DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

May 9, 2011

Report Number: A-01-11-00507

Mr. Robert Rovella
CFO/Director of Finance
Central Vermont Medical Center
130 Fisher Road
Berlin, VT 05602

Dear Mr. Rovella:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Verification of Central Vermont Medical Center's Refund of Place-of-Service Overpayments for Calendar Years 2007–2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact David Lamir, Audit Manager, at (617) 565-2704 or through email at David.Lamir@oig.hhs.gov. Please refer to report number A-01-11-00507 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare and Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

VERIFICATION OF CENTRAL VERMONT MEDICAL CENTER'S REFUND OF PLACE-OF-SERVICE OVERPAYMENTS FOR CALENDAR YEARS 2007–2010

Daniel R. Levinson
Inspector General

May 2011
A-01-11-00507

Office of Inspector General

http://oig.hhs.gov

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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

BACKGROUND

Medicare Part B pays for services physicians provide to program beneficiaries. Although physicians routinely perform many of these services in hospital outpatient departments or freestanding ambulatory surgical centers (ASC), physicians also perform some services in nonfacility settings such as physician offices, urgent care centers, or independent clinics. To account for the increased overhead expense that physicians incur by performing services in nonfacility locations, Medicare reimburses physicians at a higher rate for certain services performed in these locations. However, when physicians perform these same services in facility settings Medicare reimburses the overhead expenses to the facilities and physicians receive a lower reimbursement rate.

Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare contractors. The correct place-of-service code ensures that Medicare does not reimburse a physician incorrectly for the overhead portion of the payment if the service was performed in a facility setting.

Our previous nationwide reviews found that several contractors overpaid physicians who did not correctly identify the place of service on their claims. These audits identified over a million nonfacility-coded physician services that matched outpatient hospital claims for the same type of service provided to the same beneficiary on the same day. These reviews identified numerous instances of overpayments to Central Vermont Medical Center (the Hospital) physicians because claims the Hospital submitted contained an incorrect place-of-service code. The Hospital submits claims for the overhead expenses of medical services performed at the Hospital and bills on behalf of its physicians for Part B physician services.

The Hospital's officials insisted on refunding all overpayments received resulting from these place-of-service coding errors. The Hospital asked the Office of Inspector General to verify the accuracy of its overpayment calculations so it could refund its Medicare contractor.

OBJECTIVE

The objective of our audit was to determine the amount of overpayments for claims with place-of-service coding errors submitted by the Hospital to its Medicare contractor for calendar years (CYs) 2007 through 2010.

SUMMARY OF FINDING

We determined that the Hospital submitted 17,728 claims with overpayments totaling $237,368 for physician services for CYs 2007 through 2010. The Hospital, billing on behalf of its physicians, incorrectly coded these claims by using nonfacility place-of-service codes for services that were performed in one of the Hospital's outpatient facilities.

RECOMMENDATIONS

We recommend the Hospital refund a total of $237,368 for overpayments resulting from coding errors on claims submitted on behalf of Hospital physicians for CYs 2007 through 2010.

CENTRAL VERMONT MEDICAL CENTER COMMENTS

In written comments to our draft report, the Hospital concurred with our findings and recommendation. The Hospital's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare Part B Payments for Physician Services

Medicare Part B pays for services physicians provide to program beneficiaries. Physician services include medical and surgical procedures, office visits, and medical consultations. These services may be provided in facility settings, such as hospital outpatient departments and freestanding ambulatory surgical centers (ASC), or in nonfacility locations, such as physician offices, urgent care centers, and independent clinics.

Physicians are paid for services according to the Medicare physician fee schedule. This schedule is based on a payment system that includes three major categories of costs required to provide physician services: practice expense, physician work, and malpractice insurance.

Medicare Reimbursement for Practice Expense

Practice expense reflects the overhead costs involved in providing a service. To account for the increased practice expense that physicians generally incur by performing services in their offices and other nonfacility locations, Medicare reimburses physicians at a higher rate for certain services performed in these locations rather than in a hospital outpatient department or an ASC. Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare contractors. The correct place-of-service code ensures that Medicare does not reimburse a physician incorrectly for the overhead portion of the service if the service was performed in a facility setting.

