Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF MERCY HOSPITAL IN SAINT LOUIS 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

March 2015
A-07-14-05057

Office of Inspector General

http://oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Mercy Hospital in Saint Louis did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately $329,000 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 Mercy Hospital in Saint Louis (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 979-bed acute care hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately $227 million for 17,599 inpatient and 183,797 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered $6,096,388 in Medicare payments to the Hospital for 205 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 163 inpatient and 42 outpatient claims. Of the 205 claims, 196 claims had dates of service in CY 2011 or CY 2012, and 9 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010 or CY 2013.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 151 of the 205 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 54 claims, resulting in overpayments of $329,054 for CYs 2011 and 2012 (48 claims) and CYs 2010 and 2013 (6 claims). Specifically, 40 inpatient claims

had billing errors, resulting in overpayments of $206,051, and 14 outpatient claims had billing errors, resulting in overpayments of $123,003. 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 $329,054, consisting of $206,051 in overpayments for 40 incorrectly billed inpatient claims and $123,003 in overpayments for 14 incorrectly billed outpatient 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 our findings for 52 of the 54 claims that we identified as having been billed in error, and described corrective actions that it had taken or planned to take to further enhance and strengthen its controls.

Regarding four inpatient claims in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services, the Hospital disagreed with our findings for two of these claims but added that, "in the interest of expeditiously resolving this matter," it would not further appeal.

After reviewing the Hospital's comments, we maintain that all of our findings and the associated recommendations remain valid. We used Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether the 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. Based on the contractor's conclusion, we determined, and continue to believe, that the Hospital should have billed the inpatient claims as outpatient or outpatient with observation services.

TABLE OF CONTENTS

INTRODUCTION 1

Why We Did This Review 1

Objective 1

Background 1
The Medicare Program 1
Hospital Inpatient Prospective Payment System 1
Hospital Outpatient Prospective Payment System 1
Hospital Claims at Risk for Incorrect Billing 2
Medicare Requirements for Hospital Claims and Payments 2
Mercy Hospital in Saint Louis 3

How We Conducted This Review 3

FINDINGS 3

Billing Errors Associated With Inpatient Claims 4
Unsupported Codes 4
Incorrectly Billed as Separate Inpatient Stays 4
Incorrectly Billed as Inpatient 5
Manufacturer Credits for Replaced Medical Devices Not Reported 5
Unsupported Charges 6

Billing Errors Associated With Outpatient Claims 6
Manufacturer Credits for Replaced Medical Devices Not Reported 6
Services Not Billable to Medicare 7

RECOMMENDATIONS 7

AUDITEE COMMENTS 7

OFFICE OF INSPECTOR GENERAL RESPONSE 7

APPENDIXES

A: Audit Scope and Methodology 8

B: Results of Review by Risk Area 10

C: Auditee Comments 11

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 Mercy Hospital in Saint Louis (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 DRG verification,
- inpatient claims billed with high severity level DRG codes,
- inpatient same-day discharges and readmissions,
- inpatient short stays,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims billed with cancelled elective surgical procedures,
- inpatient claims with payments greater than $150,000,
- inpatient claims paid in excess of charges,
- outpatient claims billed with dental services,
- outpatient claims billed with Doxorubicin Hydrochloride,
- outpatient claims with payments greater than $25,000,
- outpatient surgeries billed with units greater than one, 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

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

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).

Mercy Hospital in Saint Louis

The Hospital is a 979-bed acute care hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately $227 million for 17,599 inpatient and 183,797 outpatient 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 $6,096,388 in Medicare payments to the Hospital for 205 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 163 inpatient and 42 outpatient claims. Of the 205 claims, 196 claims had dates of service in CY 2011 or CY 2012, and 9 claims had dates of service in CY 2010 or CY 2013.[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 151 of the 205 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 54 claims, resulting in overpayments of $329,054 for CYs

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

2011 and 2012 (48 claims) and CYs 2010 and 2013 (6 claims). Specifically, 40 inpatient claims had billing errors, resulting in overpayments of $206,051, and 14 outpatient claims had billing errors, resulting in overpayments of $123,003. 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 40 of 163 selected inpatient claims that we reviewed. These errors resulted in overpayments of $206,051.

