Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF BILLINGS CLINIC HOSPITAL FOR 2012 AND 2013

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

Patrick J. Cogley
Regional Inspector General
for Audit Services

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Office of Inspector General

http://oig.hhs.gov/

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EXECUTIVE SUMMARY

Billings Clinic Hospital did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately $57,000 over 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2013, Medicare paid hospitals $156 billion, which represents 45 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 Billings Clinic Hospital (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification. 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.

The Hospital is a 285-bed hospital located in Billings, Montana. Medicare paid the Hospital approximately $174 million for 319,920 outpatient and 10,016 inpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

Our audit covered $3,383,844 in Medicare payments to the Hospital for 179 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 31 outpatient and 148 inpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 173 of the 179 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining six claims, resulting in overpayments of $56,626 for CYs 2012 and 2013. Specifically, five outpatient claims had billing errors, resulting in overpayments of $52,126, and one inpatient claim had a billing error, resulting in an overpayment of $4,500. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor $56,626, consisting of $52,126 in overpayments for 5 incorrectly billed outpatient claims and $4,500 in overpayments for 1 incorrectly billed inpatient claim, and

- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with all our findings and described corrective actions that it had taken or planned to take, including the processing of refunds, to implement our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2013, Medicare paid hospitals $156 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether Billings Clinic Hospital (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital 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 Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). The rates vary according to the diagnosis-related group

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

(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 Claims at Risk for Incorrect Billing

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- outpatient and inpatient manufacturer credits for replaced medical devices,
- outpatient claims with payments greater than $25,000,
- outpatient and inpatient claims paid in excess of charges,
- inpatient claims billed with high severity level DRG codes,
- inpatient DRG verification,
- inpatient claims billed with elective admissions,
- inpatient claims billed with kyphoplasty services,
- inpatient short stays, and
- inpatient claims billed with cancelled elective surgical procedures.

For the purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas." We reviewed these risk areas as part of this review.

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items or services that "… are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Social Security Act (the Act) § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

Federal regulations state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). In addition, the Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Billings Clinic Hospital

The Hospital is a 285-bed hospital located in Billings, Montana. Medicare paid the Hospital approximately $174 million for 319,920 outpatient and 10,016 inpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $3,383,844 in Medicare payments to the Hospital for 179 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 31 outpatient and 148 inpatient claims. We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and did not use medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

See Appendix A for the details of our scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 173 of the 179 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining six claims, resulting in overpayments of $56,626 for CYs 2012 and 2013. Specifically, five outpatient claims had billing errors, resulting in overpayments of $52,126, and one inpatient claim had a billing error, resulting in an overpayment of $4,500. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 5 of 31 selected outpatient claims that we reviewed. These errors resulted in overpayments of $52,126.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives

partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45). For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier "FB" and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than $1 for the device.[2]

For 4 out of 31 selected claims, the Hospital received full credits for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims. The Hospital said that Medicare reimbursement rules, which it described as "complex and confusing," made interpreting the billing requirements very difficult. As a result of these errors, the Hospital received overpayments of $51,061.

Unsupported Number of Service Units

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 1 out of 31 selected claims, the Hospital billed Medicare for an unsupported number of service units. The Hospital said this was an anomalous situation in which the medication administration record could not be located. As a result of this error, the Hospital received an overpayment of $1,065.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 1 of 148 selected inpatient claims that we reviewed. This error resulted in an overpayment of $4,500.

Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code "FD" (chapter 3, § 100.8).

For 1 out of 148 selected claims, the Hospital received a reportable medical device credit from the manufacturer but did not adjust its inpatient claim with the appropriate condition and value codes to reduce payment as required. The Hospital said that Medicare reimbursement rules, which it described as "complex and confusing," made interpreting the billing requirements very difficult. As a result of this error, the Hospital received an overpayment of $4,500.

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

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $56,626, consisting of $52,126 in overpayments for 5 incorrectly billed outpatient claims and $4,500 in overpayments for 1 incorrectly billed inpatient claim, and

- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with all our findings and described corrective actions that it had taken or planned to take, including the processing of refunds, to implement our recommendations.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $3,383,844 in Medicare payments to the Hospital for 179 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 31 outpatient and 148 inpatient claims.

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and did not use medical review to determine whether the services were medically necessary.

