

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
STORMONT-VAIL
REGIONAL HEALTH CENTER
FOR 2011 AND 2012**

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**Patrick J. Cogley
Regional Inspector General
for Audit Services**

**December 2014
A-07-13-05051**

Office of Inspector General

<http://oig.hhs.gov/>

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EXECUTIVE SUMMARY

Stormont-Vail Regional Health Center did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately \$111,000 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 Stormont-Vail Regional Health Center (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

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

The Hospital is a 586-bed acute care hospital located in Topeka, Kansas. Medicare paid the Hospital approximately \$193 million for 70,226 outpatient and 17,288 inpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered \$4,062,050 in Medicare payments to the Hospital for 196 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 32 outpatient and 164 inpatient claims. Of the 196 claims, 186 claims had dates of service in CY 2011 or CY 2012, and 10 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 183 of the 196 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 13 claims, resulting in overpayments of \$110,943 for CYs 2011 and 2012 (9 claims) and CY 2010 (4 claims). Specifically, seven outpatient claims had billing errors, resulting in overpayments of \$66,141, and six inpatient claims had billing errors, resulting

in overpayments of \$44,802. 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 \$110,943, consisting of \$66,141 in overpayments for seven incorrectly billed outpatient claims and \$44,802 in overpayments for six incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital agreed with the majority of our findings and described corrective actions that it had taken to further enhance and strengthen its controls.

The Hospital did not agree with our finding on one inpatient claim, with \$6,192 in associated questioned cost, in which we found that the Hospital should have billed the claim as outpatient or outpatient with observation services. The Hospital said that it believed "... that this claim satisfied the criteria for inpatient admission" and described its process for internal review of short stays (that is, Hospital admissions in which the length of stay was 1 day or less) in order to validate the physician resource determination. The Hospital stated that at the time this claim was billed, its process involved random audits of a sample of short stays, and added that since then, it had initiated a process to review all short-stay inpatient admissions. The Hospital also said that determining the medical necessity of a course of treatment and method of care is a matter of professional medical judgment and acknowledged that such interpretations could differ. Additionally, the Hospital stated that, in light of current controls, it is comfortable that its process of short-stay claim review is complete, accurate, and timely.

After reviewing the Hospital's comments, we maintain that all of our findings and recommendations remain valid. We used Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether the inpatient claim with which the Hospital disagreed met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claim according to Medicare requirements. Based on the contractor's conclusion, we determined, and continue to believe, that the Hospital should have billed the inpatient claim as outpatient or outpatient with observation services.

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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 Stormont-Vail Regional Health Center (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

The Medicare Program

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

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

Hospital Outpatient Prospective Payment System

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

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

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 Claims at Risk for Incorrect Billing

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

- outpatient and inpatient manufacturer credits for replaced medical devices,
- outpatient and inpatient claims paid in excess of charges,
- outpatient claims billed with modifiers,
- outpatient claims with payments greater than \$25,000,
- inpatient claims billed with high severity level DRG codes,
- inpatient short stays (that is, Hospital admissions in which the length of stay was 1 day or less),
- inpatient DRG verification,
- inpatient claims with payments greater than \$150,000,
- inpatient claims billed with cancelled elective surgical procedures,
- inpatient same-day discharges and readmissions, and
- inpatient claims billed with kyphoplasty services.

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).

Stormont-Vail Regional Health Center

The Hospital is a 586-bed acute care hospital located in Topeka, Kansas. Medicare paid the Hospital approximately \$193 million for 70,226 outpatient and 17,288 inpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$4,062,050 in Medicare payments to the Hospital for 196 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 32 outpatient and 164 inpatient claims. Of the 196 claims, 186 claims had dates of service in CY 2011 or CY 2012, and 10 claims had dates of service in CY 2010.² 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 and subjected seven 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 183 of the 196 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 13 claims, resulting in overpayments of \$110,943 for CYs 2011 and 2012 (9 claims) and CY 2010 (4 claims). Specifically, seven outpatient claims had billing errors, resulting in overpayments of \$66,141, and six inpatient claims had billing errors, resulting in overpayments of \$44,802. These errors occurred primarily because the Hospital did not have

² We selected these 10 claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 7 of 32 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$66,141.

