Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF ST. VINCENT HEALTHCARE FOR 2011 AND 2012

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

January 2015
A-07-13-05052

Office of Inspector General

http://oig.hhs.gov/

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EXECUTIVE SUMMARY

St. Vincent Healthcare did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately $267,000 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 St. Vincent Healthcare (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 286-bed acute care hospital located in Billings, Montana. Medicare paid the Hospital approximately $118 million for 136,196 outpatient and 8,777 inpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered $4,034,719 in Medicare payments to the Hospital for 213 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 25 outpatient and 188 inpatient claims. Of the 213 claims, 207 claims had dates of service in CY 2011 or CY 2012, and 6 claims (involving manufacturer credits for replaced medical devices) had dates of service in CY 2010.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 191 of the 213 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 22 claims, resulting in overpayments of $266,637 for CYs 2011 and 2012 (20 claims) and CY 2010 (2 claims). Specifically, 13 outpatient claims had billing errors, resulting in overpayments of $205,509, and 9 inpatient claims had billing errors, resulting

in overpayments of $61,128. 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 $266,637, consisting of $205,509 in overpayments for 13 incorrectly billed outpatient claims and $61,128 in overpayments for 9 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 said that it did not contest our findings with respect to 13 outpatient claims and 4 inpatient claims, and described corrective actions that it had taken or planned to take to further enhance and strengthen its controls.

The Hospital strongly disagreed with our findings with regard to the clinical merits of five inpatient claims, with $36,719 in associated questioned costs, in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services. The Hospital stated that Executive Health Resources (EHR), which the Hospital described as "a nationally-recognized, independent third party reviewer," had re-reviewed the claims and had "assured the Hospital that [these five claims] were properly treated as inpatient stays, as supported by each corresponding medical record."

The Hospital stated that we should defer to the patient's physician rather than second-guessing the "critical, complex medical decision" in each of these five cases after the fact. The Hospital added that, because it provided care and treated the patients in these cases as ordered by their physicians, and given the clinical presentation of the patients at the times of service, it acted in accordance with Medicare policy and in ways that were confirmed by the results of EHR's independent, third-party physician reviews. The Hospital said that accordingly, it believed that there is a lack of evidence to support our findings related to these five claims.

Additionally, the Hospital stated that we should not recommend a refund of the entire overpayment associated with this category of claims. According to the Hospital, we should, instead, recommend only that once the full adjudication process has determined which of these inpatient claims should have been paid by Medicare Part B, that the Medicare contractor work in good faith with the Hospital to calculate and deduct from the Part A overpayment the amount that would have been paid by Part B. The Hospital then pointed to several administrative law and CMS rulings to support its position that we should recommend that CMS calculate the precise overpayment at issue by determining the difference between the inpatient reimbursement received and the outpatient reimbursement the Hospital would have received "as an efficient and fair approach in this matter."

OUR RESPONSE

After reviewing the Hospital's comments, we maintain that all of our findings and recommendations are valid. We used Noridian Healthcare Solutions, LLC (the Hospital's Medicare administrative contractor), to determine whether the five inpatient claims 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 claims according to Medicare requirements. Medical reviews of this nature are inherent in both the responsibilities and the expertise of Medicare administrative contractors.

With respect to the Hospital's description of EHR as the "independent third party reviewer" which the Hospital engaged to re-review these five claims, we note that EHR already had a contractual agreement to provide the Hospital with Medicare admission review and compliance. Specifically, EHR physicians worked with case management and attending physicians at the Hospital to review Medicare admissions and make recommendations on claim status. In fact, for four of the five claims in question, EHR had recommended to the Hospital that the patients be classified as inpatient before the Hospital billed Medicare.

The Hospital also said that we should not make a recommendation until we determine which claims would have been paid by Medicare Part B and that we should recommend that CMS calculate the precise amount of the overpayment by determining the difference between the inpatient and outpatient reimbursement. However, Medicare Part B claims that have not been billed are outside the scope of our review. As we note in the body of this report, 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. Based on our own audit work as fully supported by the Medicare administrative contractor's review, we continue to believe that the Hospital should have billed these five inpatient claims 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 St. Vincent Healthcare (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.

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

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

(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 kyphoplasty services,
- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient DRG verification, and
- inpatient claims with payments greater than $150,000.

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).

