

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HOSPITAL PROVIDER
COMPLIANCE AUDIT:
ST. VINCENT HOSPITAL**

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



Gloria L. Jarmon
Deputy Inspector General
for Audit Services

November 2019
A-05-18-00040

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 <https://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 website.

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.

Report in Brief

Date: November 2019
Report No. A-05-18-00040

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

This audit is part of a series of hospital compliance audits. 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 2017, Medicare paid hospitals \$206 billion, which represents 55 percent of all fee-for-service payments for the year.

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

How OIG Did This Audit

We selected for audit a stratified random sample of 135 inpatient and 10 outpatient claims with payments totaling \$3.2 million for our 2-year audit period (January 1, 2016, through December 31, 2017).

We focused our audit on the risk areas that we identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements.

Medicare Hospital Provider Compliance Audit: St. Vincent Hospital

What OIG Found

The Hospital complied with Medicare billing requirements for 87 of the 145 inpatient and outpatient claims we audited. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 58 claims, resulting in net overpayments of \$293,404 for the audit period. Specifically, 49 inpatient claims had billing errors, resulting in overpayments of \$284,753, and 9 outpatient claims had billing errors, resulting in overpayments of \$8,651.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$2.1 million for the audit period.

What OIG Recommends and Auditee Comments

We recommend that the Hospital refund to the Medicare contractor \$2.1 million in estimated overpayments for incorrectly billed services; exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements. The detailed recommendations are included in the body of the report.

In written comments on our draft report, the Hospital generally disagreed with our findings and recommendations. The Hospital agreed with some of the errors in the sample and stated that corrective actions were underway and, in most cases, complete. The Hospital disagreed with the OIG findings for all 16 errors related to the Incorrectly Billed as Inpatient and Inpatient Rehabilitation Facility risk areas. The Hospital stated that the medical necessity criteria were met in all cases and plans to appeal these findings. The hospital agreed with the 60-day recommendation as it related to 3 error categories.

We maintain that all our findings and the associated recommendations are valid. We submitted these claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Each denied case was reviewed by two clinicians, including a physician. We stand by those determinations.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objective.....	1
Background.....	1
The Medicare Program.....	1
Hospital Inpatient Facility Prospective Payment System.....	1
Hospital Inpatient Rehabilitation Prospective Payment System	1
Inpatient Psychiatric Facilities Prospective Payment System	2
Hospital Outpatient Prospective Payment System	2
Hospital Claims at Risk for Incorrect Billing.....	2
Medicare Requirements for Hospital Claims and Payments	3
St. Vincent Hospital	4
How We Conducted This Audit	4
FINDINGS.....	5
Billing Errors Associated With Inpatient Claims	5
Incorrectly Billed Inpatient Rehabilitation Facility Services.....	6
Incorrectly Billed as Inpatient.....	7
Incorrectly Billed Diagnosis-Related-Group Codes	8
Incorrectly Billed Discharge Status Codes	8
Incorrectly Billed Admission Source Code.....	9
Billing Errors Associated With Outpatient Claims.....	10
Incorrectly Billed Number of Units.....	10
Incorrectly Billed Right Heart Catheterizations.....	10
Overall Estimate of Overpayments	11
RECOMMENDATIONS	11
ST. VINCENT HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	12
OTHER MATTERS.....	13

APPENDICES

A: Audit Scope and Methodology	14
B: Sample Design and Methodology.....	16
C: Sample Results and Estimates	19
D: Results of Audit by Risk Area.....	20
E: St. Vincent Hospital Comments	21

INTRODUCTION

WHY WE DID THIS AUDIT

This audit is part of a series of hospital compliance audits. 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 (CY) 2017, Medicare paid hospitals \$206 billion, which represents 55 percent of all fee-for-service payments; accordingly, it is important to ensure that hospital payments comply with requirements.

OBJECTIVE

Our objective was to determine whether St. Vincent Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims from January 1, 2016, through December 31, 2017.

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 administrative contractors (MACs) to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Facility Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system. 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. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Inpatient Rehabilitation Prospective Payment System

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for inpatient rehabilitation facilities. CMS implemented the payment system for cost-reporting periods

beginning on or after January 1, 2002. Under the payment system, CMS established a Federal prospective payment rate for each of 92 distinct case-mix groups (CMGs). The assignment to a CMG is based on the beneficiary's clinical characteristics and expected resource needs.

