Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MERITUS MEDICAL CENTER REFUNDED OVERPAYMENTS FOR PHYSICIAN CLAIMS WITH PLACE-OF-SERVICE CODING ERRORS FOR 2009 THROUGH 2012

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

David Lamir
Acting Regional
Inspector General

June 2013
A-01-12-00531

Office of Inspector General

https://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 8L 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

We verified that Meritus Medical Center submitted 17,000 claims with overpayments of $568,000 for physician services.

WHY WE DID THIS REVIEW

Prior nationwide reviews found that Medicare 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. One review identified instances of overpayments to Meritus Medical Center (the Hospital) because it submitted incorrectly coded nonfacility place-of-service claims for services provided in its wound care facility by its employed physicians**.** The Hospital also submitted claims for the facility overhead expense of many of these medical services. Hospital officials performed a self-audit after receiving our initial inquiry and voluntarily refunded all place-of-service coding overpayments. The Hospital requested that the Office of Inspector General verify the accuracy of the overpayment amount that it refunded to its Medicare contractor.

The objective of this review was to verify the amount of overpayments for physician claims with place-of-service coding errors submitted by the Hospital to its Medicare contractor for calendar years (CY) 2009 through 2012.

BACKGROUND

Medicare Part B pays for services physicians provide to program beneficiaries. Although physicians routinely perform many of these services in hospital outpatient departments or freestanding ambulatory surgical centers, physicians also perform some services in nonfacility settings such as physician offices, urgent care centers, or independent clinics. To account for the increased practice expense overhead 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 expense 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.

The Hospital is a 306-bed acute-care hospital located in Hagerstown, MD.

Our review covered $1,578,887 in Medicare payments to the Hospital for 17,259 nonfacility-coded physician services. These services had dates of service from CY 2009 through 2012.

WHAT WE FOUND

We verified that the Hospital submitted 17,259 claims with overpayments totaling $568,420 for physician services for CYs 2009 through 2012. The Hospital, billing on behalf of its wound care facility physicians, incorrectly coded these claims by using nonfacility place-of-service codes for services that were actually performed in the Hospital's wound care center.

As a result of our initial inquiry, the Hospital performed a comprehensive review, discovered that faulty billing software design caused the incorrect coding, fixed the software error, planned future management reviews of this billing system, and has already refunded its Medicare contractor $568,420 for the overpayments for physician services.

WHAT WE RECOMMEND

We recommend the Hospital continue to:

- monitor the functioning of its newly designed internal controls for the correct coding of the place of service on its employee physician claims to ensure full compliance with Medicare requirements and

- conduct periodic reviews of its billing system software and refund any additional place-of-service coding overpayments identified.

MERITUS MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations and stated that it would continue to monitor the effectiveness of its internal controls for place-of-service coding and periodically audit its billing system to ensure all overpayments are identified and refunded.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

Prior nationwide reviews found that Medicare contractors overpaid physicians who did not correctly identify the place of service on their claims.[1] 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. One review identified instances of overpayments to Meritus Medical Center (the Hospital) because it submitted incorrectly coded nonfacility place-of-service claims for services provided in its wound care facility by its employed physicians**.** The Hospital also submitted claims for the facility overhead expense of many of these medical services. Hospital officials performed a self-audit after receiving our initial inquiry and voluntarily refunded all place-of-service coding overpayments. The Hospital requested that the Office of Inspector General verify the accuracy of the overpayment amount that it refunded to its Medicare contractor.

OBJECTIVE

Our objective was to verify the amount of overpayments for physician claims with place-of-service coding errors submitted by the Hospital to its Medicare contractor for calendar years (CY) 2009 through 2012.

BACKGROUND

Medicare Part B Payments for Physician Services

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

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

[1] *Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2008 (A-01-10-00513) and Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2009 (A-01-10-00516).*

Medicare Reimbursement for Practice Expense

To account for the increased practice expense overhead 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 must be 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.

Meritus Medical Center

The Hospital is a 306-bed acute-care hospital located in Hagerstown, MD. The Hospital submits claims for the overhead expense of medical services performed at the Hospital. In addition, the Hospital bills on behalf of its wound care employee physicians for their Part B services.

As the Medicare contractor for hospitals and physicians in Maryland, Novitas Solutions, Inc. (Novitas), processes and pays the Hospital's claims for Medicare outpatient services and its claims for physician services**.**

HOW WE CONDUCTED THIS REVIEW

Our review covered $1,578,887 in Medicare payments to the Hospital for 17,259 nonfacility-coded physician services with dates of service from CY 2009 through 2012. We limited our review of the Hospital's internal controls to billing controls in place at the Hospital to prevent future program overpayments resulting from place-of-service billing errors.

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 A contains the details of our scope and methodology.

