

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
GENESIS MEDICAL CENTER
FOR 2010 AND 2011**

*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**

**September 2014
A-07-13-05041**

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 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

Genesis Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$434,000 over more than 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) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Genesis Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is a 317-bed acute care hospital located in Davenport, Iowa. Medicare paid the Hospital approximately \$169 million for 15,273 inpatient and 74,753 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$6,143,726 in Medicare payments to the Hospital for 357 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 283 inpatient and 74 outpatient claims. Of the 357 claims, 313 claims had dates of service in CY 2010 or CY 2011, and 44 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2012.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 286 of the 357 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 71 claims, resulting in overpayments of \$434,306 for CYs 2010 and 2011 (44 claims) and CYs 2009 and 2012 (27 claims). Specifically, 56 inpatient

claims had billing errors, resulting in overpayments of \$296,219, and 15 outpatient claims had billing errors, resulting in overpayments of \$138,087. 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 \$434,306, consisting of \$296,219 in overpayments for 56 incorrectly billed inpatient claims and \$138,087 in overpayments for 15 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital described corrective actions that it had taken or planned to take in accordance with our recommendations. The Hospital pointed out that 61 of the 71 claims for which we had identified billing errors involved manufacturer credits for replaced medical devices, and said that the rules governing the correct billing of these devices are not well understood by many in the industry. The Hospital added, though, that it was in the process of refunding all overpayments to the Medicare contractor. The Hospital also described corrective actions that it had taken to further enhance and strengthen its controls.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
The Medicare Program	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System	1
Hospital Claims at Risk for Incorrect Billing	2
Medicare Requirements for Hospital Claims and Payments	2
Genesis Medical Center	3
How We Conducted This Review	3
FINDINGS	3
Billing Errors Associated With Inpatient Claims	4
Manufacturer Credits for Replaced Medical Devices Not Reported	4
Incorrectly Billed as Inpatient	4
Incorrectly Billed Diagnosis-Related Group Code	5
Billing Errors Associated With Outpatient Claims	5
Manufacturer Credits for Replaced Medical Devices Not Reported	5
Insufficiently Documented Procedures	6
RECOMMENDATIONS	6
AUDITEE COMMENTS	6
APPENDIXES	
A: Audit Scope and Methodology	7
B: Results of Review by Risk Area	9
C: Auditee Comments	10

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) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether Genesis Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient 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 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 (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services

EXECUTIVE SUMMARY

Genesis Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$434,000 over more than 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) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Genesis Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is a 317-bed acute care hospital located in Davenport, Iowa. Medicare paid the Hospital approximately \$169 million for 15,273 inpatient and 74,753 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$6,143,726 in Medicare payments to the Hospital for 357 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 283 inpatient and 74 outpatient claims. Of the 357 claims, 313 claims had dates of service in CY 2010 or CY 2011, and 44 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2012.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 286 of the 357 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 71 claims, resulting in overpayments of \$434,306 for CYs 2010 and 2011 (44 claims) and CYs 2009 and 2012 (27 claims). Specifically, 56 inpatient

claims had billing errors, resulting in overpayments of \$296,219, and 15 outpatient claims had billing errors, resulting in overpayments of \$138,087. 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 \$434,306, consisting of \$296,219 in overpayments for 56 incorrectly billed inpatient claims and \$138,087 in overpayments for 15 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital described corrective actions that it had taken or planned to take in accordance with our recommendations. The Hospital pointed out that 61 of the 71 claims for which we had identified billing errors involved manufacturer credits for replaced medical devices, and said that the rules governing the correct billing of these devices are not well understood by many in the industry. The Hospital added, though, that it was in the process of refunding all overpayments to the Medicare contractor. The Hospital also described corrective actions that it had taken to further enhance and strengthen its controls.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
The Medicare Program	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System	1
Hospital Claims at Risk for Incorrect Billing	2
Medicare Requirements for Hospital Claims and Payments	2
Genesis Medical Center	3
How We Conducted This Review	3
FINDINGS	3
Billing Errors Associated With Inpatient Claims	4
Manufacturer Credits for Replaced Medical Devices Not Reported	4
Incorrectly Billed as Inpatient	4
Incorrectly Billed Diagnosis-Related Group Code	5
Billing Errors Associated With Outpatient Claims	5
Manufacturer Credits for Replaced Medical Devices Not Reported	5
Insufficiently Documented Procedures	6
RECOMMENDATIONS	6
AUDITEE COMMENTS	6
APPENDIXES	
A: Audit Scope and Methodology	7
B: Results of Review by Risk Area	9
C: Auditee Comments	10

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) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether Genesis Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient 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 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 (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services

within each APC group.¹ All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient short stays,
- inpatient and outpatient claims paid in excess of charges,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims with payments greater than \$150,000,
- inpatient claims billed with kyphoplasty services,
- outpatient claims billed with modifiers,
- outpatient claims with payments greater than \$25,000, and
- outpatient claims billed with Doxorubicin Hydrochloride.

