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

Office of Audit Services, Region I
John F. Kennedy Federal Building
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Boston, MA 02203
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September 29, 2011

Report Number: A-01-11-00512

Mr. Steven C. Bjelich
President and CEO
Saint Francis Medical Center
211 Saint Francis Drive
Cape Girardeau, MO 63703

Dear Mr. Bjelich:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Verification of Saint Francis Medical Center's Refund of Place-of-Service Overpayments for Calendar Years 2009 Through 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 dlamir@oig.hhs.gov. Please refer to report number A-01-11-00512 in all correspondence.

Sincerely,

/Michael Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
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601 East 12th Street, Room 235
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

VERIFICATION OF SAINT FRANCIS MEDICAL CENTER'S REFUND OF PLACE-OF-SERVICE OVERPAYMENTS FOR CALENDAR YEARS 2009 THROUGH 2010

Daniel R. Levinson
Inspector General

September 2011
A-01-11-00512

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 that physicians provide to program beneficiaries. Although physicians routinely perform many of these services in a hospital outpatient department or a freestanding ambulatory surgical center, 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 Saint Francis 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 their Part B physician services. In addition, two independent physician practices use the same billing service as the Hospital for Part B services performed at the Hospital; we included these practices' billing claims in our review of the Hospital's overpayments. As the Medicare contractor for hospital and physicians in Missouri, Wisconsin Physician Services processes and pays the Hospital's claims for Medicare outpatient services and its claims for 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

Our objective 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 (CY) 2009 through 2010.

SUMMARY OF FINDING

We determined that the Hospital and two independent physicians who performed services at the Hospital submitted 24,561 claims totaling $1,193,275 with overpayments totaling $267,433 for physician services for CYs 2009 through 2010. The Hospital and the two independent physicians used a third-party billing company that 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 that the Hospital complete its total refund of $267,433 for overpayments from coding errors submitted on behalf of Hospital physicians for CYs 2009 and 2010.

SAINT FRANCIS MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed that the total refund amount was $267,433 for overpayments from coding errors on behalf of Hospital-employed physicians and two independent physicians for CYs 2009 and 2010, but the Hospital disagreed with the amount of repayment it owed for outstanding overpayments for CY 2010. The Hospital stated that it had completed repayment for CY 2009 and had been resubmitting corrected claims for CY 2010. The Hospital stated that the remaining outstanding overpayments were approximately $28,264. The Hospital's comments are included in their entirety as Appendix A.

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INTRODUCTION

BACKGROUND

Medicare Part B Payments for Physician Services

Medicare Part B pays for services that 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.

Saint Francis Medical Center

Saint Francis Medical Center (the Hospital) is a 258-bed acute-care hospital located in Cape Girardeau, Missouri. The Hospital submits claims for the overhead expenses of medical services performed at the hospital and bills on behalf of its physicians, for their Part B physician services. In addition, two independent physician practices use the same billing service as the Hospital for Part B services performed at the Hospital; we included these practices' billing claims in our review of the Hospital's overpayments. As the Medicare contractor for hospitals and physicians in Missouri, Wisconsin Physician Services (WPS) 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 WPS to the Hospital for physician claims that contained an incorrect place-of-service code in calendar year (CY) 2009. Hospital officials insisted on refunding all overpayments received resulting from these place-of-service coding errors.[1] The Hospital has stated that it has corrected and resubmitted claims with overpayments in CY 2010. For claims in CY 2009, the Hospital has stated that it has prepared files of all miscoded claims billed with calculated overpayments totaling $144,054. The Hospital sent WPS three refund checks totaling $144,054 for CY 2009.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective 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 2009 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 2009 through 2010.

Our audit covered 24,561 nonfacility-coded physician services valued at $1,193,275 that were provided in CYs 2009 and 2010 and that matched hospital outpatient claims for the same type of service provided to the same beneficiary on the same day.

[1] The Hospital will include in its refund for place-of-service overpayments the overpayments made to two independent physician practices that performed services at one of the Hospital's clinics.

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 from February through July 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

- used data from our prior place-of-service reviews for CY 2009 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 2009 and 2010;

- compared our data to the Hospital's support documentation 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 WPS.