St. Vincent Healthcare

The Hospital is a 286-bed acute care hospital located in Billings, Montana. Medicare paid the Hospital approximately $118 million for 136,196 outpatient and 8,777 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 $4,034,719 in Medicare payments to the Hospital for 213 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 25 outpatient and 188 inpatient claims. Of the 213 claims, 207 claims had dates of service in CY 2011 or CY 2012, and 6 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 eight 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 191 of the 213 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 22 claims, resulting in overpayments of $266,637 for CYs 2011 and 2012 (20 claims) and CY 2010 (2 claims). Specifically, 13 outpatient claims had billing errors, resulting in overpayments of $205,509, and 9 inpatient claims had billing errors, resulting in overpayments of $61,128. 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 OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 13 of 25 selected outpatient claims that we reviewed. These errors resulted in overpayments of $205,509.

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

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 13 out of 25 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 13 claims, 1 had a date of service in CY 2010, 6 had dates of service in 2011, and 6 had dates 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 $205,509.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 9 of 188 selected inpatient claims that we reviewed. These errors resulted in overpayments of $61,128.

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.

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[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).

For 6 out of 188 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 conducted its own review of these six claims, and responded that it disagreed with our finding for five of the six claims. However, the Medicare administrative contractor evaluated the medical necessity requirements associated with these six claims and found that the Hospital had incorrectly billed all six of them. As a result of these errors, the Hospital received estimated overpayments of $46,228.[4]

Manufacturer Credit 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 3 out of 188 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 three claims, one had a date 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 condition and value codes to accurately reflect credits it had received from manufacturers. As a result of these errors, the Hospital received overpayments of $14,900.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $266,637, consisting of $205,509 in overpayments for 13 incorrectly billed outpatient claims and $61,128 in overpayments for 9 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 said that it did not contest our findings with respect to 13 outpatient claims and 4 inpatient claims, and described corrective actions that it had taken or planned to take to further enhance and strengthen its controls.

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[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 strongly disagreed with our findings with regard to the clinical merits of five inpatient claims, with $36,719 in associated questioned costs, in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services. The Hospital stated that Executive Health Resources (EHR), which the Hospital described as "a nationally-recognized, independent third party reviewer," had re-reviewed the claims and had "assured the Hospital that [these five claims] were properly treated as inpatient stays, as supported by each corresponding medical record."

The Hospital stated that we should defer to the patient's physician rather than second-guessing the "critical, complex medical decision" in each of these five cases after the fact. The Hospital added that, because it provided care and treated the patients in these cases as ordered by their physicians, and given the clinical presentation of the patients at the times of service, it acted in accordance with Medicare policy and in ways that were confirmed by the results of EHR's independent, third-party physician reviews. The Hospital said that accordingly, it believed that there is a lack of evidence to support our findings related to these five claims.

Additionally, the Hospital stated that we should not recommend a refund of the entire overpayment associated with this category of claims. According to the Hospital, we should, instead, recommend only that once the full adjudication process has determined which of these inpatient claims should have been paid by Medicare Part B, that the Medicare contractor work in good faith with the Hospital to calculate and deduct from the Part A overpayment the amount that would have been paid by Part B. The Hospital then pointed to several administrative law and CMS rulings to support its position that we should recommend that CMS calculate the precise overpayment at issue by determining the difference between the inpatient reimbursement received and the outpatient reimbursement the Hospital would have received "as an efficient and fair approach in this matter."

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 are valid. We used Noridian Healthcare Solutions, LLC (the Hospital's Medicare administrative contractor), to determine whether the five inpatient claims 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 claims according to Medicare requirements. Medical reviews of this nature are inherent in both the responsibilities and the expertise of Medicare administrative contractors.

With respect to the Hospital's description of EHR as the "independent third party reviewer" which the Hospital engaged to re-review these five claims, we note that EHR already had a contractual agreement to provide the Hospital with Medicare admission review and compliance. Specifically, EHR physicians worked with case management and attending physicians at the Hospital to review Medicare admissions and make recommendations on claim status. In fact, for

four of the five claims in question, EHR had recommended to the Hospital that the patients be classified as inpatient before the Hospital billed Medicare.