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

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

We conducted our audit work from October 2014 to May 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient and inpatient paid claim data from CMS's National Claims History file for CYs 2012 and 2013;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2012 and 2013;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 179 claims (31 outpatient and 148 inpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;

- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;

- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;

- calculated the correct payments for those claims requiring adjustments; and

- discussed the results of our review with Hospital officials on November 12, 2015.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Outpatient				
Manufacturer Credits for Replaced Medical Devices	5	$76,459	4	$51,061
Claims With Payments Greater Than $25,000	17	537,234	1	1,065
Claims Paid in Excess of Charges	9	58,481	0	0
Outpatient Totals	**31**	**$672,174**	**5**	**$52,126**
Inpatient				
Manufacturer Credits for Replaced Medical Devices	1	$31,390	1	$4,500
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	47	1,139,874	0	0
Diagnosis-Related-Group Verification	70	934,380	0	0
Claims Paid in Excess of Charges	22	483,187	0	0
Claims Billed With Elective Admissions	2	55,592	0	0
Claims Billed With Kyphoplasty Services	3	29,773	0	0
Short Stays	1	18,836	0	0
Claims Billed With Cancelled Elective Surgical Procedures	2	18,638	0	0
Inpatient Totals	**148**	**$2,711,670**	**1**	**$4,500**
Outpatient and Inpatient Totals	**179**	**$3,383,844**	**6**	**$56,626**

Notice: The table above illustrates the results of our review by risk area. In it, we have organized outpatient and inpatient 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.

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January 11, 2016

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
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Re: Response to OIG Draft Audit Report A-07-15-05071

Dear Mr. Cogley:

Billings Clinic has reviewed the draft report entitled *Medicare Compliance Review of Billings Clinic Hospital for 2012 and 2013*. Thank you for providing the opportunity to respond and comment. We also appreciated the assistance and helpful guidance from the OIG auditors during this process. Billings Clinic has a robust compliance program and strives to conduct its activities in compliance with Medicare rules. We take the OIG's findings and recommendations very seriously.

Billings Clinic does not disagree with the OIG's findings regarding the six (6) claims in which repayments are recommended. We are in the process of refunding the recommended repayments to our MAC, Noridian Healthcare Solutions.

1. Billing Errors Associated With Outpatient Claims

A. Manufacturer Credits for Replaced Medical Devices Not Reported

The draft report found that Billings Clinic billed incorrectly for four (4) outpatient claims related to reporting manufacturer credits for replaced medical devices. These errors related to the use of the "FB" modifier to indicate replacement devices. Billings Clinic concurs with this finding.

As we described to the auditors, Billings Clinic self-identified this issue as part of our compliance program prior to the initiation of this OIG audit. We voluntarily repaid certain amounts to Noridian as the result of our internal review. After discussions with the auditors, we now better understand the specific and complex billing rules related to the use of the FB modifier, as well as the methodology used by the OIG to calculate repayments under these rules. Billings Clinic is in the process of repaying the suggested $52,126 to Noridian. We have put in place specific corrective action steps for manual review of all claims in connection with vendor invoices for replaced medical devices prior to submission to ensure appropriate coding and billing.

B. Unsupported Number of Service Units

OIG found one (1) outpatient claim in which the medical record was incomplete and did not support the number of units billed for a drug. We concur with the OIG's findings. This error was due to a Medication Administration Record document that could not be located for the audit. In 2012 some drug-related services were billed based on paper charge tickets that were destroyed after the claim was coded and manually keyed. Our current billing system submits codes and charges directly from the electronic medical record when the administration is documented in the Medication Administration Record. This corrective measure is already in place and involves using technology to assist in compliant billing supported by complete and accurate documentation.

2. Billing Errors Associated with Inpatient Claims

The OIG audit found one (1) erroneous inpatient claim which was not coded using the appropriate combination of condition codes and value codes. Billings Clinic agrees with this finding and is in the process of refunding the suggested dollar amounts. Inpatient claims were also included in our self-audit and the corrective actions and strengthened controls described in 1(A) above are being applied to inpatient medical device claims to prevent this error from recurring.

* * *

Billings Clinic is committed to complying with all applicable Medicare rules and billing requirements. We would like to thank the OIG audit team for their assistance in this review process.

Sincerely,

Karla B. Stauffer
Corporate Compliance Officer