

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF MOSES H. CONE
MEMORIAL HOSPITAL FOR 2012**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Brian P. Ritchie
Assistant Inspector General
for Audit Services

August 2015
A-04-14-04023

Office of Inspector General

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

Section 8M 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

Moses H. Cone Memorial Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated overpayments of at least \$1.8 million during 2012.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 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 Moses H. Cone Memorial Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of 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 comprises four acute care facilities: Moses H. Cone Memorial Hospital (536 beds), Annie Penn Hospital (110 beds), Wesley Long Hospital (175 beds), and Women's Hospital (134 beds). According to CMS's National Claims History (NCH) data, Medicare paid the Hospital (including all four acute care facilities) approximately \$163 million for 13,824 inpatient and 85,192 outpatient claims for services provided to beneficiaries during January 1, through December 31, 2012 (audit period).

Our audit covered \$9,598,982 in Medicare payments to the Hospital for 1,349 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 225 claims with payments totaling \$1,990,430. These 225 claims had dates of service in our audit period and consisted of 221 inpatient and 4 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 152 of the 225 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 73 claims, resulting in net overpayments of \$457,590 for

the audit period. Specifically, 70 inpatient claims had billing errors resulting in net overpayments of \$430,418, and 3 outpatient claims had billing errors resulting in overpayments of \$27,172. 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.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,826,464 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$1,826,464 in estimated overpayments for the audit period for claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare requirements.

MOSES H. CONE MEMORIAL HOSPITAL COMMENTS AND OUR RESPONSE

Moses H. Cone Memorial Hospital Comments

In written comments on our draft report, the Hospital pointed out that we drew the sample from a sample frame that included claims from four hospitals (that all bill under the same provider number) and, therefore, the Hospital contended that the sample was flawed and extrapolation was invalid. The Hospital cited differences in the four different locations as cause for not combining the locations for sampling purposes. Specifically, the Hospital noted that each location has its own separate coding staff, medical staff, utilization management committee, and professional staff performing utilization reviews for inpatient admissions. The Hospital also noted differences in the specific types of clinical services provided at each location.

With regard to our specific medical necessity determinations, the Hospital recognized that there could be instances when admission was not fully supported and indicated that it has worked to retrain admitting providers and utilization review staff to improve processes. The Hospital said that it disagreed with many of our incorrect coding determinations and that it intends to appeal adverse determinations that are appropriately supported in the medical records; however, it acknowledged that it has ongoing third party audits on a monthly basis to improve its coding and compliance programs. The Hospital disagreed with our determination that one claim was billed with the incorrect discharge status code because it said that it did not know that the patient received home health services after discharge. Finally, the Hospital acknowledged errors in billing outpatient claims for medical devices and described steps it had taken to ensure that such errors do not happen in the future.

Our Response

We disagree with the Hospital's contention that the sample was flawed and that extrapolation was not valid. Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims. Because the Hospital consisted of four acute care facilities that billed under the same provider number, our audit was consistent with our audit objective and it was appropriate to include in our sample frame the claims paid during the audit period for all four acute care facilities.

Our sampling approach did not assume or require that all claims were selected from a single facility. We properly executed our statistical sampling methodology, by defining our sampling frame and sampling unit, selecting a random sample, applying relevant criteria in evaluating the sample, and using statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

In practice, there are many factors that can lead to differences among sampled claims. We account for variability caused by all factors, including facility, by recommending recovery at the lower-limit of a two sided 90 percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment amount 95 percent of the time. In addition, this approach accounts for subgroups within the frame that are, by chance, not selected as part of the statistical sample.

We acknowledge that the Hospital disagrees with, and plans to appeal many of our medical necessity and incorrect coding determinations. During our audit we used an independent medical review contractor to determine whether certain claims in our sample, including the claims in question met medical necessity requirements and were properly coded. The contractor examined all of the medical records documentation submitted for these claims and determined that the Hospital incorrectly billed Medicare Part A for these claims. On the basis of the contractor's conclusions, we maintain that the Hospital billed the disputed claims incorrectly. We provided our contractor's conclusions to the Hospital. Additionally, the Hospital's not being at fault for the incorrect discharge status code on one claim does not change our determination that the claim was billed in error and the related overpayment should be included in our sample results.

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

 Moses H. Cone Memorial Hospital 2

 How We Conducted This Review 3

FINDINGS 3

 Billing Errors Associated With Inpatient Claims 3

 Incorrectly Billed as Inpatient 4

 Incorrectly Billed Diagnosis-Related-Group Codes 4

 Incorrect Discharge Status 4

 Billing Errors Associated With Outpatient Claims 5

 Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained ... 5

 Overall Estimate of Overpayments 6

RECOMMENDATIONS 6

MOSES H. CONE MEMORIAL HOSPITAL COMMENTS AND OFFICE OF INSPECTOR
GENERAL RESPONSE 6

 Moses H. Cone Memorial Hospital Comments 6

 Office of Inspector General Response 7

APPENDIXES

 A: Audit Scope and Methodology 8

 B: Sample Design and Methodology 10

C: Sample Results and Estimates.....13

D: Results of Review by Risk Area14

E: Moses H. Cone Memorial Hospital Comments.....15

INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 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 Moses H. Cone Memorial Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of 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

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

Hospital 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 claims paid in excess of charges,
- inpatient claims billed with high-severity-level DRG codes, and
- outpatient manufacturer credits for replaced medical devices.

