Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF IOWA METHODIST 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.

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Regional Inspector General
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Office of Inspector General

http://oig.hhs.gov/

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EXECUTIVE SUMMARY

Iowa Methodist Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately $216,000 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 Iowa Methodist 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 469-bed acute care hospital located in Des Moines, Iowa. Medicare paid the Hospital approximately $206 million for 17,535 inpatient and 92,769 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered $4,831,825 in Medicare payments to the Hospital for 252 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 209 inpatient and 43 outpatient claims. Of the 252 claims, 244 claims had dates of service in CY 2010 or CY 2011, and 8 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 216 of the 252 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 36 claims, resulting in overpayments of $216,412 for CYs 2010 and 2011 (30 claims) and CYs 2009 and 2012 (6 claims). Specifically, 25 inpatient claims

had billing errors, resulting in overpayments of $131,268, and 11 outpatient claims had billing errors, resulting in overpayments of $85,144. 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 $216,412, consisting of $131,268 in overpayments for 25 incorrectly billed inpatient claims and $85,144 in overpayments for 11 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 concurred with all of our findings and described corrective actions that it had taken or planned to take, including the processing of refunds, to implement our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 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 Iowa Methodist 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 claims billed with high severity level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient and outpatient claims paid in excess of charges,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient claims with payments greater than $150,000,
- inpatient short stays,
- inpatient claims billed with kyphoplasty services, and
- outpatient claims billed with modifiers.

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

Medicare Requirements for Hospital Claims and Payments

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

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

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

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

Iowa Methodist Medical Center

The Hospital is a 469-bed acute care hospital located in Des Moines, Iowa. Medicare paid the Hospital approximately $206 million for 17,535 inpatient and 92,769 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 $4,831,825 in Medicare payments to the Hospital for 252 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 209 inpatient and 43 outpatient claims. Of the 252 claims, 244 claims had dates of service in CY 2010 or CY 2011, and 8 claims 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 subject claims to focused 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 216 of the 252 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 36 claims, resulting in overpayments of $216,412 for CYs 2010 and 2011 (30 claims) and CYs 2009 and 2012 (6 claims). Specifically, 25 inpatient claims had billing errors, resulting in overpayments of $131,268, and 11 outpatient claims had billing errors, resulting in overpayments of $85,144. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 25 of 209 selected inpatient claims that we reviewed. These errors resulted in overpayments of $131,268.

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

Claims Billed With Unsupported Codes

Medicare payment may not be made for items or services that "… are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act, § 1862(a)(1)(A)).

For 16 out of 209 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain diagnosis and procedure codes were not supported in the medical records. The Hospital stated that its primary objective is to bill correctly and thus prevent or minimize overpayments, but added that it does not perform audits of all accounts and therefore cannot identify all potential errors. As a result of these errors, the Hospital received overpayments of $99,033.

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 9 out of 209 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 payments as required. (Of the nine claims, three had dates of service in CY 2010, five had dates of service in CY 2011, and one had a date of service in CY 2012.) The Hospital stated that its primary objective is to bill correctly and thus prevent or minimize overpayments, and added that it now performs audits of all accounts with credits for medical devices. As a result of these errors, the Hospital received overpayments of $32,235.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 11 of 43 selected outpatient claims that we reviewed. These errors resulted in overpayments of $85,144.

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.[3]

For 9 out of 43 selected claims, the Hospital received full credits for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims. (Of the nine claims, five had dates of service in CY 2009, two had dates of service in CY 2010, and two had dates of service in CY 2012.) The Hospital stated that its primary objective is to bill correctly and thus prevent or minimize overpayments, and added that it now performs audits of all accounts with credits for medical devices. As a result of these errors, the Hospital received overpayments of $77,262.

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 2 out of 43 selected claims, the Hospital submitted the claims to Medicare with certain procedure codes that were unsupported in the medical records. The Hospital stated that its primary objective is to bill correctly and thus prevent or minimize overpayments, but added that it does not perform audits of all accounts and therefore cannot identify all potential errors. As a result of these errors, the Hospital received overpayments of $7,882.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $216,412, consisting of $131,268 in overpayments for 25 incorrectly billed inpatient claims and $85,144 in overpayments for 11 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 concurred with all of our findings and described corrective actions that it had taken or planned to take, including the processing of refunds, to implement our recommendations.

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

[3] 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).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $4,831,825 in Medicare payments to the Hospital for 252 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 209 inpatient and 43 outpatient claims. Of the 252 claims, 244 claims had dates of service in CY 2010 or CY 2011, and 8 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 subject claims to focused 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 March 2013 to August 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 252 claims (209 inpatient and 43 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 August 12, 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				
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	109	$1,485,957	13	$68,035
Manufacturer Credits for Replaced Medical Devices	10	202,619	9	32,235
Claims Paid in Excess of Charges	18	379,677	2	24,401
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	64	1,627,034	1	6,597
Claims With Payments Greater Than $150,000	3	510,494	0	0
Short Stays	4	40,021	0	0
Claims Billed With Kyphoplasty Services	1	8,004	0	0
Inpatient Totals	**209**	**$4,253,806**	**25**	**$131,268**
Outpatient				
Manufacturer Credits for Replaced Medical Devices	13	$128,597	9	$77,262
Claims Billed With Modifiers	27	439,459	2	7,882
Claims Paid in Excess of Charges	3	9,963	0	0
Outpatient Totals	**43**	**$578,019**	**11**	**$85,144**
Inpatient and Outpatient Totals	**252**	**$4,831,825**	**36**	**$216,412**

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

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December 19, 2014

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RE: Report Number A-07-13-05042
Iowa Methodist Medical Center, Des Moines, IA

Dear Mr. Cogley:

This correspondence is in response to your letter dated November 6, 2014 regarding particular the OIG's compliance review of certain Medicare billings for 2010 and 2011. You have requested a statement of concurrence or nonconcurrence with each of the OIG recommendations that resulted from this review.

My comments to each section of the report are as follows:

Inpatient Claims Billed With Unsupported Codes

Iowa Methodist Medical Center concurs with this finding. Since this review, our coding department has now centralized to a corporate department within UnityPoint and has a dedicated compliance and education team. Feedback from multiple different sources is supplied to the coding staff to ensure coding compliance along with monthly random reviews to monitor quality.

All refunds have been processed.

Manufacturer Credit for Replaced Medical Devices Not Reported (Inpatient & Outpatient)

Iowa Methodist Medical Center concurs with these findings.

We have held discussions with our device vendors to ensure that credits are properly communicated. A credit report is now being issued by each of our vendors to ensure that claims are adjusted appropriately to reflect these credits. Additionally, as mentioned above, our coding department has now centralized to a corporate department within UnityPoint and has a dedicated compliance and education team. Feedback from multiple different sources is

supplied to the coding staff to ensure coding compliance along with monthly random review to monitor quality.

All refunds have been processed.

Insufficiently Documented Procedures (Outpatient)

Iowa Methodist Medical Center concurs with this finding.
Since this review, our coding department has now centralized to a corporate department within UnityPoint and has a dedicated compliance and education team. Feedback from multiple different sources is supplied to the coding staff to ensure coding compliance along with monthly random reviews to monitor quality.

We do not perform audits of all accounts and therefore cannot identify all potential errors; however, we believe that the above-described processes and improvements are effective.

Thank you for your consideration.

Sincerely,

Joseph Corfits