The Hospital also said that we should not make a recommendation until we determine which claims would have been paid by Medicare Part B and that we should recommend that CMS calculate the precise amount of the overpayment by determining the difference between the inpatient and outpatient reimbursement. However, Medicare Part B claims that have not been billed are outside the scope of our review. As we noted earlier in this report (footnote 4), 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. Based on our own audit work as fully supported by the Medicare administrative contractor's review, we continue to believe that the Hospital should have billed these five inpatient claims as outpatient or outpatient with observation services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $4,034,719 in Medicare payments to the Hospital for 213 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 25 outpatient and 188 inpatient claims. Of the 213 claims, 207 claims had dates of service in CY 2011 or CY 2012, and 6 claims (involving outpatient 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 eight 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 July 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 213 claims (25 outpatient and 188 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;

- asked Noridian Healthcare Solutions, LLC (the Hospital's Medicare administrative contractor), to determine whether eight 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 July 17, 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	19	$255,078	13	$205,509
Claims Billed With Modifiers	2	53,111	0	0
Claims With Payments Greater Than $25,000	1	35,540	0	0
Claims Paid in Excess of Charges	3	20,289	0	0
Outpatient Totals	**25**	**$364,018**	**13**	**$205,509**
Inpatient				
Claims Billed With Kyphoplasty Services	5	$52,571	4	$41,742
Manufacturer Credits for Replaced Medical Devices	7	111,608	3	14,900
Short Stays	3	10,735	2	4,486
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	114	2,234,760	0	0
Diagnosis-Related-Group Verification	47	521,924	0	0
Claims With Payments Greater Than $150,000	3	520,587	0	0
Claims Paid in Excess of Charges	9	218,516	0	0
Inpatient Totals	**188**	**$3,670,701**	**9**	**$61,128**
Outpatient and Inpatient Totals	**213**	**$4,034,719**	**22**	**$266,637**

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

Sisters of Charity of Leavenworth Health System

October 23, 2014

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
HHS-OIG Office of Audit Services, Region VII
601 East 12th Street, Room 429
Kansas City, MO 64106

VIA: Federal Express

Re: ***Medicare Compliance Review of St. Vincent Healthcare for 2011 and 2012,*** **Report Number: A-07-13-05052**

Dear Mr. Cogley:

St. Vincent Healthcare, a non-profit, tax-exempt, faith-based, acute care hospital located in Billings, Montana ("St. Vincent" or the "Hospital") respectfully submits this letter in response to the U.S. Department of Health and Human Services, Office of Inspector General ("HHS-OIG") draft audit report entitled, *Medicare Compliance Review of St. Vincent Healthcare for 2011 and 2012*, Report Number: A-07-13-05052, dated September 2014 ("Draft Report"). It is the Hospital's hope that HHS-OIG will carefully review and consider St. Vincent's position, as set forth below.

I. Draft Report: Background

The Draft Report is a product of an audit (the "Audit"), which was undertaken by HHS-OIG as part of a national auditing initiative designed to determine whether hospitals were complying with Medicare billing requirements for certain types of claims that HHS-OIG believed were at risk for noncompliance. The Audit focused on nine categories of claims: (1) Outpatient and Inpatient Claims Paid In Excess of Charges; (2) Outpatient and Inpatient Medical Device Credits; (3) Outpatient Claims Billed with Modifiers; (4) Outpatient Claims with Payment Greater Than $25,000; (5) Inpatient Short Stays; (6) Inpatient Kyphoplasty Procedures; (7) Inpatient Claims Billed with High Severity Level DRG Codes; (8) Inpatient DRG Verification; and (9) Inpatient Claims with Payments Greater Than $150,000 ("Risk Categories").

The Audit covered claims with dates of services in calendar years 2010, 2011 and 2012. In all, HHS-OIG identified a total universe of 213 claims (188 inpatient hospital claims and 25 outpatient hospital claims) within the nine Risk Categories, representing a total of $4,034,719 in Medicare payments (the "Universe of Claims").[1]

II. Draft Report: Findings

HHS-OIG's Audit found that the Hospital complied with Medicare billing requirements for 191 of the 213 claims reviewed. Specifically, the Audit only identified 22 alleged errors (13 outpatient and nine inpatient), which

[1] Of the 213 claims, 207 claims had dates of service in CY 2011 or CY 2012 and six claims (involving manufacturer credits for replaced medical devices) had dates of service in CY 2010.

were found in three of the nine Risk Areas: (1) Outpatient and Inpatient Medical Device Credits; (2) Inpatient Short Stays; and (3) Inpatient Kyphoplasty Procedures.[2] The other six Risk Areas were error free.