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), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

Moses H. Cone Memorial Hospital

The Hospital comprises four acute care facilities: Moses H. Cone Memorial Hospital (536 beds), Annie Penn Hospital (110 beds), Wesley Long Hospital (175 beds), and Women’s Hospital (134 beds). According to CMS’s National Claims History (NCH) data, Medicare paid the Hospital (including all four acute care facilities) approximately \$163 million for 13,824 inpatient and 85,192 outpatient claims for services provided to beneficiaries during January 1, through December 31, 2012 (audit period).

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

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$9,598,982 in Medicare payments to the Hospital for 1,349 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 225 claims with payments totaling \$1,990,430. These 225 claims had dates of service in our audit period and consisted of 221 inpatient and 4 outpatient claims.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 115 claims to medical review and coding review to determine whether the services were medically necessary and properly coded. 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 152 of the 225 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 73 claims, resulting in net overpayments of \$457,590 for the audit period. Specifically, 70 inpatient claims had billing errors resulting in net overpayments of \$430,418, and 3 outpatient claims had billing errors resulting in overpayments of \$27,172. 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.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,826,464 for the audit period.

See Appendix B for sample design and methodology, Appendix C for sample results and estimates, and Appendix D for the results of review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 70 of the 221 inpatient claims that we reviewed. These errors resulted in net overpayments of \$430,418.

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)).

For 55 of the 221 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital agreed that 33 of the 55 did not meet medical necessity to be admitted as inpatient. The Hospital stated that these errors may have occurred because in 2012 it did not fully staff its Case Management Department, which reviewed cases to determine whether inpatient admission was appropriate and thus did not always have staff available to review cases. The Hospital said that, subsequent to the audit period, it has expanded the Case Management Department’s hours. The Hospital did not provide a cause for the remaining 22 claims because it believed that the beneficiaries were admitted, treated, and billed appropriately as inpatients.

As a result of these errors, the Hospital received overpayments of \$373,615.²

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)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 14 of the 221 inpatient claims, the Hospital submitted claims to Medicare with incorrect DRG codes. The Hospital agreed that 8 claims had errors. The Hospital stated that these errors occurred because its internal controls did not provide for review of the coding for 100 percent of claims. The Hospital did not offer a cause for the remaining errors because it did not believe the claims were billed in error.

As a result of these errors, the Hospital received net overpayments of \$46,619.

Incorrect Discharge Status

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 home under a home health agency’s written plan of care for home health services that begin within 3 days after the date of discharge (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstance is paid a graduated per diem rate for each day of the

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 contractor prior to the issuance of our report.

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)).

For 1 of the 221 inpatient claims, the Hospital incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. Specifically, the Hospital coded the discharge status as to intermediate care facility instead of to home health. Thus, the Hospital received the full DRG payment instead of the graduated per diem payment it would have received if it had correctly coded the patient's discharge status. The Hospital said that this error occurred because the coding staff coded what was given to them on the discharge summary, and the Hospital was not aware of the home health services.

As a result of this error, the Hospital received overpayments of \$10,184.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 3 of the 4 outpatient claims that we reviewed. These errors resulted in overpayments of \$27,172.

Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

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). The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements in additional detail (Pub. No. 15-1).³

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPSS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier "FB" and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device. 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.

For 3 of the 4 outpatient claims, the Hospital incorrectly billed Medicare for medical devices that were under warranty. The Hospital said that the sample item errors were caused by human error. Furthermore, the Hospital said that the process for dealing with medical device credits is

³ The PRM states: "Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service" (part 1, § 2102.1). Section 2103 further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example: "Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment."

complicated and involves multiple hospital departments, as well as vendors, and can be prone to human error.

As a result of these errors, the Hospital received overpayments of \$27,172.

OVERALL ESTIMATE OF OVERPAYMENTS

Based on our sample results, we estimated that the Hospital received overpayments of at least \$1,826,464 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$1,826,464 in estimated overpayments for the audit period for claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare requirements.