Inpatient Psychiatric Facilities Prospective Payment System

CMS pays inpatient psychiatric facilities (IPFs) a standardized Federal per diem payment per discharge and represents reimbursement in full for the inpatient operating and capital-related costs of furnishing Medicare-covered services in an IPF. The payment for an individual patient is further adjusted for factors such as the DRG classification, age, length of stay, and the presence of specified comorbidities. Additional payments are provided for cost outlier cases, qualifying emergency department, and electroconvulsive therapy treatments. The IPFs affected by the prospective payment system are freestanding psychiatric facilities, distinct part psychiatric units of acute care hospitals, and distinct part units of critical access 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 Claims at Risk for Incorrect Billing

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

- inpatient rehabilitation claims,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims paid in excess of charges,
- inpatient elective procedures,

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

- inpatient hospital-acquired conditions and “present on admission”² indicator reporting,
- inpatient mechanical ventilation,
- inpatient Comprehensive Error Rate Testing (CERT) DRG codes,
- inpatient psychiatric facility emergency department adjustments,
- outpatient right heart catheterizations with hemodynamic data, and
- outpatient surgeries billed with units greater than one.

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 audit.³

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 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 (§§ 1815(a) and 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). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23 § 20.3).

² “Present on admission” refers to diagnoses that are present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are also considered present on admission. Acute care hospitals are required to complete the present on admission indicator field on the Medicare inpatient claim for every diagnosis billed.

³ For purposes of selecting claims for medical review, CMS instructs its Medicare contractors to follow the “two-midnight presumption” in order not to focus their medical review efforts on stays spanning two or more midnights after formal inpatient admission in the absence of evidence of systemic gaming, abuse, or delays in the provision of care (*Medicare Program Integrity Manual*, ch. 6, § 6.5.2). We are not constrained by the two-midnight presumption in selecting claims for medical review.

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of a potential overpayment, providers must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).⁴

St. Vincent Hospital

The Hospital, which is part of the Ascension healthcare organization, is a 720-bed not-for-profit acute-care hospital located in Indianapolis, Indiana. Medicare paid the Hospital approximately \$376 million for 20,937 inpatient and 116,013 outpatient claims for services provided to beneficiaries during CYs 2016 and 2017.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$35,736,430 in Medicare payments to the Hospital for 2,286 claims that were potentially at risk for billing errors. We selected a stratified random sample of 145 claims paid to the Hospital during CYs 2016 or 2017 (audit period) for services provided to Medicare beneficiaries with payments totaling \$3,179,748 for audit. These claims consisted of 135 inpatient and 10 outpatient claims.

We focused our audit on the risk areas that we had identified during prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted these claims for focused medical review to determine whether the services met medical necessity and coding requirements. 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 audit scope and methodology.

⁴ The Act § 1128J(d); 42 CFR, part 401, subpart D (the 60-day rule); 42 CFR § 401.305(a)(2)(f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