A. Outpatient Claims

HHS-OIG found 13 outpatient claim errors, all of which involved reported medical device credits.[3] These claims resulted in alleged overpayments of $205,509.[4]

B. Inpatient Claims

HHS-OIG found that nine inpatient claims that contained at least one error, resulting in alleged overpayments of $61,128:[5]

- Three of the inpatient claims contained errors due to the Hospital not adjusting inpatient claims to reflect manufacturer medical device credits. These three claims resulted in overpayments totaling $14,900.
- Six of the inpatient claims allegedly should have been billed as outpatient claims. These six claims resulted in overpayments totaling $46,228.[6]

III. Summary of Findings

According to the Draft Report, the above referenced 22 resulted in alleged overpayments totaling $205,509 for the outpatient claims and $61,128 for the inpatient claims, for a total alleged overpayment of $266,637.

IV. HHS-OIG Recommendations

HHS-OIG recommends that the Hospital: (1) refund the $266,637 in overpayments and (2) strengthen its Medicare billing controls.[7]

V. Hospital's Response

A. Outpatient Medical Device Credits

The Hospital has reviewed these claims and determined that it had previously developed and implemented a process for ensuring that Medicare was not charged for replacement devices when a reportable credit applied. However, for several reasons, including a change in the claims/billing technology at the Hospital, that process was not applied uniformly. As such, the Hospital does not contest the HHS-OIG's findings with regard to these 13 outpatient claims.

When this inadvertent misapplication of the process was discovered, the Hospital compliance team developed a new process pursuant to which a coding specialist identifies any patient who receives a full or partially credited replacement device and charges the patient account for the device that is being replaced. The coding specialist appends the "FD" value code and applicable condition code (49 or 50) within the billing and

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2 In the Draft Report, Short Stays and Inpatient Kyphoplasty have been consolidated into one category labeled "Incorrectly Billed as Inpatient."

3 HHS-OIG Draft Report, *Medicare Compliance Review of St. Vincent Healthcare for 2011 and 2012*, Report No. A-07-13-05052 (Sept. 25, 2014), at 3 [hereinafter "Draft Report"].

4 Id. at 3.

5 Id. at 4.

6 Id. at 5.

7 Id.

claims software. The coding specialist also enters the dollar amount of the credit. That information is then reviewed by Decision Support, which determines the correct price to enter and changes the charge accordingly. This new process also includes an edit in the system that automatically triggers an account review by Decision Support for all claims with an FD value code or 49/50 occurrence code. When the edit is triggered, Decision Support reviews the claim and ensures that all applicable Medicare requirements (e.g., application of credits) have been addressed. In addition, a retrospective monitoring and auditing process will be implemented in which all replacement device claims will be reviewed monthly to ensure correct Medicare payments. The results of this monthly review will be reported and discussed at the regularly scheduled St. Vincent Compliance Committee Meeting. The Hospital's controls and review processes are intended to minimize the recurrence of such issues in the outpatient setting, including incorporation of the updated CMS guidance on medical device credit recording, effective January 1, 2014.

B. Inpatient Claims

1. Incorrectly Billed As Inpatient

With respect to the claims incorrectly billed as inpatient, HHS-OIG found that for six claims (identified as F2, F3, I1, I2, I4 and I5), the Hospital "incorrectly billed Medicare Part A for beneficiary stays that did not qualify for inpatient status." HHS-OIG determined that these six claim submissions resulted in overpayments in the amount of $46,228.

The Hospital does not contest HHS-OIG's finding with respect to one of the six claims (I5). However, the Hospital strongly disagrees with HHS-OIG with regard to the clinical merits of the five other claims (i.e., F2, F3, I1, I2 and I4). The Hospital had these claims re-reviewed by Executive Health Resources ("EHR"), a nationally-recognized, independent third party reviewer that (i) specializes in conducting forensic evaluations of hospital inpatient and outpatient medical records, and (ii) has a formidable record in the administrative appeals process. EHR has assured the Hospital that claims F2, F3, I1, I2 and I4 were properly treated as inpatient stays, as supported by each corresponding medical record.