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 4 out of 32 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 four claims, two had dates of service in CY 2010, one had a date 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 \$41,700.

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 3 out of 32 selected claims, the Hospital submitted the claim to Medicare with procedure codes that were unsupported in the medical record. The Hospital attributed these overpayments to a combination of miscommunication and human error. As a result of these errors, the Hospital received overpayments of \$24,441.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 6 of 164 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$44,802.

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).

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)).

For 3 out of 164 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain diagnosis codes on these claims were not supported in the medical records. The Hospital attributed the overpayments to unintentional coding mistakes. As a result of these errors, the Hospital received overpayments of \$26,690.

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 2 out of 164 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. (These two claims had dates of service in CY 2010.) 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 \$11,920.

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 1 out of 164 selected claims, the Hospital incorrectly billed Medicare Part A for a beneficiary stay that should have been billed as outpatient or outpatient with observation services. The Hospital did not agree with our finding and said that CMS’s guidance was not clear and was open to judgmental opinion. However, the Medicare administrative contractor found that the Hospital had incorrectly billed based on medical necessity. As a result of this error, the Hospital received an estimated overpayment of \$6,192.⁴

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$110,943, consisting of \$66,141 in overpayments for seven incorrectly billed outpatient claims and \$44,802 in overpayments for six incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with our findings for 12 of the 13 claims that we identified as having been billed in error, and it described corrective actions that it had taken to further enhance and strengthen its controls.

The Hospital did not agree with our finding on the one claim, with \$6,192 in associated questioned cost, which we identified as having been incorrectly billed as an inpatient claim. The Hospital said that it believed “... that this claim satisfied the criteria for inpatient admission” and described its process for internal review of short stays in order to validate the physician resource determination. The Hospital stated that at the time this claim was billed, its process involved random audits of a sample of short stays, and added that since then, it had initiated a process to review all short-stay inpatient admissions. The Hospital also said that determining the medical necessity of a course of treatment and method of care is a matter of professional medical judgment, best reviewed in light of the objective circumstances and subjective knowledge of a practitioner involved in a patient’s medical treatment on the date of service. The Hospital acknowledged that because this determination is an interpretive analysis, well-intended and resourced interpretations could differ. Additionally, the Hospital stated that, in light of current controls, it is comfortable that its process of short-stay claim review is complete, accurate, and timely.

⁴ 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.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, we maintain that all of our findings and recommendations remain valid. We used Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether the inpatient claim with which the Hospital disagreed met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claim according to Medicare requirements. Based on the contractor's conclusion, we determined, and continue to believe, that the Hospital should have billed the inpatient claim as outpatient or outpatient with observation services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$4,062,050 in Medicare payments to the Hospital for 196 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 32 outpatient and 164 inpatient claims. Of the 196 claims, 186 claims had dates of service in CY 2011 or CY 2012, and 10 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010 (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 and subjected seven 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 outpatient and inpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

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

We conducted our audit work from June 2013 to August 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient and inpatient paid claim data from CMS's National Claims History file for CYs 2011 and 2012;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2010 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 196 claims (32 outpatient and 164 inpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- used Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether seven selected claims met medical necessity 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; and
- discussed the results of our review with Hospital officials on August 20, 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
Outpatient				
Manufacturer Credits for Replaced Medical Devices	20	\$83,847	4	\$41,700
Claims Paid in Excess of Charges	8	74,535	3	24,441
Claims Billed With Modifiers	3	55,389	0	0
Claims With Payments Greater Than \$25,000	1	48,197	0	0
Outpatient Totals	32	\$261,968	7	\$66,141
Inpatient				
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	53	\$1,293,652	3	\$26,690
Manufacturer Credits for Replaced Medical Devices	17	229,116	2	11,920
Short Stays	7	51,241	1	6,192
Diagnosis-Related-Group Verification	71	1,156,228	0	0
Claims With Payments Greater Than \$150,000	4	870,958	0	0
Claims Paid in Excess of Charges	7	153,597	0	0
Claims Billed With Cancelled Elective Surgical Procedures	2	21,149	0	0
Same-Day Discharges and Readmissions	2	13,419	0	0
Claims Billed With Kyphoplasty Services	1	10,722	0	0
Inpatient Totals	164	\$3,800,082	6	\$44,802
Outpatient and Inpatient Totals	196	\$4,062,050	13	\$110,943