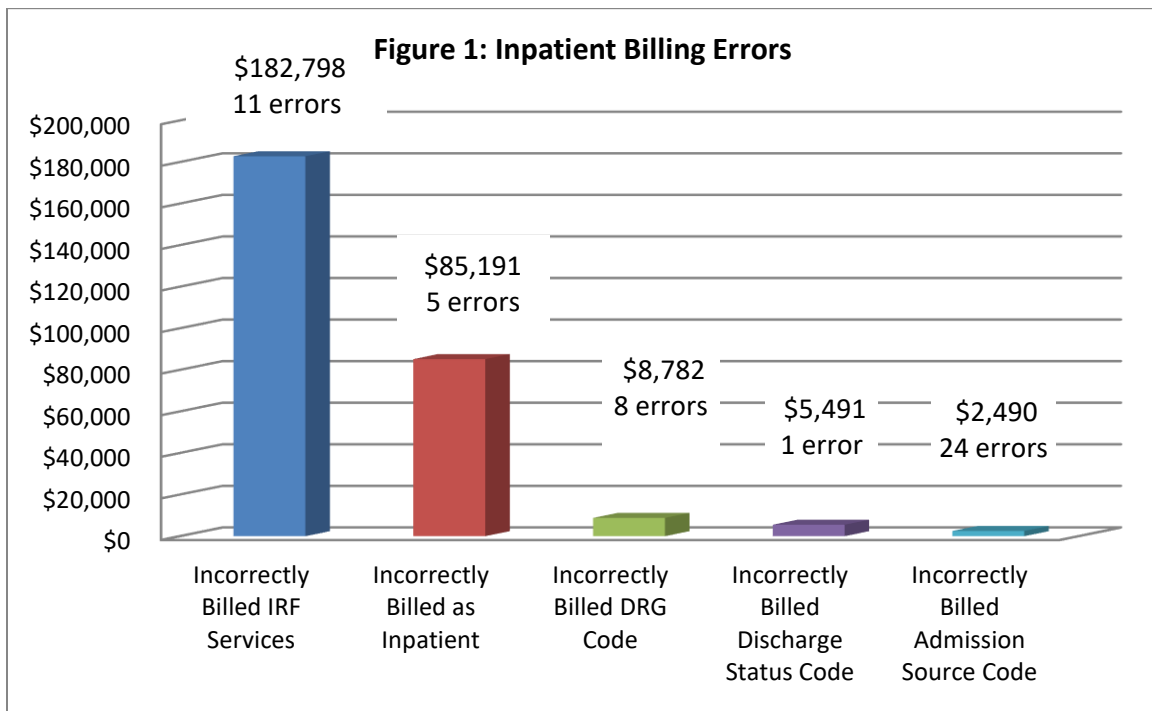
FINDINGS

The Hospital complied with Medicare billing requirements for 87 of the 145 inpatient and outpatient claims we audited (or \$2.6 million of \$3.2 million⁵ paid from the sample population). However, the Hospital did not fully comply with Medicare billing requirements for the remaining 58 claims, resulting in net overpayments of \$293,404 for the audit period. 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 \$2.1 million⁶ for the audit period.⁷ See Appendix B for our sample design and methodology, Appendix C for our sample results and estimates, and Appendix D for the results of our audit by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 49 of 135 sampled inpatient claims, which resulted in net overpayments of \$284,753, as shown in Figure 1.



⁵ The actual numbers were \$2,624,842 and \$3,179,748, respectively.

⁶ The actual number was \$2,111,647.

⁷ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

Incorrectly Billed Inpatient Rehabilitation Facility Services

Medicare may not pay 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)).

The *Medicare Benefit Policy Manual* states that “the IRF benefit is designed to provide intensive rehabilitation therapy in a resource-intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care” (Pub. No. 100-02, chapter 1, § 110).

The *Medicare Benefit Policy Manual* also states that a primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient’s IRF medical record must document a reasonable expectation that, at the time of admission to the IRF, the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs (Pub. No. 100-02, chapter 1, § 110.2.2).

For an IRF claim to be considered reasonable and necessary, Federal regulations require that there be a reasonable expectation that, at the time of admission, the patient (1) required the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally required and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) was sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; and (4) required physician supervision by a rehabilitation physician (42 CFR § 412.622(a)(3)(i-iv)).

Federal regulations require that the patient’s medical record must contain certain documentation to ensure that the IRF coverage requirements are met. The record must include (1) a comprehensive preadmission screening, (2) a post-admission physician evaluation, and (3) an individualized overall plan of care (42 CFR § 412.622(a)(4)(i-iii)).

For 11 of the 135 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation level of care. IRF services for these beneficiaries were not considered reasonable and necessary because these beneficiaries did not require the active and ongoing therapeutic intervention of multiple therapy disciplines; generally did not require and could not reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; were not sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; or did not require supervision by a rehabilitation physician. The Hospital did not provide a cause for the errors because it believes that these claims met Medicare requirements.

As a result of these errors, the Hospital received overpayments totaling \$182,798.

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)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1815(a)).

A payment for services furnished to an individual may be made only to providers of services that are eligible and only if, “with respect to inpatient hospital services . . . , which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual’s medical treatment . . .” (the Act § 1814(a)(3)). Federal regulations require an order for inpatient admission by a physician or other qualified provider at or before the time of the inpatient admission (42 CFR § 412.3(a)-(c)).

In addition, the regulations provide that an inpatient admission, and subsequent payment under Medicare Part A, is generally appropriate if the ordering physician expects the patient to require care for a period of time that crosses two midnights (42 CFR § 412.3(d)(1)).

Furthermore, the *Medicare Benefit Policy Manual* states that physicians “should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation” (Pub. No. 100-02, chapter 1, § 10). The *Medicare Benefit Policy Manual* further states that:

the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and

- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered on the basis of the length of time the patient actually spends in the hospital (Pub. No. 100-02, chapter 1, § 10).

For 5 of the 135 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services. The Hospital did not provide a cause for the errors identified because it believes that the medical record documentation supports the inpatient status for these claims based on CMS's Two-Midnight rule criteria.

As a result of these errors, the Hospital received overpayments of \$85,191.

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 8 of the 135 sampled inpatient claims, the Hospital billed Medicare with incorrect DRG codes, which resulted in payments that were either higher or lower than what should have been made. For these claims, the Hospital used incorrect diagnosis codes to determine the DRG codes. The Hospital stated that the eight claims were inadvertently coded incorrectly and attributed seven of the errors to an incorrect selection of the principal diagnosis and one error to the addition of a secondary diagnosis code assignment.

As a result of these errors, the Hospital received net overpayments of \$8,782.