MOSES H. CONE MEMORIAL HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Moses H. Cone Memorial Hospital Comments

In written comments on our draft report, the Hospital pointed out that we drew the sample from a sample frame that included claims from four hospitals (that all bill under the same provider number) and, therefore, the Hospital contended that the sample was flawed and extrapolation was invalid. The Hospital cited differences in the four different locations as cause for not combining the locations for sampling purposes. Specifically, the Hospital noted that each location has its own separate coding staff, medical staff, utilization management committee, and professional staff performing utilization reviews for inpatient admissions. The Hospital also noted differences in the specific types of clinical services provided at each location.

With regard to our specific medical necessity determinations, the Hospital recognized that there could be instances when admission was not fully supported and indicated that it has worked to retrain admitting providers and utilization review staff to improve processes. The Hospital said that it disagreed with many of our incorrect coding determinations and that it intends to appeal adverse determinations that are appropriately supported in the medical records; however, it acknowledged that it has ongoing third party audits on a monthly basis to improve its coding and compliance programs. The Hospital disagreed with our determination that one claim was billed with the incorrect discharge status code because it said that it did not know that the patient received home health services after discharge. Finally, the Hospital acknowledged errors in billing outpatient claims for medical devices and described steps it had taken to ensure that such errors do not happen in the future.

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

Office of Inspector General Response

We disagree with the Hospital's contention that the sample was flawed and that extrapolation was not valid. Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims. Because the Hospital consisted of four acute care facilities that billed under the same provider number, our audit was consistent with our audit objective and it was appropriate to include in our sample frame the claims paid during the audit period for all four acute care facilities. We edited the background section of the report to clarify that the Hospital comprises four acute care facilities.

The fact that there is a variety of clinical services offered at the various locations does not invalidate the sample. Our sampling approach did not assume or require that all claims were selected from a single facility. We properly executed our statistical sampling methodology by defining our sampling frame and sampling unit, selecting a random sample, applying relevant criteria in evaluating the sample, and using statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

In practice, there are many factors that can lead to differences among sampled claims. We account for variability caused by all factors, including facility, by recommending recovery at the lower-limit of a two sided 90 percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment amount 95 percent of the time. The greater the differences between claims, the smaller the lower limit will tend to be. The use of the lower limit ensures that our extrapolation methodology handles the potential differences between facilities in a manner that is fair to the auditee. In addition, this approach accounts for subgroups within the frame that are, by chance, not selected as part of the statistical sample.

We acknowledge that the Hospital disagrees with, and plans to appeal many of our medical necessity and incorrect coding determinations. As we indicated in Appendix A, during our audit we used an independent medical review contractor to determine whether certain claims in our sample, including the claims in question met medical necessity requirements and were properly coded. The contractor examined all of the medical records documentation submitted for these claims and determined that the Hospital incorrectly billed Medicare Part A for these claims. On the basis of the contractor's conclusions, we maintain that the Hospital billed the disputed claims incorrectly. We provided our contractor's conclusions to the Hospital. Additionally, the Hospital's not being at fault for the incorrect discharge status code on one claim does not change our determination that the claim was billed in error and the related overpayment should be included in our sample results.

In addition, we acknowledge the Hospital's efforts to strengthen its compliance with Medicare requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$9,598,982 in Medicare payments to the Hospital for 1,349 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 225 claims with payments totaling \$1,990,430. These 225 claims consisted of 221 inpatient and 4 outpatient claims and had dates of service from January 1 through December 31, 2012.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 115 claims to medical review and coding review to determine whether the services were medically necessary and properly coded.

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 NCH 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.

Our fieldwork included contacting the Hospital in Greensboro, North Carolina, from April 2014, through March 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's NCH file for the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 225 claims (221 inpatient and 4 outpatient) totaling \$1,990,430 for detailed review (Appendix B);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning DRG and admission status codes for Medicare claims;
- used an independent medical review contractor to determine whether 115 claims met medical necessity and coding 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;
- used the results of the sample review to calculate the estimated Medicare overpayment to the Hospital (Appendix C); and
- discussed the results of our review with Hospital officials.

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: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population contained inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during the audit period.

SAMPLING FRAME

According to CMS's NCH data, Medicare paid the Hospital \$163,136,048 for 13,824 inpatient and 85,192 outpatient claims for services provided to beneficiaries during the audit period.

We obtained a database of claims from the NCH data totaling \$112,176,839 for 8,043 inpatient and 37,575 outpatient claims in 23 risk areas. From these 23 areas, we selected 4 consisting of 5,807 claims totaling \$39,082,517 for further review. We then removed the following:

- inpatient claims billed with High-Severity-Level DRG codes with payment amounts less than \$3,000,
- inpatient claims paid in excess of charges with payment amounts less than \$5,000 over the charged amount,
- inpatient short stay claims with payment amounts less than \$3,000 and that were on the Inpatient Only Procedure List,
- outpatient medical device claims with payment amounts less than \$5,000,
- claims under review by the Recovery Audit Contractor (RAC),⁴ and
- claims duplicated within individual risk areas.