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

APPENDIX C: AUDITEE COMMENTS

Stormont-Vail HealthCare

October 31, 2014

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

*Delivery by Certified Mail and
Electronic Mail*

Re: Report Number: A-07-13-05051

Dear Mr. Cogley:

Stormont-Vail HealthCare ("Stormont-Vail") appreciates this opportunity to respond to the U.S. Department of Health and Human Services, Office of Inspector General's ("OIG") report entitled "*Medicare Compliance Review of Stormont-Vail Regional Health Center for 2011 and 2012*" ("Compliance Review"). As a preliminary note, Stormont-Vail would like to acknowledge the professionalism and courtesy displayed by OIG auditors during this Compliance Review. We would also like to recognize Stormont-Vail workforce members for their efforts to continuously monitor the effectiveness and efficiency of our internal controls, in light of an ever-changing regulatory environment.

The objective of this audit was to determine Stormont-Vail's compliance with Medicare billing requirements for selected outpatient and inpatient claims. In order to satisfy this objective, the OIG selected 196 claims for review, totaling \$4,062,050 in Medicare payments. Of these claims sampled, the OIG had findings related to 13 claims, totaling \$110,943. Stormont-Vail agrees with the findings related to 12 claims, amounting to \$104,751, and disagrees with the finding related to 1 claim, amounting to \$6,192.

Stormont-Vail responds to the OIG's Compliance Review report as follows:

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

We agree with the overall finding that 7 of 32 selected outpatient claims were incorrectly billed, resulting in overpayments of \$66,141.

Manufacturer Credits for Replaced Medical Devices Not Reported

We agree with the specific finding that medical device credits were not appropriately reported in 4 out of 32 selected claims, resulting in overpayments of \$41,700. In addition to previously-established controls, Stormont-Vail has taken corrective action by implementing the following internal controls:

- Patient Financial Services, together with the Cath. Lab and Financial Management Accounts Payable staff, developed a new policy in mid-2012 and revised procedures that improved communication of medical device credits between departments within the organization;
- In August, 2014, Patient Financial Services implemented additional compensating controls, including monthly device credit report reconciliations and random audits to determine whether Medicare reimbursement is appropriately reduced; and
- Additional instruction on reporting appropriate modifiers and reducing charges for device credits related to outpatient claims has been provided to Billing Representatives within Patient Financial Services. This education included reminders about changes to the Medicare guidelines related to manufacturer credits that were effective as of January 1, 2014.

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Insufficiently Documented Procedures

We agree with the specific finding that 3 out of 32 selected claims included procedure codes that were unsupported in the corresponding medical record, resulting in overpayments of \$24,441. In addition to previously-established controls, Stormont-Vail has taken corrective action by implementing the following internal controls:

- As a preventative control, the pharmacy, together with Patient Financial Services, performed an audit of the entire pharmacy charge master file in order to reconcile billing codes with their appropriate corresponding medications;
- The pharmacy created three new generic non-formulary codes that automatically trigger a request from Patient Financial Services to validate the correct HCPCS code prior to processing patient bills;
- December 18, 2013 marked the first meeting of Stormont-Vail's Revenue Integrity Committee, which now meets monthly and includes a multidisciplinary Management team representing Cardiac, Pharmacy, and Operating Room. This committee discusses changes in Medicare billing requirements to ensure charges are accurately updated in a timely manner; and
- During the transition to Stormont-Vail's new electronic medical records system, workforce members received adequate information systems training to ensure that all credits for medications replaced in inventory are processed correctly and in a timely manner.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

We agree with the overall finding that 5 of 164 selected inpatient claims were incorrectly billed, resulting in overpayments of \$38,610. However, we disagree with the specific finding that 1 of these 164 selected inpatient claims amounting to \$6,192 was incorrectly billed as inpatient.