Incorrectly Billed Discharge Status Codes

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 (1) a hospital or a hospital unit excluded from the prospective payment system, (2) a skilled nursing facility, or (3) a patient's home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(c)).

A hospital that transfers an inpatient under these circumstances is paid a graduated per diem rate for each day of the 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 135 sampled claims, the Hospital incorrectly billed Medicare for a patient discharge to home that should have been billed as a transfer to a skilled nursing facility. Thus, the Hospital should have received the per diem payment instead of the full DRG payment. Hospital officials stated that the discharge status code was coded in error.

As a result of this error, the Hospital received an overpayment of \$5,491.

Incorrectly Billed Admission Source Code

According to 42 CFR § 412.424(d)(1)(v), CMS adjusts the Federal per diem base rate upward for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary uses emergency department services. However, the IPF should not receive the additional payment if the beneficiary is discharged from the acute-care section of the same hospital. In that case, the costs of emergency department services are covered by the Medicare payment to the hospital for the immediately preceding acute-care stay.

CMS designated source-of-admission code D for a hospital-based IPF to enter on its Medicare claim form to indicate that a beneficiary was admitted from the acute-care section of the same hospital.⁸ This code is designed to ensure that the hospital-based IPF does not receive an additional payment for the costs of emergency department services that Medicare covers in its payment to the acute-care hospital.

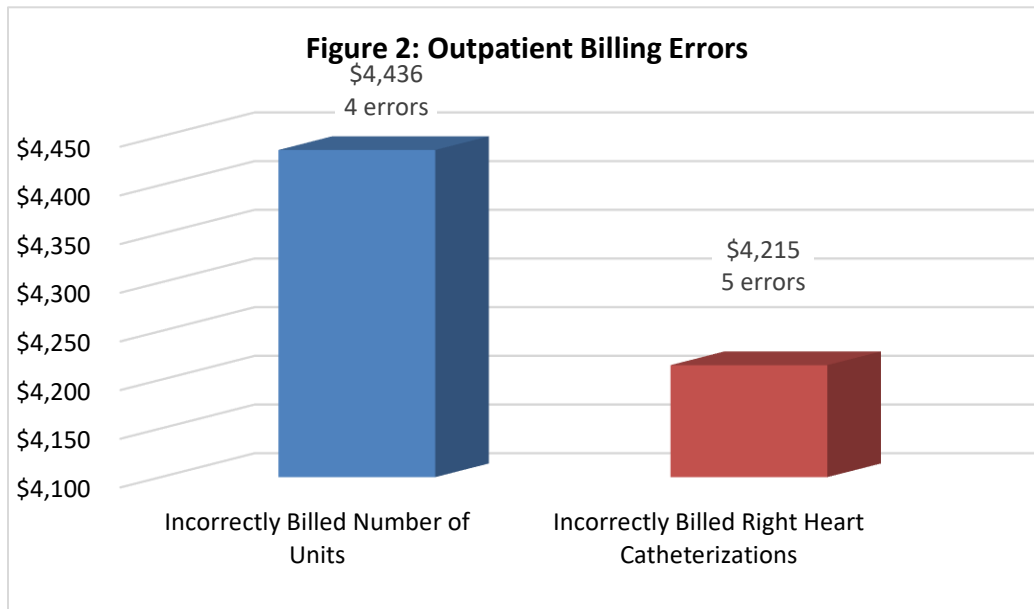
For 24 of the 135 inpatient claims, the Hospital-based IPF incorrectly billed the source-of-admission code (Code 4 – Transfer from a Hospital – Different Facility). As a result, the hospital-based IPF inappropriately received a payment adjustment for emergency department services even though the costs were already included in the Medicare payment to the same acute-care hospital for the beneficiary's immediately preceding stay. Hospital officials stated that this incorrect coding occurred because the coding software at the IPF did not include an Admit Source Code for transfer within a facility (Code D – Transfer from hospital inpatient in the same facility). The Hospital stated that the IPF is a department of the main hospital but located in a separate building. For this reason, registration personnel considered the IPF to be a different hospital and inappropriately used Code 4 for transfer from another hospital.

As a result of these errors, the Hospital received overpayments of \$2,490.

⁸ The Manual, chapter 3 § 190.6.4.1 (Rev. 3030, effective Oct. 1, 2015). In Change Request 3881, dated Oct. 21, 2005, and effective Apr. 1, 2006, CMS established the more specific source-of-admission code D to identify an IPF claim for a beneficiary who was admitted from the acute-care section of the same hospital. An IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 9 of 10 sampled outpatient claims, which resulted in net overpayments of \$8,651, as shown in Figure 2.