For inpatient claims, we assigned each claim that appeared in multiple risk areas to just one area based on the following hierarchy: Claims Billed With High-Severity-Level DRG Codes, Claims Paid in Excess of Charges, and Short Stays. This resulted in a sample frame of 1,349 unique Medicare claims in 4 risk categories totaling \$9,598,982.

⁴ To ensure that our overpayment extrapolation is valid, any sample items that have been reviewed or are currently under review by a RAC will be treated as non-errors. This adjustment results in a valid overpayment estimate regardless of when the RAC claims are identified. As an extra precaution, repayment of claims in the sampling frame reviewed by the RAC will be subtracted from the total overpayments.

Table 1: Risk Categories

| Medicare Risk Area | Number of Claims | Amount of Payments |
|---|-------------------------|---------------------------|
| 1. Inpatient Claims Billed With High-Severity-Level DRG Codes | 592 | \$4,605,124 |
| 2. Inpatient Claims Paid in Excess of Charges | 21 | 462,550 |
| 3. Inpatient Short Stays | 732 | 4,471,160 |
| 4. Outpatient Manufacturer Credits for Replaced Medical Devices | 4 | 60,148 |
| Total | 1,349 | \$9,598,982 |

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified sample. We stratified the sampling frame into four strata based on the Medicare risk area. All claims were unduplicated, appearing in only one area and only once in the entire sampling frame.

SAMPLE SIZE

We selected 225 claims for review as follows:

Table 2: Claims by Stratum

| Stratum | Medicare Risk Area | Claims in Sample Frame | Claims in Sample |
|----------------|--|-------------------------------|-------------------------|
| 1 | Inpatient Claims Billed With High-Severity-Level DRG Codes | 592 | 100 |
| 2 | Inpatient Claims Paid in Excess of Charges | 21 | 21 |
| 3 | Inpatient Short Stays | 732 | 100 |
| 4 | Outpatient Manufacturer Credits for Replaced Medical Devices | 4 | 4 |
| | TOTAL | 1,349 | 225 |

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software Random Number Generator.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata 1 and 3. After generating the random numbers for strata 1 and 3, we selected the corresponding claims in each stratum. We selected all claims in strata 2 and 4.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate our estimates. We used the lower-limit of the 90-percent confidence interval to estimate the amount of improper Medicare payments in our sampling frame during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

| Stratum | Frame Size (Claims) | Value of Frame | Sample Size | Total Value of Sample | Number of Incorrectly Billed Claims in Sample | Value of Overpayments in Sample |
|----------------|----------------------------|-----------------------|--------------------|------------------------------|--|--|
| 1 | 592 | \$4,605,124 | 100 | \$852,115 | 18 | \$89,652 |
| 2 | 21 | 462,550 | 21 | 462,550 | 10 | 129,289 |
| 3 | 732 | 4,471,160 | 100 | 615,617 | 42 | 211,477 |
| 4 | 4 | 60,148 | 4 | 60,148 | 3 | 27,172 |
| Total | 1,349 | \$9,598,982 | 225 | \$1,990,430 | 73 | \$457,590 |

Table 4: Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval

| | |
|----------------|-------------|
| Point Estimate | \$2,235,216 |
| Lower limit | \$1,826,464 |
| Upper limit | \$2,643,968 |

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

| Risk Area | Selected Claims | Value of Selected Claims | Claims With Underpayments/Overpayments | Value of Net Overpayments |
|---|------------------------|---------------------------------|---|----------------------------------|
| Inpatient | | | | |
| Short Stays | 100 | \$615,617 | 42 | \$211,477 |
| Claims Paid in Excess of Charges | 21 | 462,550 | 10 | 129,289 |
| Claims Billed With High-Severity-Level DRG Codes | 100 | 852,115 | 18 | 89,652 |
| Inpatient Totals | 221 | \$1,930,282 | 70 | \$430,418 |
| | | | | |
| Outpatient | | | | |
| Manufacturer Credits for Replaced Medical Devices | 4 | \$60,148 | 3 | \$27,172 |
| Outpatient Totals | 4 | \$60,148 | 3 | \$27,172 |
| | | | | |
| Inpatient and Outpatient Totals | 225 | \$1,990,430 | 73 | \$457,590 |

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.



June 10, 2015

Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health & Human Services, Region IV
61 Forsyth Street, SW
Suite 3T41
Atlanta, Georgia 30303

Re: Draft Report: *Medicare Compliance Review of Moses H. Cone Memorial Hospital for 2012*
OIG Draft Report Number A-04-14-04023

Dear Ms. Pilcher:

We appreciate the opportunity to review the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled *Medicare Compliance Review of Moses H. Cone Memorial Hospital for 2012* (the "Report") and submit responses to the proposed findings.

Overall, the OIG recommends that The Moses H. Cone Memorial Hospital strengthen its Medicare program controls and compliance efforts as well as refund its Medicare contractor \$1,826,464 in estimated overpayments for the audit period for claims that were alleged to have been billed incorrectly.