Medicare claim form instructions specifically state that each provider or practitioner is responsible for becoming familiar with Medicare coverage and billing requirements. Some physician offices submit their own claims to Medicare; other offices hire billing agents to submit their claims. Physicians are responsible for any Medicare claims submitted by billing agents.

Prior Office of Inspector General Reports

Our previous nationwide reviews (A-01-08-00528 and A-01-09-00503) found that several contractors overpaid physicians who did not correctly identify the place of service on their claims. These audits identified over a million nonfacility-coded physician services that matched outpatient hospital claims for the same type of service provided to the same beneficiary on the same day. Our recommendations in those reports called for the Medicare contractors to educate physicians regarding proper billing, recover identified overpayments, and analyze postpayment data to detect and recover overpayments for improperly billed claims. The Medicare contractors and CMS generally concurred with our recommendations.

Central Vermont Medical Center

Central Vermont Medical Center (the Hospital) is a 122-bed acute-care hospital located in Berlin, Vermont. The Hospital submits claims for the overhead expenses of medical services performed at the hospital. In addition, the Hospital also bills on behalf of its physicians for their Part B physician services. As the Medicare contractor for hospitals and physicians in Vermont, National Heritage Insurance Corporation, Corp. (NHIC), processes and pays the Hospital's claims for Medicare outpatient services and its claims for physician services.

Our nationwide reviews identified numerous instances of overpayments by NHIC to the Hospital for physician claims that contained an incorrect place-of-service code in calendar years (CYs) 2007 through 2010. The Hospital's officials insisted on refunding all overpayments received resulting from these place-of-service coding errors. The Hospital asked the Office of Inspector General to verify the accuracy of its overpayment calculations so it could refund NHIC. We provided our data on the miscoded claims to the Hospital to reach agreement on the amount of the overpayments for these miscoded claims with dates of service from January 2007 through December 2010.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to determine the amount of overpayments for claims with place-of-service coding errors submitted by the Hospital to its Medicare contractor for CYs 2007 through 2010.

Scope

Based on the Hospital's request, we performed a limited scope review to determine the accuracy of overpayments to be refunded by the Hospital for claims with physician place-of-service coding errors for CYs 2007 through 2010.

Our audit covered 17,807 nonfacility-coded physician services valued at $868,518 that were provided in CYs 2007 through 2010 and that matched hospital outpatient claims for the same type of service provided to the same beneficiary on the same day.

The objective of our audit did not require an understanding or assessment of the complete internal control structure at the Hospital. Therefore, we limited our review of internal controls to the billing controls in place at the Hospital to prevent future program overpayments resulting from place-of-service billing errors.

We conducted our fieldwork in January 2011 through March 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

- used data from our place-of-service reviews for CYs 2007 through 2010 to identify all office-coded physician claims that matched claims submitted by the Hospital for the same service performed for the same beneficiary on the same date;

- calculated the difference for each of these claims between the amount paid and the amount that would have been paid had the place-of-service been coded correctly;

- obtained support for the Hospital-calculated overpayments on claims with place-of-service errors in CYs 2007 through 2010;

- compared our data to the Hospital's support and worked with the Hospital to verify the accuracy of the overpayment total to ensure the completeness of the refund; and

- discussed the results of our review with officials of both the Hospital and NHIC.

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 objective.

FINDINGS AND RECOMMENDATIONS

We determined that the Hospital submitted claims with overpayments totaling $237,368 for physician services for CYs 2007 through 2010. The Hospital, billing on behalf of its physicians, incorrectly coded these claims by using nonfacility place-of-service codes for services that were actually performed in one of the Hospital's outpatient clinic facilities.