Incorrectly Billed Number of Units

The Manual states that the definition of service units is the number of times the service or procedure being reported was performed (chapter 4 § 20.4). 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 4 of the 10 outpatient claims, the Hospital incorrectly billed Medicare for multiple units for outpatient surgery procedures when it should have billed for only 1 unit. Hospital officials stated that these errors occurred because of a billing system interface issue in which 15-minute increments did not properly convert to the correct number of units.

As a result of these errors, the Hospital received net overpayments of \$4,436.

Incorrectly Billed Right Heart Catheterizations

The Manual, chapter 1, § 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

“The ‘-59’ modifier is used to indicate a distinct procedural service. * * * This may represent a different session or patient encounter, different procedure or surgery, different site, or organ

system, separate incision/excision, or separate injury (or area of injury in extensive injuries)” (the Manual, chapter 23, § 20.9.1.1(B)).⁹

Effective January 1, 2015, CMS established four new HCPCS modifiers to define subsets of modifier 59. The four new HCPCS modifiers used to identify subsets of Distinct Procedural Services are: Modifier XE – Separate Encounter, Modifier XS – Separate Structure, Modifier XP – Separate Practitioner, and Modifier XU – Unusual Non-Overlapping Service. CMS will continue to recognize modifier 59, but providers should use one of the more descriptive modifiers in place of modifier 59 when it is appropriate (Pub. No. 100-20, “One Time Notification,” Transmittal 1422, Aug. 15, 2014).

For 5 of the 10 outpatient claims, the Hospital incorrectly billed Medicare for right heart catheterization (RHC) procedures performed during the same patient encounter as heart biopsy procedures. The Hospital incorrectly appended modifier 59 on three claims and modifier XS on two claims with the HCPCS code 93451, indicating that the RHCs were separate and distinct procedures from the heart biopsies even though the medical record documentation did not support using the modifier. Although additional steps taken during the encounter, such as measuring hemodynamic pressures, may have been reasonable and necessary, the documentation showed that obtaining the heart biopsies was the primary purpose of the RHCs. Therefore, the RHCs were an inherent component of the heart biopsies, and the payments for the biopsies already covered the RHCs. Hospital officials stated that the RHC and the heart biopsies were incorrectly coded as separate and distinct procedures.

As a result of these errors, the Hospital received overpayments of \$4,215.

OVERALL ESTIMATE OF OVERPAYMENTS

The combined net overpayments on our sampled claims totaled \$293,404. Based on our sample results, we estimated that the Hospital received overpayments of at least \$2.1 million for the audit period.

RECOMMENDATIONS

We recommend that St. Vincent Hospital:

- refund to the Medicare contractor \$2,111,647 (of which \$293,404 was net overpayments identified in our sample) in estimated overpayments for incorrectly billed services;¹⁰

⁹ This manual provision was revised after our audit period by Change Request 10868, dated December 28, 2018, and effective January 30, 2019.

¹⁰ OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to HHS action officials. Action officials at CMS, acting through a MAC or other contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with its policies

- exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements; specifically, ensure that:
 - all IRF beneficiaries meet Medicare criteria for acute inpatient rehabilitation;
 - all inpatient beneficiaries meet Medicare criteria for inpatient hospital services;
 - diagnosis, discharge status, and admission source codes are supported in the medical records and staff are properly trained; and
 - medical records accurately document the appropriate number of units and distinct procedural services and that staff are properly trained.

ST. VINCENT HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital generally disagreed with our findings and recommendations. The Hospital agreed with some of the errors in the sample and stated that corrective actions were underway and, in most cases, complete. The Hospital disagreed with the OIG findings for all 16 errors related to the Incorrectly Billed as Inpatient and Inpatient IRF risk areas. The Hospital stated that the medical necessity criteria were met in all cases and that it plans to appeal these findings. The hospital agreed with the 60-day recommendation as it related to 3 error categories.

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

We maintain that all our findings and the associated recommendations are valid. We submitted these claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Each denied case was reviewed by two clinicians, including a physician. We stand by those determinations.

and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Part A/B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a hearing before an Administrative Law Judge. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeals. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

OTHER MATTERS

For 2 of the 135 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays of less than two midnights, which it should have billed as outpatient or outpatient with observation. Because the medical records did not support the necessity for inpatient hospital services, the services should have been provided at a lower level of care. As a result of these errors, the hospital received overpayments totaling \$12,533. None of the claims in this audit were targeted because they were short stays but rather because they fell into one of the high-risk categories discussed in the background section of this report. OIG has voluntarily suspended audits of inpatient short-stay claims after October 1, 2013. As such, we are not including the number and estimated dollar amount of these errors in our overall estimate of overpayments and repayment recommendation.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$35,736,430 in Medicare payments to the Hospital for 2,286 claims that were potentially at risk for billing errors. These claims consisted of 135 inpatient and 10 outpatient claims paid to the Hospital during CYs 2016 or 2017 (audit period) for services provided to Medicare beneficiaries. We selected a stratified random sample of 145 claims with payments totaling \$3,179,748 for audit.