Importantly, because the auditors sampled claims that were drawn from four different acute care hospitals – *not just the Moses H. Cone Memorial Hospital* - we respectfully request that the Report be modified to correct certain findings and conclusions. In addition, because the sample design and methodology to support the estimated overpayment were based on the erroneous assumption that only **one** hospital's claims were being drawn to assess its operations, the extrapolation across four hospitals should not be finalized.

Before further explaining the operational differences that impact billing issues reviewed for each of the four Hospitals, we want to emphasize that management and staff at **all** Hospitals owned by The Moses H. Cone Memorial Hospital Operating Corporation are committed to and have adopted programs to support Medicare Program compliance in billing, coding and other requirements. We take compliance with Program requirements seriously and have conducted pre-billing reviews as well as auditing and monitoring as recommended in OIG's *Compliance Program Guidelines for Hospitals*. As part of our commitment, we have engaged recognized, independent third parties that perform monthly audits focused on identified risk areas in our clinical, coding and billing activities at each Hospital. Those independent experts review claims billed by each coder and have regular discussions and continuing training for staff at each facility.

In addition, at each of the four Hospitals, case management teams and physician advisors work together to improve documentation efforts supporting appropriate inpatient admissions. As noted in the Report, we have already secured additional case management support for timely review of admissions for patients, including staff support at each facility for weekend and holiday coverage. We have trained attending physicians at each facility regarding Medicare standards for inpatient admissions, including additional education regarding the new standards for status determinations after October 1, 2013. We have also adopted enhancements in our electronic medical records to support compliance efforts in these areas.

With regard to the coding and reporting of medical devices replaced under warranty or credit, we understand the need to enhance our monitoring and control efforts to support accurate billing. To that end, we have formed a multi-disciplinary task force to coordinate efforts and

review monthly vendor reports to identify any claims for which credits should be reported. Any relevant information will be reported to our coding, accounts payable, and patient accounting departments to ensure that claims are coded properly. Importantly, compliance efforts are ongoing to support accurate coding and billing at each of the four Hospitals, given the staffing and operational differences that impact claims submissions such as those reviewed here.

- **Background: The Auditors Designed Their Sampling And Audit Methods To Assess Certain Coding Issues For One Acute Care Hospital; However, Auditors Reviewed A Total Of 225 Inpatient And Outpatient Claims Drawn From *Four Different Hospitals, Not Solely The Moses H. Cone Memorial Hospital.***

In order to respond to the findings in the proposed Report, we wanted to clarify at the outset that the auditors informed us at the entrance conference that they had **already** identified a universe of claims for review and drawn a sample of 225 claims based on certain erroneous assumptions. Specifically, although they had designed the audit and sampled claims billed under a single National Provider Identifier (“NPI”), **they did not realize that they had drawn claims from four different acute care hospitals that bill under the same NPI. Therefore, the 225 sampled claims were admissions and coding determinations which could have been prepared and submitted by different professionals at any one of four separate acute care hospitals: (1) Wesley Long Community Hospital; (2) Annie Penn Hospital; (3) Women’s Hospital and (4) The Moses H. Cone Memorial Hospital (collectively, the “Hospitals” or the “Providers”).**

Upon learning this information, the auditors did not modify the universe or sampled claims to account for the fact that their underlying assumption about how to conduct this review was mistaken. Instead, the sample design assumed that a sufficient spectrum of claims were

being for **one hospital with uniform processes, namely, the same coding staff submitting claims and the same physicians and case managers working together to assess appropriateness of inpatient hospital admissions as well as coding and billing claims.** That is not the case. Despite knowing that their sample design was based on a fundamentally erroneous assumption, the auditors did not re-draw the universe to review claims solely from The Moses H. Cone Memorial Hospital to prepare the Report, nor did they draw additional claims from each of the other Hospitals to ensure that any findings could be representative of each of those facilities' operations. Therefore, the findings in the Report should be modified to ensure accuracy in identifying the scope of the review as well as ensure that any conclusions are supportable based on the claims that were actually sampled.