The Hospital submits that HHS-OIG's contention notwithstanding, it complied with the Medicare Benefit Policy Manual ("MBPM"), chapter 1, § 10. Specifically, the MBPM provides that "a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight." Thus, as long as there is an "expectation" of an overnight stay, whether the patient is — in fact — discharged after six, 12 or 18 hours (for example) is irrelevant: the patient was properly treated as an inpatient. Moreover:

> [t]he physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient...the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.[8]

In other words, deference should be afforded to the patient's physician and this critical, complex medical decision should not be second-guessed by HHS-OIG after-the-fact. Given that the Hospital provided care and treated the patient in the status as ordered by his/her physician, and given the clinical presentation of the patient at the time of service, the Hospital submits that it acted in accordance with Medicare policy, as further confirmed

[8] Medicare Benefit Policy Manual ("MBPM"), CMS Pub. 100-02, ch. 1, § 10.

by the results of EHR's independent third party physician review of the cases. Thus, the Hospital posits that there is a lack of evidence to support HHS-OIG's claim that for five of these six claims, they were incorrectly billed as inpatient, and, as such, should not be treated as an "overpayment." In the event that HHS-OIG continues to maintain that these claims were incorrectly billed, then the Hospital intends to appeal that finding through the Medicare claims appeal process.

The Hospital further notes that this category of claims involves the question of whether a particular medical record, in its totality, supports an inpatient versus an outpatient stay. The answer to this question is rarely straightforward, requiring, instead, a nuanced, multi-factor analysis that more often than not requires independent medical review. However, the HHS-OIG Draft Report and internal control questionnaires ("ICQ") gloss over the complexity of the inpatient versus outpatient status determination.

Indeed, Hospital posits that if the inpatient versus outpatient determinations were as straightforward as HHS-OIG suggests, why have hospitals, including St. Vincent, had so much success in overturning inpatient stay claims denied by the RAC in the past several years? In addition, if the process was clear, and not the subject of perpetual confusion and disagreement, why did CMS effectively overhaul the regulations governing proper patient status in a hospital setting, effective October 1, 2013?

The answer to these questions is straightforward. There was, and is, nothing remotely simple or intuitive about the process of determining whether certain patients are properly categorized as inpatients or outpatients or whether their medical documentation supports a certain level of coding.

Furthermore, HHS-OIG's Draft Report for this category of claims demonstrates that HHS-OIG does not dispute that the services at issue were both furnished and medically necessary. Specifically, HHS-OIG recognizes that Hospital may be able to bill Medicare Part B for all services associated with the six claims that would have been reasonable and necessary had the beneficiary been treated as an outpatient rather than admitted as an inpatient.[9] As such, and consistent with both law and equity, Hospital respectfully submits that HHS-OIG should not recommend that Hospital refund the Medicare contractor the entire "overpayment" associated with this category of claims, but instead recommend that only once it is determined (i.e., after full adjudication) which claims should have properly been paid by Medicare Part B (as opposed to Medicare Part A), the Medicare contractor should work in good faith with the Hospital to calculate and deduct from the Part A overpayment the amount that would have been paid by Part B.

The proposed recommendation would be consistent with Medicare guidance regarding similarly postured matters. In fact, in 2010, the Medicare Appeals Council upheld an ALJ's ruling that the hospital was entitled to reimbursement for full outpatient services under Medicare Part B even though the hospital initially billed the claim as an inpatient service under Medicare Part A.[10] In support of its conclusion, the Council quoted the Medicare Claims Processing Manual: "although providers may sometimes bill for services that are not covered as billed, they are nonetheless entitled to correct payment."[11]

CMS' first clear public pronouncement of its position was issued in CMS1455-R ("CMS Ruling") dated March 13, 2013. In it, the CMS Administrator specifically referred to the above noted ALJ decisions and endorsed hospitals' being paid "under Medicare Part B following a denial of a Medicare Part A hospital inpatient claim . . .

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[9] Draft Report at 5, n.4.

[10] See In the case of O'Connor Hospital, Med & Med GD (CCH) P 122133 (H.H.S. Feb. 1, 2010), 2010 WL 425107, consistent with In the case of UMDNJ - University Hospital, 2005 WL 6290383 (H.H.S. Mar. 14, 2005) (directing the CMS contractor to reimburse the hospital for outpatient services pursuant to Medicare Part B after payment was denied for inpatient services pursuant to Medicare Part A).