We focused our audit on the risk areas that we had identified during prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted 145 claims for focused medical review to determine whether the services met medical necessity and coding requirements.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of audit 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 fieldwork from August 2018 through January 2019.

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 National Claims History file 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 145 claims (135 inpatient and 10 outpatient) totaling \$3,179,748 for detailed audit (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 submitting Medicare claims;
- used an independent medical review contractor to determine whether 145 sampled 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 audit to calculate the estimated Medicare overpayments to the Hospital (Appendix C); and
- discussed the results of our audit 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

TARGET POPULATION

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

SAMPLE FRAME

Medicare paid the Hospital approximately \$376 million for 20,937 inpatient and 116,013 outpatient claims (CMS's National Claims History data) for services provided to beneficiaries during the audit period.

We downloaded claims from the National Claims History database totaling \$256,544,443 for 11,571 inpatient and 33,894 outpatient claims in 35 risk areas. From these 35 risk areas, we selected 10, consisting of 4,955 claims totaling \$64,015,296 for further review.

We performed data analysis of the claims within each of the 10 risk areas. The specific data filtering and analysis steps we performed varied depending on the risk area and Medicare issue but included such procedures as removing:

- \$0 paid claims,
- claims with certain patient discharge status codes,
- claims with specific diagnosis and HCPCS codes,
- claims under review by the Recovery Audit Contractor as of May 15, 2018, and
- all duplicated claims within individual risk areas.

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: Inpatient Claims Billed with High-Severity-Level DRG Codes, Inpatient Comprehensive Error Rate Testing (CERT) DRG Codes, Inpatient Hospital-Acquired Conditions and Present on Admission Indicator, Inpatient Elective Procedures, and Inpatient Claims Paid in Excess of Charges. This assignment hierarchy resulted in a sample frame of 2,286 unique Medicare paid claims in 10 risk areas totaling \$35,736,430 (Table 1).

Table 1: Risk Areas Sampled

Risk Area	Number of Claims	Amount of Payments
Inpatient Rehabilitation Facility	232	\$4,362,390
Inpatient Claims Billed with High-Severity-Level DRG Codes	409	5,537,331
Inpatient CERT High Error DRG Codes	818	15,716,850
Inpatient Elective Procedures	526	6,657,611
Inpatient Hospital-Acquired Conditions and Present on Admission Indicator Reporting	248	2,838,757
Inpatient Mechanical Ventilation	8	281,812
Inpatient Claims Paid in Excess of Charges	3	94,333
Inpatient Psychiatric Facility Emergency Adjustments	32	218,227
Outpatient Surgeries Billed With Units Greater Than 1	5	16,059
Outpatient Right Heart Catheterizations	5	13,060
Total	2,286	\$35,736,430

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into eight strata based on the risk area.

SAMPLE SIZE

We selected 145 claims for audit, as follows:

Table 2: Sampled Claims by Stratum

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Rehabilitation Facility	232	30
2	Inpatient Claims Billed with High-Severity-Level DRG Codes, Inpatient Elective Procedures, Inpatient Hospital-Acquired Conditions and Present on Admission Indicator Reporting, Inpatient Mechanical Ventilation	1,191	30
3	Inpatient CERT High Error DRG Codes > \$33,605	97	20
4	Inpatient CERT High Error DRG Codes < \$33,605	721	20
5	Inpatient Claims Paid in Excess of Charges	3	3
6	Inpatient Psychiatric Facility Emergency Adjustments	32	32
7	Outpatient Surgeries Billed With Units Greater Than 1	5	5
8	Outpatient Right Heart Catheterizations	5	5
	Total	2,286	145

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG/Office of Audit Services (OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata one through four. After generating the random numbers for these strata, we selected the corresponding frame items. We selected all claims in strata five through eight.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments paid to the Hospital during the audit period. To be conservative, we recommend recovery of any overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

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 Over-payments in Sample
1	232	\$4,362,390	30	\$542,488	11	\$182,798
2	1,191	15,315,511	30	363,490	8	44,242
3	97	7,356,155	20	1,687,147	0	0
4	721	8,360,695	20	244,944	5	15,074
5	3	94,333	3	94,333	1	40,149
6	32	218,227	32	218,227	24	2,490
7	5	16,059	5	16,059	4	4,436
8	5	13,060	5	13,060	5	4,215
Total	2,286	\$35,736,430	145	\$3,179,748	58	\$293,404

