

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
AVERA MCKENNAN HOSPITAL
FOR 2010 AND 2011**

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**Patrick J. Cogley
Regional Inspector General
for Audit Services**

October 2014
A-07-13-05044

Office of Inspector General

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

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EXECUTIVE SUMMARY

Avera McKennan Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$174,000 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) 2012, Medicare paid hospitals \$148 billion, which represents 43 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 Avera McKennan Hospital (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 545-bed acute care hospital located in Sioux Falls, South Dakota. Medicare paid the Hospital approximately \$161 million for 13,489 inpatient and 80,512 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$4,145,627 in Medicare payments to the Hospital for 262 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 152 inpatient and 110 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 227 of the 262 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 35 claims, resulting in overpayments of \$173,612 for CYs 2010 and 2011. Specifically, 29 inpatient claims had billing errors, resulting in overpayments of \$166,817, and 6 outpatient claims had billing errors, resulting in overpayments of \$6,795. 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 \$173,612, consisting of \$166,817 in overpayments for 29 incorrectly billed inpatient claims and \$6,795 in overpayments for 6 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 generally agreed with our findings and recommendations. Specifically, the Hospital stated that it had refunded the \$173,612 in overpayments, and described corrective actions that it had taken to further enhance and strengthen its controls.

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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) 2012, Medicare paid hospitals \$148 billion, which represents 43 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 Avera McKennan Hospital (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 claims billed with high severity level DRG codes,
- inpatient and outpatient claims paid in excess of charges,
- inpatient short stays,
- inpatient transfers,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient claims with payments greater than \$150,000,
- inpatient claims billed with kyphoplasty services,
- outpatient claims billed with Doxorubicin Hydrochloride,
- outpatient claims billed with modifiers, and
- outpatient claims with payments greater than \$25,000.

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)).

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

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

Avera McKennan Hospital

The Hospital is a 545-bed acute care hospital located in Sioux Falls, South Dakota. Medicare paid the Hospital approximately \$161 million for 13,489 inpatient and 80,512 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 \$4,145,627 in Medicare payments to the Hospital for 262 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 152 inpatient and 110 outpatient claims. 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 but did not use 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 227 of the 262 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 35 claims, resulting in overpayments of \$173,612 for CYs 2010 and 2011. Specifically, 29 inpatient claims had billing errors, resulting in overpayments of \$166,817, and 6 outpatient claims had billing errors, resulting in overpayments of \$6,795. 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.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 29 of 152 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$166,817.

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 26 out of 152 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, diagnosis or procedure codes on these claims were not supported in the medical records. The Hospital attributed the overpayments to human error. As a result of these errors, the Hospital received overpayments of \$162,066.

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* (Pub. No. 100-02), 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 1 out of 152 selected claims, the Hospital incorrectly billed Medicare Part A for a beneficiary stay that should have been billed as outpatient or outpatient with observation services. The Hospital attributed the incorrect billing to clerical error. As a result of this error, the Hospital received an overpayment of \$4,307.²

Incorrect Discharge Status Code

Federal regulations state that a discharge of a hospital inpatient is considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to a

² 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 before the issuance of our report.

skilled nursing facility (SNF) (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)(1)).

For 2 out of 152 selected claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to a SNF. However, the Hospital used the incorrect discharge status codes; thus, the Hospital should have received the per diem payment instead of the full DRG payment. The Hospital explained that submitting the appropriate discharge status consists of a two-step process. First, the discharge status is entered by the case manager upon discharge from the hospital. Next, the coding staff validates the discharge status when coding the medical record. In these cases, the correct discharge code was not entered and/or validated appropriately. As a result of these errors, the Hospital received overpayments of \$444.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 6 of 110 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$6,795.

Incorrect 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 5 out of 110 selected claims, the Hospital billed Medicare for an incorrect number of units for a medication. The Hospital stated that these errors occurred because the pharmacists selected incorrect billing items. As a result of these errors, the Hospital received overpayments of \$5,716.

Insufficiently Documented Procedures

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).