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 and two independent physicians who performed services at the Hospital submitted 24,561 claims totaling $1,193,275 with overpayments of $267,433 for physician services for CYs 2009 and 2010. The Hospital and two independent physicians used a third-party billing company that incorrectly coded these claims by using nonfacility place-of-service codes for services that actually were performed in one of the Hospital's outpatient 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.[2]

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), which, during the audit period, provided: "The higher nonfacility 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 24,561 incorrectly coded claims for physician services for CYs 2009 through 2010. The Hospital, billing on behalf of physicians, incorrectly coded these claims by using nonfacility place-of-service codes for services that actually were performed in one of the Hospital's outpatient facilities. When these services were billed with the incorrect office place-of-service code, the physicians were paid the higher nonfacility practice expense payment that they were not entitled. As a result, WPS 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 WPS overpaid the Hospital, on behalf of its physicians, $267,433 for the 24,561 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 2009 through 2010. At that time, the Hospital identified that these coding errors resulted from a change in billing companies which occurred January 1, 2009. Specifically, an undetected flaw in the design or implementation of the software used for billing physician services claims caused all physician services claims to be submitted with a nonfacility location as the place of service.

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

We verified that the Hospital had corrected the cause of the coding errors in November 2010 by correcting billing software for physician services performed at the Hospital to correctly reflect the facility place-of-service code.

RECOMMENDATION

We recommend that the Hospital complete its total refund of $267,433 for overpayments from coding errors submitted on behalf of Hospital physicians for CYs 2009 and 2010.

SAINT FRANCIS MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed that the total refund amount was $267,433 for overpayments from coding errors on behalf of Hospital-employed physicians and two independent physicians for CYs 2009 and 2010, but the Hospital disagreed with the amount of repayment it owed for outstanding overpayments for CY 2010. The Hospital stated that it had completed repayment for CY 2009 and had been resubmitting corrected claims for CY 2010. The Hospital stated that the remaining outstanding overpayments were approximately $28,264. The Hospital's comments are included in their entirety as Appendix A.

APPENDIX

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September 13, 2011

VIA EMAIL
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and UNITED STATES MAIL

Michael Armstrong
Regional Inspector General for Audit Services
Department of Health and Senior Services, Region I
John F. Kennedy Federal Building, Room 2425
Boston, MA 02203

Re: Report No. A-01-11-00512

Dear Mr. Armstrong:

This is to comment on the draft report "Verification of Saint Francis Medical Center's Refund of Place-of-Service Overpayments for Calendar Years 2009-2010."

General Comments:

We first wish to clarify that all billing was done by a third party billing company, not the Hospital. Second, while most of the physicians were Hospital employees on whose behalf the Hospital retained the billing company, two physicians were independent of the Hospital and they chose to contract with the same independent company because they felt that would be the most cost effective, since the billing company was billing for the same services by Hospital-employed physicians. As stated in previous communications, when the new billing company was put in place as of January 1, 2009, erroneous place of service codes were keyed into its billing software system for certain "places" of service, which is why the errors occurred for both the employed and non-employed physicians when they provided services at those miscoded places.

The $267,433 overpayment cited in the Report is for both CY's 2009 and 2010. The $144,054 in refunds already made represents refunds made for CY 2009 overpayments. The errors were first discovered in late 2010 and the Hospital immediately began refiling corrected claims for almost all of 2010. WPS began making adjustments to future payments eliminating the need to submit cash refunds for the CY 2010 overpayments. To date, all 2010 payments have been corrected except for approximately $28,264. Thus, there is very little overpayment remaining for CY 2010 and certainly not $123,379.

Michael Armstrong
Regional Inspector General for Audit Services
Department of Health and Senior Services, Region I
September 13, 2011
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Recommendation

With respect to the Report's one "Recommendation," that the Hospital refund $123,379 to WPS to complete its total refund of $267,433, we do not concur because all but $28,264 of this amount has already been recouped by WPS through the timely submission of amended and refiled claims resulting in WPS making adjustments in future payments to the physicians in question.

Very truly yours,

Richard D. Watters

Richard D. Watters

RDW/dk

cc: David Lamir