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

Point estimate	\$3,764,735
Lower limit	2,111,647
Upper limit	5,417,823

APPENDIX D: RESULTS OF AUDIT BY RISK AREA

Table 5: Sample Results by Risk Area

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Inpatient Rehabilitation Facility	30	\$542,488	11	\$182,798
Inpatient Claims Billed With High-Severity-Level DRG Codes	14	222,588	4	28,407
Inpatient CERT High Error DRG Codes	40	1,932,091	5	15,074
Inpatient Elective Procedures	9	65,428	2	2,299
Inpatient Hospital-Acquired Conditions and Present on Admission Indicator Reporting	7	75,474	2	13,536
Inpatient Claims Paid in Excess of Charges	3	94,333	1	40,149
Inpatient Psychiatric Facility Emergency Adjustments	32	218,227	24	2,490
Inpatient Totals	135	\$3,150,629	49	\$284,753
Outpatient				
Outpatient Surgeries Billed With Units Greater Than 1	5	\$16,059	4	\$4,436
Outpatient Right Heart Catheterizations	5	13,060	5	4,215
Outpatient Totals	10	\$29,119	9	\$8,651
Inpatient and Outpatient Totals	145	\$3,179,748	58	\$293,404

We submitted these claims for a focused medical review to determine whether the services met medical necessity and coding requirements.

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

APPENDIX E: ST. VINCENT HOSPITAL COMMENTS



August 8, 2019
Report number: A-05-18-00040

Sheri L. Fulcher
Regional Inspector General
Audit Services
Office of Audit Services,
Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

Re: St. Vincent Hospital Response to the OIG Draft Report A-05-18-00040
(Medicare Compliance Review of St. Vincent Hospital)

Dear Ms. Fulcher:

St. Vincent Hospital and Health Care Center, Inc. (“St. Vincent”) has reviewed the July 2019 U.S. Department of Health and Human Services, Office of Inspector General (“OIG”), draft report entitled *Medicare Compliance Review of St. Vincent Hospital* (“Draft Audit Report”). St. Vincent understands the OIG’s audit was conducted as part of a series of routine hospital compliance reviews with a focus on claims it believes to be at a higher risk of noncompliance with Medicare billing requirements.

The principal findings of the Draft Audit Report suggest net overpayments of \$293,404 were made from \$3,179,748 in payments reviewed in the sample. St. Vincent agrees with \$25,415 of the \$293,404 and will initiate its opportunity to appeal on the remaining \$267,989. For those errors where St. Vincent agrees with the OIG, corrective actions are underway and in most cases are complete. St. Vincent appreciates the opportunity to provide the following written comments of concurrence or nonconcurrence with each recommendation contained within the Draft Audit Report as follows:

OIG Recommendation – Refund Estimated Overpayment: St. Vincent should refund to the Medicare contractor \$2,111,647 (of which \$293,404 was net overpayments identified in the audit sample), which is the amount the OIG calculates as the extrapolated value of the amount OIG deemed to be billed in error (“Estimated Overpayment”).

St. Vincent Statement – Refund Estimated Overpayment: St. Vincent does not concur with this recommendation. St. Vincent disagrees with the OIG findings for the sixteen (16) claims representing \$267,989 in overpayments related to the medical necessity for the Incorrectly Billed as Inpatient and Inpatient Rehabilitation Facility (IRF) categories. St. Vincent’s review of the claims indicate medical necessity criteria were met in all cases. Therefore, St. Vincent does not believe any repayment is necessary with respect to this subset of claims and that it is inappropriate to perform extrapolation of these claims at this time. St. Vincent will pursue its appeal rights with the Medicare Administrative Contractor (MAC) for these findings at the appropriate time. Should St. Vincent be successful on appeal, the Estimated Overpayment amount is no longer valid.

OIG Recommendation – Additional Due Diligence: St. Vincent should exercise reasonable diligence to identify and return any additional similar overpayments received outside of the OIG’s audit period, in accordance with the 60-day repayment rule and identify any returned overpayments as having been made in accordance with this recommendation.

St. Vincent Statement – Additional Due Diligence: St. Vincent concurs with this recommendation as it relates to the following categories of: (i) Incorrectly Billed Admission Source Code, (ii) Incorrectly Billed Number of Units, and (iii) Incorrectly Billed Right Heart Catheterizations Performed During the Same Patient Encounter as Heart Biopsies, as these errors appeared to be more systemic in nature. In addition to strengthening the controls for these categories (as discussed below), St. Vincent has identified overpayments outside of this audit period and have returned the overpayments for those claims.

St. Vincent does not concur with this recommendation as it relates to the categories of: (i) Incorrectly Billed DRG, and (ii) Incorrectly Billed Discharge Status Code, as the findings were not systemic and included underpayments as well as overpayments. St. Vincent does not believe it is necessary to conduct a formal review outside of this audit period to identify similar overpayments. Instead, St. Vincent will continue its proactive pre-billing reviews and retrospective coding and billing audits to validate the medical record documentation supports the coding. St. Vincent will continue to return any overpayments identified by these retrospective audits.

St. Vincent disagrees with the findings for the categories of: (i) Incorrectly Billed as Inpatient, and (ii) IRF Services Incorrectly Billed as Inpatient; therefore, St. Vincent does not believe it is necessary to conduct a formal review outside of this audit period to identify similar overpayments. St. Vincent will continue to use its existing tools and processes to confirm medical necessity as described in the following pages and return any overpayments identified by retrospective audits.

OIG Recommendation – Strengthen Controls: St. Vincent should strengthen controls to ensure full compliance with Medicare requirements, specifically ensuring that:

1. All IRF beneficiaries meet Medicare criteria for acute inpatient rehabilitation;

St. Vincent Statement - IRF: St. Vincent does not concur with this recommendation. Per the *Medicare Benefit Policy Manual*, inpatient rehabilitation services are appropriate where, as determined at the time of admission, the patient: (1) required the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally required an intensive rehabilitation therapy program; (3) actively participated in, and benefited significantly from, the intensive rehabilitation therapy program; (4) required physician supervision by a rehabilitation physician; and (5) required an intensive and coordinated interdisciplinary approach to providing rehabilitation.¹¹ St. Vincent believes the medical record documentation for these eleven (11) claims supports that these requirements were met. It should also be noted that the St. Vincent acute inpatient rehabilitation unit closed effective November 2, 2018.

2. Documentation supporting the medical necessity for inpatient hospital services is contained in the medical records;

St. Vincent Statement – Inpatient Hospital Services: St. Vincent does not concur with this recommendation and believes the medical record documentation for these five (5) claims supports medical necessity for inpatient services as it relates to the CMS Two-Midnight Rule. Probe and Educate sessions conducted by the MACs indicate the intent of the rule is that any patient receiving hospital-required services crossing two midnights should be billed as inpatient. St. Vincent also uses the Change Healthcare InterQual Level of Care tool to determine the appropriate patient status. Additionally, if there are questions regarding admission status, R1 Revenue Cycle Management’s Physician Advisory Services is consulted. In addition to these processes, short-stay (i.e., length of stay of 1-2 days) reviews are conducted by Case Management personnel prior to discharge.

3. Diagnosis, discharge status, and admission source codes are supported in the medical records and staff are properly trained;

St. Vincent Statement – Diagnosis, Discharge Status, and Admission Source Codes: St. Vincent concurs with this recommendation as it relates to admission source codes and has found the feedback from the OIG’s audit to be valuable. Prior to receiving the Draft Audit Report, St. Vincent began implementing corrective actions for admission source codes. Specifically, the registration system was updated to accurately capture patient admission source code D. Following this system change, education was provided to registration and departmental staff. Additionally, the existing St. Vincent monitoring and auditing activities have been updated to include this review area moving forward.

As noted previously, the errors related to diagnosis and discharge status were not systemic in nature; therefore, St. Vincent will continue its current pre-billing reviews and retrospective audits to validate the medical record documentation supports the coding.

¹¹ Pub. No. 100-02, chapter 1, § 110.2.2

4. Medical records accurately document the appropriate number of units and distinct procedural services and that staff are properly trained.

St. Vincent Statement – Number of Units and Distinct Procedural Services: St. Vincent concurs with this recommendation. St. Vincent has already implemented corrective actions for number of units and right heart catheterization with biopsy. For example:

- a. the billing system interface was updated to accurately reflect the number of units billed for surgery instead of the number of 15-minute increments; and
- b. a charge code was created for the cardiac catheterization laboratory to capture the right heart catheterization with biopsy and prevent these procedures from being billed separately in error.

Education related to these charging and billing procedures was provided to coders and departmental staff. These review areas were also added to the St. Vincent monitoring and auditing program.

St. Vincent appreciates the opportunity to respond in writing to the Draft Audit Report. We agree that certain areas required attention and have valued the information obtained through the audit findings. For the claims where we do not agree on medical necessity, we respectfully disagree with an extrapolation approach and will exercise our appeal rights and make payments to the MAC to avoid accruing interest during that appeals process.

Please do not hesitate to contact me if you would like to discuss St. Vincent's response to the OIG Draft Report at 317-338-7094 or Erica.Wehrmeister@ascension.org.

Sincerely,

/Erica Wehrmeister/

Erica Wehrmeister, RN, BSN, MBA
President for St. Vincent Indiana Central Region