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)).

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

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).

Genesis Medical Center

The Hospital is a 317-bed acute care hospital located in Davenport, Iowa. Medicare paid the Hospital approximately \$169 million for 15,273 inpatient and 74,753 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$6,143,726 in Medicare payments to the Hospital for 357 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 283 inpatient and 74 outpatient claims. Of the 357 claims, 313 claims had dates of service in CY 2010 or CY 2011, and 44 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2012.² 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 but 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 286 of the 357 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 71 claims, resulting in overpayments of \$434,306 for CYs 2010 and 2011 (44 claims) and CYs 2009 and 2012 (27 claims). Specifically, 56 inpatient claims had billing errors, resulting in overpayments of \$296,219, and 15 outpatient claims had billing errors, resulting in overpayments of \$138,087. 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.

² We selected these 44 claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 56 of 283 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$296,219.

Manufacturer Credits for Replaced Medical Devices 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 53 out of 283 selected claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate condition and value codes to reduce payment as required. (Of the 53 claims, 23 had dates of service in CY 2009, 16 had dates of service in CY 2010, 12 had dates of service in CY 2011, and 2 had dates of service in CY 2012.) These overpayments occurred because the Hospital did not have adequate controls to report the appropriate condition and value codes to accurately reflect credits it had received from manufacturers. As a result of these errors, the Hospital received overpayments of \$263,699.

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)).

According to chapter 1, section 10, of the CMS *Benefit Policy Manual* (Pub. No. 100-02), factors that determine whether an inpatient admission is medically necessary include:

- 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.

For 2 out of 283 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The

Hospital attributed the incorrect billing to clerical error. As a result of these errors, the Hospital received overpayments of \$19,239.³

Incorrectly Billed Diagnosis-Related Group Code

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 1 out of 283 selected claims, the Hospital billed Medicare for an incorrect DRG code that was not supported in the medical record. The Hospital attributed this overpayment to human error. As a result of this error, the Hospital received an overpayment of \$13,281.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 15 of 74 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$138,087.

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.⁴

For 8 out of 74 selected claims, the Hospital received full credit for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims. (Of the eight claims, one had a date of service in CY 2010, six had dates of service in CY 2011, and one had a date of service in CY 2012.) These overpayments occurred because the Hospital did not have adequate controls to report the appropriate modifiers and charges to reflect credits received from manufacturers. As a result of these errors, the Hospital received overpayments of \$123,025.

³ The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor before the issuance of our report.

⁴ 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).

Insufficiently Documented Procedures

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

For 7 out of 74 selected claims, the Hospital submitted the claims to Medicare with unsupported HCPCS codes. The Hospital attributed these overpayments to coding errors. As a result of these errors, the Hospital received overpayments of \$15,062.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$434,306, consisting of \$296,219 in overpayments for 56 incorrectly billed inpatient claims and \$138,087 in overpayments for 15 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital described corrective actions that it had taken or planned to take in accordance with our recommendations. The Hospital pointed out that 61 of the 71 claims for which we had identified billing errors involved manufacturer credits for replaced medical devices, and said that the rules governing the correct billing of these devices are not well understood by many in the industry. The Hospital added, though, that it did not have adequate controls in place to process these credits and correctly bill Medicare for them.

The Hospital stated that it was in the process of refunding all overpayments to the Medicare contractor. The Hospital also described corrective actions that it had taken to further enhance and strengthen its controls.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$6,143,726 in Medicare payments to the Hospital for 357 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 283 inpatient and 74 outpatient claims. Of the 357 claims, 313 claims had dates of service in CY 2010 or CY 2011, and 44 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2012 (footnote 2).