- **The Four Hospitals Have Separate Operations, Patient Populations As Well As Medical And Coding Staff. Accordingly, Any Conclusions Regarding Billing Or Coding Accuracy Should Be Limited To The Individual Claims Reviewed For Each Hospital.**

Although the four Providers may share one NPI, there are fundamental differences in operations at each and critical to understand in assessing accuracy in claims submissions at each. **Accordingly, findings for claims reviewed for one Provider do not predict how admissions and coding were performed at another hospital nor support the conclusions in the Report.**

Specifically, each of the four Hospitals is a physically distinct "brick and mortar" facility, with different professionals delivering care and support operations. Three of the Hospitals are in Greensboro; however the fourth is located in Reidsville, North Carolina, approximately 20 miles away. Each Hospital has its separate coding staff, medical staff, utilization management

committee and its own professional staff performing utilization reviews for inpatient admissions.¹

As for clinical care services, the data regarding overall patient acuity and average lengths of stay (ALOS) admitted to each facility in 2012 varied, likely reflecting differences in the populations served. For example, Moses H. Cone Memorial Hospital (“MHC Hospital”) is a 536-bed teaching hospital with a Level II trauma center and operates as a referral center to the region. MHC Hospital has established centers of excellence in orthopedics, neurosciences, stroke, and heart and vascular care. Accordingly, the case mix index (CMI) for MHC Hospital is relatively high, at 1.6966, and its ALOS can be longer than those for the other Hospitals.

For example, the sampled claims include those billed by the Women’s Hospital (“Women’s”), a 134-bed acute care facility that has Level II and Level III neonatal units. Women’s staff clinicians include an experienced neonatal intensive care team to treat critically ill newborns. The Women’s CMI is only 0.8820, and its ALOS is generally less than that for the other three Hospitals.

The sampled claims also include billings for the Wesley Long Hospital (“WL Hospital”), a community hospital with 175 beds. The WL Hospital provides a variety of acute care services, and its providers have established clinics and departments focused on treating patients with oncology, urology, medical and surgical issues. The Annie Penn Hospital (“AP Hospital”) is located in Reidsville, North Carolina, a fairly rural community which is slightly more than 20 miles away from Greensboro, where the other Hospitals are located. The AP Hospital has only

¹ There could be some providers with staff privileges at more than one of the Hospitals. In addition, there can be some overlapping staff; however, each Hospital has separate individuals performing critical functions that are

110 beds, with its medical staff treating patients at the inpatient and short stay surgery centers, the heart care center or one of the other specialty clinics.

Accordingly, to ensure accuracy in the final Report, we respectfully request that the draft document be revised to clarify that the universe of claims reviewed included those from each of the four different Hospitals, not just Moses H. Cone Memorial Hospital.

Furthermore, because the sample was drawn based on a fundamental misunderstanding that four different hospitals' billing and coding operations were under review, the results cannot support extrapolation. Merely sharing the same provider number is insufficient to support the extrapolation, particularly after recognizing that although one Hospital had no claims sampled, the purported inaccuracies in the billings for three other hospitals are being applied to reduce its payments under the proposed extrapolation. The sampling method and study design were based on an erroneous assumption and therefore any extrapolation across non-uniform populations of claims should not be finalized.²

The Hospitals' Responses To The Findings In The Draft Report

For the remainder of our response, we refer to the findings regarding claims for each of the four Hospitals individually, as appropriate.

We acknowledge that in the course of the OIG audit, we provided your staff with documentation and information in support of coding and billing accuracy for certain claims sampled from each Hospital. Importantly, although we reported our agreement in some

essential in the claims submission process.

² OIG has recognized that operational differences exist for hospitals that impact claims submission in its work conducting audits at several individual hospitals across the country, sampling claims for **each** and not merely extrapolating findings across hospitals nationally based on operations at one facility.

instances with proposed findings for individual claims, we have subsequently identified documentation and materials that modify our positions on several claims, particularly where the appropriateness of inpatient admission or coding for a claim was disputed. In consultation with independent experts, we are actively re-reviewing each claim for which an adverse conclusion was identified and will determine whether to pursue remedies through the appeals process.

Billing Errors Associated with Inpatient Claims

OIG Finding: Incorrectly Billed as Inpatient or with Incorrectly Billed DRGs:

For the MHC Hospital, auditors assert that for 2012, there were 37 claims for which medically necessary care was provided, however the patient “status” – namely that their attending physician ordered inpatient admissions – were not supported. Over that same year, auditors report that seven claims were coded inaccurately, so that the payment for care delivered should be reduced.

Similarly, for WL Hospital, auditors identified 10 inpatient hospital admissions that they contend should not be paid because the patients could have received the care on an outpatient basis. Two claims were identified as being mis-coded for higher payments than were supported, based on the auditor’s review for WL Hospital. Finally, eight claims for inpatient admissions at AP Hospital were purportedly erroneous, with five claims coded inaccurately over the year-long span. There were no adverse claim determinations identified for Women’s Hospital.

- **The Standard For Inpatient Admission In 2012**

Importantly, for the 2012 claims reviewed here, the applicable Medicare Benefit Policy Manual, Chapter 1, Section 10 stated that a hospital “inpatient” is someone formally admitted to a hospital “*with the expectation that he or she will remain at least overnight and occupy a bed*

even though it later develops that the patient can be discharged or transferred...” CMS has confirmed repeatedly that observation care should “usually” last under 24 hours, “and should rarely take longer than 48 hours.” (See, e.g., CMS Memorandum Report, *Hospitals’ Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries* (EI-02-12-00040) (July 29, 2013).