[11] Id. at 5; see also In the case of Indiana University Health Methodist Hospital, Docket No. M-12- 872 (H.H.S. May 17, 2012), 2012 WL 3067987, at *10; see also In the case of Montefiore Medical Center, Docket No. M-10-1121 (H.H.S. May 10, 2011), 2011 WL 6960290, at *22.

[if] an inpatient admission was [found] not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act."[12]

CMS concurrently issued a proposed rule, entitled "Medicare Program; Part B Billing in Hospitals," which addressed the policy of billing under Medicare Part B following the denial of a Medicare Part A hospital inpatient claim.[13] In the proposed rule, CMS acknowledged that the Medicare statute and regulations require CMS to pay hospitals under Medicare Part B for reasonable and necessary services furnished to beneficiaries. Specifically, CMS stated:

> Having reviewed the statutory and regulatory basis of our current Part B inpatient payment policy, we believe that, under section 1832 of the [Social Security] Act, Medicare should pay all Part B services that would have been reasonable and necessary (except for services that require an outpatient status) if the hospital had treated the beneficiary as a hospital outpatient rather than treating the beneficiary as an inpatient[.][14]

CMS "acquiesce[d] to the approach taken in the aforementioned ALJ and Appeals Council decisions" and found that that when a Part A inpatient admission is denied because the inpatient admission was not reasonable and necessary, the hospital may submit a Part B inpatient claim for payment for the Part B services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient, rather than admitted as an inpatient, except when those services specifically require an outpatient status.[15]

In short, consistent with the ALJ and Medicare Appeals Council Rulings and the recent CMS Ruling, HHS-OIG should recommend that CMS calculate the precise overpayment at issue by determining the difference between the inpatient reimbursement received and the outpatient reimbursement the Hospital would have received as an efficient and fair approach in this matter.

2. Inpatient Medical Device Credits

With respect to Inpatient Medical Device Credits, HHS-OIG found that for three claims (identified as J8, J19 and J23), the Hospital "received reportable medical device credits from a manufacturer but did not adjust its inpatient claims with appropriate value and condition codes to reduce payment as required." According to HHS-OIG, these three claim submissions resulted in alleged overpayments in the amount of $14,900. The Hospital does not contest HHS-OIG's findings with regard to these three claims.

The issues identified herein by HHS-OIG resulted from issues similar to those discussed in Section V.A. above (Outpatient Medical Device Credits). The Hospital is implementing the same controls and review processes discussed above.

VI. St. Vincent Internal Controls

St. Vincent is a responsible provider of healthcare items and services with a deep commitment to operating in compliance with applicable rules and regulations. As part of this commitment, the Hospital (and its sole member, SCL Health) routinely examines its coding and billing practices and procedures with the objective of achieving ever-improved accuracy and completeness.

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[12] Centers for Medicare & Medicaid Services, Ruling No. CMS-1455-R (Mar. 13, 2013) (hereinafter, "CMS Ruling"), at 1.
[13] 78 Fed. Reg. 16632 (Mar. 18, 2013).
[14] Id. at 16636.
[15] CMS Ruling, at 4, 6.

The Hospital is, and has always been, committed to operating in compliance with applicable rules and regulations. While the Hospital fundamentally disagrees with several of the HHS-OIG's findings, the Hospital takes any finding of potential errors seriously. St. Vincent will intensify its efforts to attend to any opportunities for improvements, including continuing its efforts on patient status cases.

In order to ensure that medical necessity for either an inpatient or an outpatient stay is verified, Hospital already has a process that requires a review to be conducted on all Medicare patients utilizing nationally recognized criteria at the time of admission. An internal review team conducts reviews and utilizes external physician consultants for verification on defined populations, thereby enabling adjustments prior to final billing. The HHS-OIG's determinations notwithstanding, and as noted above, the Hospital has had success in connection with appealing and reversing RAC findings of error. This strongly suggests that the Hospital's internal controls are fully operational, highly effective, and comport with applicable laws, regulations and agency guidance.

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On behalf of St. Vincent, we thank you in advance for your consideration of our position and stated concerns. We will make ourselves available to you in the event that you have any questions or require further information.

Sincerely,

Steve Loveless
President and CEO

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