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 but 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 inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the 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 at the Hospital from January 2013 to May 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2010 and 2011;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2009 through 2012;
- 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 357 claims (283 inpatient and 74 outpatient) 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 May 22, 2014.

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
Inpatient				
Manufacturer Credits for Replaced Medical Devices	65	\$1,334,451	53	\$263,699
Short Stays	52	412,682	2	19,239
Claims Paid in Excess of Charges	32	453,598	1	13,281
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	56	1,244,009	0	0
Claims Billed With High Severity Level Diagnosis-Related Group Codes	74	1,086,402	0	0
Claims With Payments Greater Than \$150,000	3	480,879	0	0
Claims Billed With Kyphoplasty Services	1	6,124	0	0
Inpatient Totals	283	\$5,018,145	56	\$296,219
Outpatient				
Manufacturer Credits for Replaced Medical Devices	28	\$285,604	8	\$123,025
Claims Billed With Modifiers	26	249,363	6	12,185
Claims Paid in Excess of Charges	5	54,061	1	2,877
Claims With Payments Greater Than \$25,000	14	532,188	0	0
Claims Billed With Doxorubicin Hydrochloride	1	4,365	0	0
Outpatient Totals	74	\$1,125,581	15	\$138,087
Inpatient and Outpatient Totals	357	\$6,143,726	71	\$434,306

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX C: AUDITEE COMMENTS



August 6, 2014

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
HHS Office of the Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 66106

Re: Draft of HHS-OIG Audit Services Report Number A-07-13-05041

Dear Mr. Cogley:

Thank you for providing Genesis Medical Center (“Genesis”) the draft report identified above, and for allowing us to respond. Genesis is committed to the highest ethical business standards, with Integrity a key value that supports our mission to provide compassionate, quality care to all those in need.

We understand that this audit covered \$6,143,726 in Medicare payments to Genesis for 357 inpatient and outpatient claims judgmentally selected as potentially at risk for billing errors for dates of service ranging from CY 2009 to CY 2012. OIG has identified 71 claims paid in error resulting in an overpayment of \$434,306, showing 93 percent of payments made in compliance with billing rules and regulations. For Genesis, one issue brought our audit results down from what would have been over 99 percent to 93 percent compliance, that issue is medical device credits.

The OIG has stated that it elects the risk areas based upon the results of previous reviews of other hospitals. It appears the rules of how to handle replacement devices that are provided at no cost or significant discount (under warranty) by the medical device manufacturer is not well understood by many in the industry, and is even the subject of some dispute. Specifically, the issue of rebilling for credits for separate components, such as lead wires, is a source of confusion. We hope that the January 1, 2014 CMS changes for reporting full or partial credits of devices and leads, and the new unique device identifiers now required by the FDA will make it easier for providers to fully comply with billing rules in this area.

Office of the President and CEO | Genesis Health System

1227 E. Rusholme St. | Davenport, IA 52803 | 563.421.6510 | fax 563.421.6500 | www.genesishealth.com

For Genesis, this issue accounts for 61 of the 71 total identified claims in error, representing \$386,724 of the total reported overpayment (89 percent). Genesis did not have adequate controls in place to process such device credits and bill Medicare, and has since instituted new processes and controls to correctly identify, track and correctly bill in such cases. Genesis is in the process of refunding the overpayments with our Medicare Administrative Contractor (“MAC”).

The remaining 10 claims account for \$47,582 in overpayments. This amounts to 99 percent billing compliance for the non-medical device credit areas audited. Genesis is in the process of refunding all overpayments with our MAC. We acknowledge that 2 out of 52 short stay inpatient claims should have been billed as outpatients, but believe this 96 percent accuracy evidences good controls in a difficult subject area. While we have already conducted education based on these 2 cases, the “2 Midnight Rule” somewhat alters our education and controls going forward. We concur that the remaining 8 claims covering DRG and modifiers were in error. We concluded that these were the result of human error and have conducted corrective education.

Genesis is committed to complying with all rules and regulations regarding billing Medicare for services provided to members our community. We view this audit as a learning opportunity, but also as a validation of the many controls Genesis has put in place to ensure billing integrity.

We thank the audit team involved for their patience and courtesy throughout the audit process.

Sincerely,

A handwritten signature in black ink, appearing to read 'Doug Cropper', with a long horizontal flourish extending to the right.

Doug Cropper
Chief Executive Officer
Genesis Health System