Further, in accordance with CMS guidelines, when making inpatient admission determinations, treating physicians are directed to consider the “**medical predictability of something adverse happening to the patient.**” (MBPM, CMS Pub. 100-2, Ch. 1, § 10) (emphasis added). Accordingly, any evaluation of a physician’s medical decision to admit a patient must consider the medical facts available at the time of the decision. (See HCFA Ruling No. HCFAR-93-1; see also In the Case of Sacred Heart Hospital, DAB-MAC, (Nov. 10, 2009) at 10) (the “foreseeable adverse effects” related to the patient’s health condition were of such severity to support inpatient hospital care). The information and reports explaining that certain denials were based on what did or did not happen to a patient **after** admission suggest that decisions were not based on what was known when the physician admitted the beneficiary for inpatient care. Moreover, it appears that there are instances in which reviewers applied **current** standards using the “Two Midnight Rule” to deny claims, despite the fact that these claims were submitted in 2012.

For instance, based on a review by Maximus, the OIG recommends that payment be denied for an inpatient admission ordered by an attending physician for an 80+ year old patient who presented with bleeding and critically abnormal hemoglobin levels. Although the patient’s hemoglobin levels continued to drop after admission and he developed complications, reviewers

assert that because that patient did not suffer catastrophic injury, payment for inpatient care was not appropriate. In another case, reviewers denied coverage for inpatient admission for a 91 year-old patient who was admitted with shortness of breath, coughing and signs of pneumonia. Although treated initially in the emergency room, when her oxygen levels dropped despite being on 4L of supplemental treatment and clinical evidence supporting the need for acute services, she was appropriately admitted and remained hospitalized over two more days. It appears that reviewers denied coverage for inpatient admissions stating that services “could” have been provided to patients on an outpatient basis, given the facts that these patients’ conditions did not **further** deteriorate. Such a hindsight determination is improper under relevant guidelines and do not support the proposed denials.

For MHC Hospital, auditors asserted that an inpatient admission for a properly coded “Inpatient Only” procedure was inappropriate. Such a conclusion is wholly unsupported and clearly contradicts Medicare regulations and coding standards.

With regard to the coding issues raised, each of the three Hospitals has a coding department that ensures that claims are properly submitted, in accordance with the *ICD-9-CM Official Guidelines for Coding and Reporting* as well as the American Hospital Association’s *Coding Clinic* guidelines. As explained to the auditors, the coders sequenced conditions and diagnoses as contemplated by these recognized guidelines.

Conclusion: Recommended Inpatient Denials and Downcodes

For 2012, physicians at each of the four Hospitals, working in conjunction with the Hospitals’ individual utilization management staff, appropriately admitted patients for inpatient care based on their individual assessments of the prospective need for 24-48 hours of patient care

and risk of patient morbidity and mortality. The decision to admit each patient is a fact-specific determination and subject to internal reviews in accordance with our utilization management programs. Based on clinical assessments and individual physician determinations of risks for the patient in each case, the Providers appropriately admitted patients for medically necessary inpatient care. Although we initially agreed that certain claims could have been erroneously coded as inpatient admissions, upon re-review under the applicable CMS standards in effect in 2012 and consultation with independent experts, we have modified our position in several instances and will pursue remedies through the administrative appeals process as appropriate.

Because we recognize that there could be some instances in which inpatient admissions may not have been fully supported in the records, we have worked to re-train admitting providers and utilization review staff to improve processes going forward. The Hospitals have additional case management staff working at each facility to support appropriate utilization management. Admitting physicians have been trained with regard to the new CMS standard for inpatient admissions and participated in contractor “probe and educate” reviews.

With regard to the coding errors identified in the Report, we are in the process of re-review and consultation with independent experts to assess the appropriateness of claims submitted in 2012. In many instances, we disagree with proposed findings, as Coders at our Hospitals appropriately apply *ICD-9-CM Official Guidelines for Coding and Reporting* as well as examples and guidance from the American Hospital Association’s *Coding Clinics* in their work. Because professional coders can disagree regarding application of those guidelines, we intend to appeal the adverse determinations that are appropriately supported in the medical

records. Nevertheless, as explained, we have ongoing third party audits on a monthly basis to improve our coding and compliance programs.

OIG Finding: Incorrect Discharge Status

OIG asserts that for 1 of the 221 inpatient claims reviewed in its sample, Wesley Long Hospital incorrectly billed the patient's discharge disposition. Namely, although the Hospital's attending physician discharged the patient to her home, the patient began receiving home health services **after** she left the facility. The Report asserts that our coders erred despite the post-discharge delivery of this care.