PAYMENTS BASED ON INCORRECT PLACE OF SERVICE

Medicare Requirements

Medicare payment for physician services is based on the lower of the actual charge or the physician-fee-schedule amount.[1]

[1]Section 1848(a)(1) of the Social Security Act, 42 U.S.C. § 1395w-4(a)(1).

For a physician to receive the higher nonfacility practice expense payment for a service, the service must meet the requirements of 42 CFR § 414.22(b)(5)(i)(B): "The higher non-facility practice expense [relative value units] apply to services performed in a physician's office, a patient's home, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC performing an ASC approved procedure." CMS publishes a quarterly physician fee schedule in the Federal Register showing those services that have a higher payment rate if performed in a nonfacility setting.

Results of Review

The Hospital submitted 17,728 incorrectly coded claims for physician services for CYs 2007 through 2010. The Hospital, billing on behalf of its physicians, incorrectly coded these claims by using nonfacility place-of-service codes for services that were actually performed in one of the Hospital's outpatient clinic facilities. When these services were billed with the incorrect office place-of-service code, the physicians were paid the higher nonfacility practice expense payment, to which they were not entitled. As a result, NHIC incorrectly reimbursed the Hospital on behalf of its physicians for the overhead portion of their services.

By repricing claims using the correct place-of-service code, we determined that NHIC overpaid the Hospital, on behalf of its physicians, $237,368 for the 17,728 services that the Hospital had billed incorrectly.

Inadequate Billing Controls

Sample items from our prior nationwide reviews identified that the Hospital did not have adequate controls to ensure that its physician services claims were billed in accordance with Medicare regulations during CYs 2007 through 2010. At that time, the Hospital researched the problem and identified that both manual and system errors contributed to the coding problem. From November 2007 through March 2008 the errors resulted from lack of understanding on the part of the coders coupled with shortcomings in the clinic patient accounting system. This problem was mostly corrected in April 2008 by modifications to practice billing software. Subsequent efforts to address place-of-service errors resulted in a programming solution to the clinic patient accounting system. However, a January 13, 2009, system problem led to the complete failure of the programming correction, resulting in incorrect place-of-service codes on virtually all subsequent claims until the error was identified and corrected on October 1, 2009. During this time, staff was unaware of these errors, as the previous system solution was thought to have resolved the incorrect coding issue.

Although a few sporadic errors occurred after October 1, 2009, the Hospital put in place additional controls such that no further errors have been identified after August 2010.

RECOMMENDATION

We recommend the Hospital refund NHIC a total of $237,368 for overpayments resulting from coding errors on claims submitted on behalf of Hospital physicians for CYs 2007 through 2010.

CENTRAL VERMONT MEDICAL CENTER COMMENTS

In written comments to our draft report, the Hospital concurred with our findings and recommendation. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: CENTRAL VERMONT MEDICAL CENTER COMMENTS

Central Vermont Medical Center

April 6, 2011

Michael J. Armstrong
Regional Inspector General
for Audit Services
Office of Inspector General
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

RE: **Central Vermont Medical Center**
Report Number: A-01-11-00507

Dear Mr. Armstrong,

This letter is being sent in response to recommendations made in the Draft Report issued by the Department of Health and Human Services Office of Inspector General titled "Verification of Central Vermont Medical Center's Refund of Place of Service Overpayments for Calendar Years 2007-2010". As it pertains to the recommendation stated on page 5 of said report:

" We recommend the Hospital:

- refund NHIC a total of $237,368 for overpayments resulting from coding errors on claims submitted on behalf of Hospital physicians for Cys 2007 through 2010."

Central Vermont Medical Center concurs with this recommendation. Central Vermont Medical Center, upon receiving the Demand Letter from National Heritage Insurance Company shall remit payment in full as requested.

Please also note that on Page 2 of the Draft Report Central Vermont Medical Center is erroneously stated as Central Vermont Baptist Medical Center.

Thank you for your consideration in this matter. Please contact me at (802) 371 4190 with any questions regarding this matter.

Sincerely,

Patricia Rickard

Patricia L. Rickard
Director of Compliance
Central Vermont Medical Center