For 1 out of 110 selected claims, the Hospital submitted the claim to Medicare with unsupported procedure codes. The Hospital attributed the overpayment to a data entry error. As a result of this error, the Hospital received an overpayment of \$1,079.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$173,612, consisting of \$166,817 in overpayments for 29 incorrectly billed inpatient claims and \$6,795 in overpayments for 6 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 generally agreed with our findings and recommendations. Specifically, the Hospital stated that it had refunded the \$173,612 in overpayments, and described corrective actions that it had taken to further enhance and strengthen its controls.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$4,145,627 in Medicare payments to the Hospital for 262 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 152 inpatient and 110 outpatient claims.

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 but did not use 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 March 2013 to June 2014.

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;
- 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 262 claims (152 inpatient and 110 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;

- 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 June 9, 2014.

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				
Claims Billed With High Severity Level Diagnosis-Related Group Codes	69	\$1,074,638	24	\$151,570
Claims Paid in Excess of Charges	6	89,039	2	10,496
Short Stays	25	248,513	1	4,307
Inpatient Transfers	7	226,859	2	444
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	40	938,569	0	0
Claims With Payments Greater Than \$150,000	2	346,500	0	0
Claims Billed With Kyphoplasty Services	3	31,967	0	0
Inpatient Totals	152	\$2,956,085	29	\$166,817
Outpatient				
Claims Billed With Doxorubicin Hydrochloride	60	\$214,901	5	\$5,716
Claims Billed With Modifiers	22	\$118,946	1	1,079
Claims With Payments Greater Than \$25,000	26	\$844,877	0	0
Claims Paid in Excess of Charges	2	\$10,818	0	0
Outpatient Totals	110	\$1,189,542	6	\$6,795
Inpatient and Outpatient Totals	262	\$4,145,627	35	\$173,612

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



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September 8, 2014

Patrick J. Cogley
Regional Inspector General for Audit Services
US Department of Health and Human Services
Office of Audit Services Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: Report Number A-07-13-05044

Dear Mr. Cogley,

Thank you for the opportunity to review the draft *Medicare Compliance Review of Avera McKennan Hospital for 2010 and 2011*. In accordance with your letter, I am responding to your request for written comments related to the validity of the draft report.

Avera McKennan Hospital is committed to compliance with regulations surrounding all federal health care programs. Our compliance program will continue to proactively monitor and audit risk areas to ensure proper controls exist to minimize billing errors.

Overall, we are in general agreement with the information contained in this draft report. The report details compliance with 227 of the 262 inpatient and outpatient claims reviewed totaling \$4,145,627 in Medicare payments. The remaining 35 claims, resulting in overpayments of \$173,612 for FYs 2010 and 2011. Listed below are the OIG's recommendations and our response:

Refund to the Medicare contractor \$173,612, consisting of \$166,817 in overpayments for 29 incorrectly billed inpatient claims and \$6,795 in overpayments for 6 incorrectly billed outpatient claims.

Avera McKennan Hospital agrees with this recommendation and has refunded the amount of \$173,612 to our CMS contractor Noridian through submission of corrected claims.

Strengthen Controls to ensure full compliance with Medicare requirements.

The majority of the issues identified were due to human error. The following controls have been instituted:

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1. *Education*

All affected departments and responsible individuals have been provided education on the specific billing errors and the proper policies and procedures for billing appropriately.

2. *Internal Quality Monitoring*

The majority of the inpatient claim issues involved incorrectly billed diagnosis related group codes. In response, effective May 2013 we have strengthened our inpatient coding monitoring process to focus on the high severity level diagnosis-related group codes. Specifically, inpatient claims with one complication or comorbidity (CC) or a major complication or comorbidity (MCC) are audited by a multidisciplinary team consisting of specialty trained registered nurses and certified inpatient coding staff. This team collaborates on the audit process to ensure claim accuracy prior to submission. Expected coder quality scores are 95% or above in order to meet all standards of the coding process. Currently, all audit results are exceeding the quality expectation.

In summary, Avera McKennan Hospital understands the importance of following all federal rules and regulations. We will continue to monitor and audit our coding and billing processes to prevent future errors and are committed to ongoing staff education. We appreciate the cooperation and professionalism demonstrated by the OIG team throughout the audit process.

Please contact me for any additional information.

Sincerely,



David Kapaska, DO
Regional President/CEO