The Wesley Long Hospital Response: Incorrect Discharge Status

Wesley Long Hospital disputes that it incorrectly billed this beneficiary's discharge status when, days after the patient returned home to an intermediate care facility, she began receiving home health services. Because the common working file ("CWF") that CMS operates should have "caught" the **subsequent** delivery of home health services that was unknown to the Hospital coders at discharge, this item should not be included as an error in the Report. CMS has acknowledged that it did not make edits to its own processes to identify cases where beneficiaries received home health care after hospital discharge until 2013, long after this claim was processed. (See, CMS Response to May 2014 OIG Report, *Medicare Inappropriately Paid Hospitals' Inpatient Claims Subject To The Postacute Care Transfer Policy* (A-09-13-02036).

Billing Errors Associated with Outpatient Claims

OIG Finding: Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

OIG reported that MHC Hospital incorrectly billed Medicare for three outpatient claims reviewed. Specifically, OIG reported that MHC Hospital incorrectly coded and submitted claims for reimbursement for medical devices that were under warranty and for which device credits were received.

The Moses H. Cone Memorial Hospital's Response

We acknowledge that comprehensive measures may not have been in place in 2012 at MHC Hospital to ensure appropriate identification of credits for devices replaced under warranty or a manufacturer's credit.

To address this finding, we have adopted new measures to ensure ongoing compliance in device credit reporting for such replaced devices and corresponding claims for the Hospitals. We have convened a multi-disciplinary team of staff and physicians to adopt and strengthen processes for appropriate reporting and billing of credits. A task-force devoted to these efforts continues to work to refine processes as explained previously. As part of our enhanced program, we will secure information from vendors on a monthly basis to verify accurate reporting.

Because Claims From Four Hospitals – Not One – Were Reviewed, The Sample Design And Method Do Not Support Extrapolation As Proposed In The Report

With regard to the proposed decision to extrapolate findings to assert that we refund \$1,826,464 in overpayments to Medicare, we respectfully request OIG not recommend any extrapolation, given the flawed assumptions at the outset in sampling. Rather, given that certain

findings were reported for each Hospital individually, we request that any recommended disallowance be modified, for a total net overpayment of \$457,590, at most.³

Although statistical sampling to extrapolate overpayments may be acceptable where universal review is not possible, samples must be representative to satisfy due process standards. ((See Chaves County Home Health Services Inc. v. Sullivan, 931 F.2d 914 (D.C. Cir. 1991) cert. denied, 502 U.S. 1091 (1992)). The Program Integrity Manual identifies the elements of a properly executed probability sample as “defining the universe, the frame, the sampling units, using proper randomization, accurately measuring the variables of interest, and using the correct formulas for estimation. . . .” (*See*, PIM Chapter 8, Section 8.4.2).

That did not occur here. Rather, the Report erroneously states that the findings are based on a universe of claims for services performed **only at Moses H. Cone Memorial Hospital**. Although that may have been the intent in designing the sample, the universe **actually** contains claims from four different Hospitals, each with significant operational differences that cannot be mathematically “extrapolated” to another. An error rate at one hospital does not transfer to another hospital simply because they share a provider number.

The sample and claims reviewed were not a valid representation of coding and billing practices at MHC Hospital at all since each of the other Providers’ operations (and coding,

³ The Report includes a footnote stating that the proposed extrapolated overpayment does not take into account partial payments that CMS would have reimbursed the Hospitals for medically necessary services as contemplated in Ruling 1599-F. Although we realize that OIG itself may not be able to perform the per-claim calculations, we request that the final Report recommend that those calculations be done before any amount is calculated as being owed. In addition, in certain cases, there could be payments to reduce an alleged denial for inpatient care, based on application of the 3-day payment window. For those instances in which inpatient care was not provided, the preceding outpatient claims should be included to reduce alleged overpayments.

admissions practices) influenced findings that are identified as those for the Moses H. Cone Memorial Hospital. The same is true were MHC Hospital's "errors" projected across claims payment for each of the other Hospitals. Indeed, the flawed method is evidenced in the illogical outcome that although the Women's Hospital was included in the sampling frame, no claims (or errors) were reported. Nevertheless, the Women's Hospital payments for 2012 overall would be reduced were the extrapolation applied as proposed in the Report.

Conclusion

We appreciate the opportunity to respond to the Report and request that the findings be modified to state accurately findings for each of the four Hospitals.

As explained, we are committed to adopt appropriate measures to support compliance with Program requirements. The four Hospitals have internal controls and external measures to support and enhance accurate billing and coding of claims, and, where appropriate, each has incorporated additional measures to prevent errors.

Thank you for your consideration, and should you have any questions, please do not hesitate to contact me.

Sincerely,



Robert Carter
Vice President and General Counsel
Cone Health

cc: Mickey Foster, President, Moses Cone Hospital
Paul Jeffrey, President, Wesley Long Hospital
Cindy Farrand, President, Women's Hospital
Debbie Green, President, Annie Penn Hospital
Terry Akin, Chief Executive Officer, Cone Health