FINDINGS

We verified that the Hospital submitted claims with overpayments totaling $568,420 for physician services for CYs 2009 through 2012. The Hospital, billing on behalf of its wound care facility physicians, incorrectly coded these claims by using nonfacility place-of-service codes for services that were actually performed in the Hospital's wound care center.

As a result of our initial inquiry, the Hospital performed a comprehensive review and has already refunded Novitas $568,420 for the overpayments for physician services.

MEDICARE REQUIREMENTS

Medicare payment for physician services is based on the lower of the actual charge or the physician-fee-schedule amount.[2]

Federal requirements state: "The non-facility practice expense RVUs [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" (42 CFR § 414.22(b)(5)(i)(B)). CMS publishes a yearly physician fee schedule in the Federal Register showing those services that have a higher payment rate if performed in a nonfacility setting.

RESULTS OF REVIEW

The Hospital submitted 17,259 incorrectly coded claims for physician services for CYs 2009 through 2012. The Hospital, billing on behalf of its physicians, incorrectly coded these claims by using a nonfacility place-of-service code for services that were actually performed in its wound care facility. When the Hospital billed these services with the incorrect "office" place-of-service code, Novitas incorrectly reimbursed the Hospital for the increased practice expense portion of these services.

As a result if its own internal review, the Hospital already refunded Novitas $568,420 for overpayments resulting from the coding errors on claims it submitted on behalf its physicians. By repricing claims using the correct facility place-of-service code and reviewing records supplied by the Hospital, we verified that Novitas overpaid the Hospital $568,420 for the 17,259 physician services.

INADEQUATE BILLING CONTROLS

We statistically sampled an incorrectly coded nonfacility physician service for this Hospital in one of our recent nationwide reviews. Once we contacted the Hospital concerning this coding error, it performed a comprehensive review of its place-of-service coding controls. The Hospital discovered a billing software error that assigned a

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

nonfacility place-of-service code to physician services performed at its wound care facility since January 1, 2009. At the time of the Hospital's discovery of this system error in February 2012, it fixed the software error by assigning the correct facility place-of-service code for its wound care facility location in its physician billing system and created the following additional internal controls:

- management approval for all changes and updates made to the billing system software and

- periodic auditing of billing system software parameters.

RECOMMENDATIONS

We recommend the Hospital continue to:

- monitor the functioning of its newly designed internal controls for the correct coding of the place of service on its employee physician claims to ensure full compliance with Medicare requirements and

- conduct periodic reviews of its billing system software and refund any additional place-of-service coding overpayments identified.

MERITUS MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations and stated that it would continue to monitor the effectiveness of its internal controls for place-of-service coding and periodically audit its billing system to ensure all overpayments are identified and refunded.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Based on the Hospital's request, we performed a limited scope review to verify the accuracy of refunded overpayments by the Hospital for claims with physician place-of-service coding errors for CYs 2009 through 2012.

Our audit covered 17,259 nonfacility-coded physician services valued at $1,578,887 that were provided in CYs 2009 through 2012

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

We conducted our fieldwork in September 2012 through January 2013**.**

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used claims data from our nationwide place-of-service reviews and from records provided by the Hospital to identify all incorrectly coded nonfacility physician services provided at the Hospital from CY 2009 through 2012;
- 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;
- worked with the Hospital to verify the accuracy of the overpayment total to ensure the completeness of the refund; and
- discussed the results of review with officials of both the Hospital and Novitas.

We conducted this performance audit in accordance with generally accepted government auditing standings. 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 on our audit objectives.

APPENDIX B: MERITUS MEDICAL CENTER COMMENTS

Meritus Medical Center
11116 Medical Campus Road
Hagerstown, MD 21742
301.790.8000

June 6, 2013

Mr. David Lamir
Acting Regional Inspector General
Office of Audit Services, Region I
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Re: Report Number: A-01-12-00531

Dear Mr. Lamir:

On behalf of Meritus Medical Center ("Meritus"), I am providing comments in response to the report entitled *Meritus Medical Center Refunded Overpayments for Physician Claims With Place-of-Service Coding Errors for 2009 Through 2012.*

As stated in the report, Meritus conducted a comprehensive review of its place-of-service coding after receiving an initial inquiry from the Office of Inspector General (the "OIG"). Meritus strives to ensure compliance with Medicare's billing requirements and we appreciate the OIG's assistance in this audit and its recognition of our corrective actions.

Meritus concurs with the OIG's findings and recommendations and will continue with the following corrective actions:

- Meritus will continue to monitor the effectiveness of our internal controls for place of service coding and
- Meritus will continue with periodic audits of our billing system to ensure all overpayments are identified and refunded.

We appreciate and thank you for the opportunity to review and comment on this report.

Sincerely,

/Laurie L. Bender/

Laurie L. Bender
Executive Director of Internal Audit & Compliance
Meritus Medical Center

cc: Joseph Ross, President and Chief Executive Officer
Carolyn Simonsen, Vice President and Chief Compliance Officer