Incorrectly Billed Diagnosis-Related Group Codes

We agree with the specific finding that the Diagnosis-Related Group codes included in 3 out of 164 selected claims billed to Medicare were not supported in the medical records, resulting in overpayments of \$26,690. In addition to previously-established controls, Stormont-Vail has taken corrective action by implementing the following internal controls:

- In April, 2011, Stormont-Vail implemented a Clinical Documentation Review program. Clinical Documentation Review team members review Medicare charts for accuracy of diagnosis and procedure codes at the point of care. Team members communicate clarifying questions directly to physicians to allow for timely and accurate information in medical records; and
- Health Information Management Coders received appropriate educational reminders on interpreting, analyzing and scrutinizing medical records.

Manufacturer Credits for Replaced Medical Devices Not Reported

We agree with the specific finding that medical device credits were not adjusted with the appropriate condition code and value codes in 2 out of 164 selected claims, resulting in overpayments of \$11,920. In addition to previously-established controls, Stormont-Vail has taken corrective action by implementing the following internal controls:

- Patient Financial Services, together with the Cath. Lab and Financial Management Accounts Payable staff, developed a new policy in mid-2012 and revised procedures that improved communication of medical device credits between departments within the organization;
- In August, 2014, Patient Financial Services implemented additional compensating controls, including monthly device credit report reconciliations and random audits to determine whether Medicare reimbursement is appropriately reduced; and

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October 31, 2014
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- Additional instruction on reporting appropriate condition codes and value codes for device credits related to inpatient claims has been provided to Billing Representatives within Patient Financial Services. This education included reminders about changes to the Medicare guidelines related to manufacturer credits that were effective as of January 1, 2014.

Incorrectly Billed as Inpatient

We disagree with the specific finding that one of the inpatient claims selected should have been billed as outpatient or outpatient with observation services, resulting in an overpayment of \$6,192. We believe that this claim satisfied the criteria for inpatient admission.

At the time that this claim was billed, Stormont-Vail performed random audits of a sample of short stays in order to validate the physician resource determination. We also used an independent physician advisor to review all observation orders and inpatient orders when published inpatient criteria was not satisfied. Since then, Stormont-Vail initiated a process to submit all short-stay inpatient admissions to screening procedures by Case Management/Utilization Review. Internal and external physician reviewers also perform a second-level independent review of the treating physician's decision.

Stormont-Vail understands that determining the medical necessity of a course of treatment and method of care is a matter of professional medical judgment,¹ best reviewed in light of the objective circumstances and subjective knowledge of a practitioner involved in a patient's medical treatment on the date of service.² Since this is an interpretive analysis, we acknowledge that well-intended and resourced interpretations may differ. In light of current controls, Stormont-Vail is comfortable that its process of short stay claim review is complete, accurate, and timely.

Closing Remarks

In addition to improving the health of our community, our healthcare professionals work together with Corporate Compliance to develop and implement control activities while performing compliance risk assessments and monitoring results. Important healthcare and regulatory compliance information is quickly disseminated throughout the organization by means of weekly employee educational newsletters, annual mandatory compliance training webinars, and on-site personal training. Stormont-Vail believes that the control environment established by Management promotes a unique control consciousness which permeates our entire workforce and is apparent to our patients in the form of high-quality healthcare services and results. Please contact me if you have any additional questions.

Sincerely,



Joshua C. Aubey, JD, CPA, CIA, CFE
Compliance Officer
Stormont-Vail HealthCare

¹ MBPM Chpt. 1 §10. Recognizes 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"

² See 42 U.S.C. § 1395. "Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided"