1	9,386	1	6,723
Claims With Payments Greater Than \$25,000	1	31,949	0	0
Claims Billed With Modifier -74	3	29,832	0	0
Outpatient Totals	34	\$305,162	3	\$48,394
Inpatient and Outpatient Totals	142	\$3,208,464	30	\$254,514

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 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 C: AUDITEE COMMENTS



Bryan Medical Center

January 14, 2014

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 East Twelfth Street, Room 0429
Kansas City, MO 64106

Re: Audit Report A-07-12-05036, Medicare Compliance Review of Bryan Medical Center for Calendar Years 2010 and 2011.

Dear Mr. Cogley:

INTRODUCTION

Bryan Medical Center ("the Medical Center") is in receipt of the December 17, 2013 draft report provided to it by the Department of Health and Human Services, Office of Inspector General ("the OIG"), entitled "Medicare Compliance Review of Bryan Medical Center for Calendar Years 2010 and 2011 ("the Draft Report"). It is our understanding that the Medical Center was not audited due to any alleged improper billing or compliance practices, but as part of a national initiative by the OIG focusing on certain hospital risk areas, and that scores of hospitals have so far been audited. We appreciate that you have provided us an opportunity to respond to the Draft Report.

In the Draft Report, the OIG states that it used computer matching, data mining, and data analysis techniques and reviewed a number of "risk areas" to identify claims of the Medical Center that were at risk for noncompliance with Medicare billing requirements. The Draft Report further states that for calendar years 2010 and 2011, Medicare paid the Medical Center approximately \$205 million for 16,375 inpatient and 57,598 outpatient claims. The OIG alleges in the Draft Report that the Medical Center billing errors resulted in Medicare overpayments of \$254,514. Not to lessen the seriousness of any incorrect overpayments, but to place the alleged overpayments in perspective, the \$254,514 is a bit more than one-tenth of one percent of the \$205 million received by the Medical Center as Medicare reimbursement, even if the Medical Center agreed with all the OIG findings in the OIG report, which it does not. As will be discussed, the Medical Center respectfully disagrees with the OIG on 8 claims that the OIG's third-party evaluator determined did not meet inpatient admission criteria. It should also be noted that in no way has the OIG determined that the quality of care provided for those patients whose claims were reviewed was in any way deficient.

The Medical Center appreciates the assistance provided by the OIG in directing the Medical Center to those areas in which compliance can be improved. We are committed to complying with the many and complex Medicare requirements and have a robust compliance program, including actively monitoring and auditing to help ensure compliance with such requirements. The Medical Center has carefully considered the recommendations made by the OIG in its Draft Report and has taken corrective action to help ensure compliance with Medicare billing requirements for the audit areas. While the Medical Center respectfully disagrees with certain of the OIG's findings as noted above, the Medical Center

Bryan East Campus • 1600 S. 48th St. • Lincoln, NE 68506-1299 • 402-481-1111
Bryan West Campus • 2300 S. 16th St. • Lincoln, NE 68502-3704 • 402-481-1111
bryanhealth.org

wishes to thank the OIG for its professionalism, transparency, and receptiveness during the course of the audit.

The following are those areas of the audit set forth in the Draft Report and the Medical Center's responses. This includes a description of any corrective action taken by the Medical Center, including any repayments made to the Medical Center's Medicare Administrative Contractor ("MAC").

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Incorrectly Billed Diagnosis-Related Group Codes

The OIG states in the Draft Report that for 7 out of the 108 selected inpatient claims, the Medical Center billed Medicare incorrectly for incorrect DRG codes that were not supported in the medical record, resulting in overpayments of \$92,503.

The Medical Center agrees with these findings. Errors identified were related to improper interpretation of documentation contained in the medical record in conjunction with not appropriately applying the coding rules and guidelines. All errors identified were reviewed with the coding staff for correction, and education was provided to all staff to improve accuracy. Ongoing internal and external audits will continue to be performed to identify potential errors and provide ongoing education. As of the date of the Draft Report, the Medical Center has filed corrected claims with its MAC and made any necessary repayments under this heading.

Incorrectly Billed as Inpatient

The OIG states in the Draft Report that for 9 of the 108 selected inpatient claims, the Medical Center incorrectly billed Medicare Part A for beneficiary stays, not meaning that care wasn't necessary or adequate, but that the 9 patients should not have been admitted as inpatients. It is claimed by the OIG that the resulting overpayments amounted to \$64,966.

The Medical Center disagrees with the OIG findings on the 9 claims. The Medical Center follows the Medicare Conditions of Participation and its Utilization Management Plan to ensure quality patient care. The Care Management nurses use nationally recognized Interqual Criteria to screen admissions for medical necessity. For patients whose condition does not meet the Interqual Criteria screen for inpatient admission, the Care Management nurse refers the case to an outside company ("Physician Consultants") for a secondary physician medical review. Per Chapter 1, Section 10 of the Medicare Benefit Policy Manual, effective controls need to be in place addressing medical necessity and appropriate billing. This expert secondary physician review ensures the correct admission status is identified.

After the OIG had its third party evaluator review the claims and render opinions regarding the 9 claims, the OIG allowed the Medical Center to engage the Physician Consultants to review the 9 claims and the opinions rendered. The opinions of the OIG evaluator and complete medical records for the 9 claims were provided by the Medical Center to the Physician Consultants to ensure a thorough review. Citing the Federal Register, federal regulations, the Medicare Quality Improvement Organization Manual, the Medicare Program Integrity Manual, clinical guidelines published by leading medical associations, and

[2]

Interqual and other nationally recognized screening criteria, as well as clinically significant facts not mentioned by the OIG evaluator in the opinions given by the OIG to the Medical Center, the Physician Consultants provided detailed reports, concluding that in 8 of the 9 claims, inpatient admission status was clearly indicated. For the one remaining claim, the Physician Consultants determined that inpatient status was arguably met, but the case was not as strong as the other 8 claims. The Medical Center then shared the findings of the Physician Consultants with the OIG. The Physician Consultants' reports were apparently rejected by the OIG.

With the recent rule changes by the Centers for Medicare and Medicaid Services ("CMS") to the "two midnight rule," which indicates that CMS recognized the unsustainability of challenging physicians' clinical decisions as to admission status, the Medical Center has received many hours of training on the rule changes and put in place forms and processes to comply with the new rule changes. While the Physician Consultants found that all 9 claims met inpatient criteria, the Physician Consultants advised the Medical Center that 1 of the claims was not as strong and that based on the time and expense, pursuing an appeal on the 1 claim would not be financially prudent. However, the Medical Center plans to appeal the other 8 claims to the extent allowed by law. For the 1 claim with which the Medical Center does not plan an appeal, the Medical Center is in the process of canceling the claim so that repayment is made to the MAC.

Manufacturer Credits for Replaced Medical Device Not Reported

The OIG states in the Draft Report that for 8 of the 108 selected inpatient claims, the Medical Center received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate conditions and value code to reduce payment, resulting in overpayments of \$30,861.

The Medical Center agrees with the OIG's findings. The process for warranty credits is to file the claim with the MAC in accordance with our customary time frames for claims submission. When the actual amount of the device credit becomes known, an adjustment claim is then filed with the MAC, showing the charge reduction. For the claims at issue, the warranty credit claims all showed the reductions of the charges; however, they did not always show appropriate codes (e.g. FD value code, or the appropriate modifier). Education and processes have been put in place to ensure that appropriate codes are put on these types of claims. As of the date of the Draft Report, the Medical Center has filed corrected claims with its MAC and made any necessary repayments under this heading.

Incorrectly Billed as Separate Inpatient Stays

The OIG states in the Draft Report that for 3 of the 108 selected inpatient claims, the Medical Center billed separately for related discharges for readmissions that occurred within the same day, resulting in overpayments of \$17,790.

The Medical Center agrees with the findings. All inpatient same day discharges and readmissions are now reviewed by a nurse auditor to determine if the two admissions are related. If they are related, the two claims are combined into one claim. As of the date of the Draft Report, the Medical Center has filed corrected claims with its MAC and made any necessary repayments under this heading.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

[3]

Manufacturer Credits for Replaced Medical Devices Not Reported

The OIG states in the Draft Report that for 2 of the 34 selected outpatient claims, the Medical Center received full credit for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims, resulting in overpayments of \$41,671.

The Medical Center agrees with the findings. The process for warranty credits is to file the claim with the MAC in accordance with our customary time frames for claims submission. When the actual amount of the device credit becomes known, we file an adjustment claim with the MAC, showing the charge reduction. The warranty credit claims at issue all showed the reductions of the charges; however, they did not always show appropriate codes (e.g. FD value code, or the appropriate modifier). Education and processes have been put in place to ensure that appropriate codes are put on these types of claims. As of the date of the Draft Report, the Medical Center has filed corrected claims with its MAC and made any necessary repayments under this heading.

Incorrectly Billed Number of Units

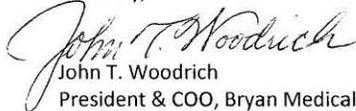
The OIG states in its Draft Report that for 1 of the 34 selected outpatient claims, the Medical Center submitted the claim to Medicare with an incorrect number of units for a medication, resulting in an overpayment of \$6,723.

The Medical Center agrees with the findings. This was a code conversion issue in the pharmacy charging system. The conversion issue was corrected. As of the date of the Draft Report, the Medical Center has filed corrected claims with its MAC and made any necessary repayments under this heading.

CONCLUSION

We wish to again thank the OIG in assisting the Medical Center to better comply with Medicare billing requirements. We regret any billing errors that were made and remain committed to having an active and strong compliance program to help ensure our billing is accurate and in compliance with Medicare billing rules.

Sincerely,


John T. Woodrich
President & COO, Bryan Medical Center

[4]