Unsupported 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 18 out of 163 selected claims, the Hospital billed Medicare with incorrectly coded claims. Specifically, certain diagnosis codes and procedure codes were not supported in the medical records. The Hospital stated that it believed there were three primary reasons for the errors:

- the extensive changes underway with the coding function across the Mercy group of hospitals at the time these accounts were coded;
- simple human error; and
- the weights assigned to errors in the Hospital's auditing process that impacted DRG assignment may not have been high enough.

As a result of these errors, the Hospital received overpayments of $126,196.

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states:

> When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 10 out of 163 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital stated that the care

management leaders' understanding of this regulation had evolved over time. As a result of these errors, the Hospital received overpayments of $33,908.

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 4 out of 163 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 disagreed with our findings for two of the four claims and stated that it believed the services provided were reasonable and necessary. However, the Medicare administrative contractor found that the Hospital had incorrectly billed based on medical necessity. As a result of these errors, the Hospital received estimated overpayments of $28,520.[3]

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 7 out of 163 selected claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate condition and value

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

codes to reduce payments as required. (Of the seven claims, one had a date of service in CY 2010, two had dates of service in CY 2012, and four had dates of service in CY 2013.) The Hospital stated that in its judgment the Medicare regulations are open to interpretation. As a result of these errors, the Hospital received overpayments of $15,923.

Unsupported Charges

The Act states: "[N]o such payments shall be made to any provider unless it has furnished such information … in order to determine the amounts due such provider … for the period with respect to which the amounts are being paid…." (§ 1815(a)).

For 1 out of 163 selected claims, the Hospital billed Medicare with unsupported charges, resulting in a higher outlier payment than was warranted. For this claim, the Hospital billed for a medication whose use was not supported by the medical records. The Hospital stated that the overpayment was the result of human error. As a result of this error, the Hospital received an overpayment of $1,504.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 14 of 42 selected outpatient claims that we reviewed. These errors resulted in overpayments of $123,003.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45). For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier "FB" and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than $1 for the device.[4]

For 10 out of 42 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 10 claims, 1 had a date of service in CY 2010, 6 had dates of service in CY 2011, and 3 had dates of service in CY 2012.) The Hospital stated that in its judgment the Medicare regulations are open to interpretation. As a result of these errors, the Hospital received overpayments of $121,108.

[4] CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

Services Not Billable to Medicare

Medicare payments may not be made for items or services "… where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth…." (the Act, § 1862(a)(12)).

For 4 out of 42 selected claims, the Hospital incorrectly billed Medicare for services related to the removal of teeth. The Hospital stated that it believed that it had adequate controls in place prior to our audit, but had since determined that a more collaborative review on its part would reduce the errors in this type of claim. As a result of these errors, the Hospital received overpayments of $1,895.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $329,054, consisting of $206,051 in overpayments for 40 incorrectly billed inpatient claims and $123,003 in overpayments for 14 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 agreed with our findings for 52 of the 54 claims that we identified as having been billed in error, and described corrective actions that it had taken or planned to take to further enhance and strengthen its controls.

Regarding the four inpatient claims in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services, the Hospital disagreed with our findings for two of these claims but added that, "in the interest of expeditiously resolving this matter," it would not further appeal.

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 the associated recommendations remain valid. We used Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether the 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. Based on the contractor's conclusion, we determined, and continue to believe, that the Hospital should have billed the inpatient claims as outpatient or outpatient with observation services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $6,096,388 in Medicare payments to the Hospital for 205 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 163 inpatient and 42 outpatient claims. Of the 205 claims, 196 claims had dates of service in CY 2011 or CY 2012, and 9 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010 or CY 2013 (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 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 from January 2014 to September 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 2011 and 2012;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2010 through 2013;
- 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 205 claims (163 inpatient and 42 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;

- used Wisconsin Physicians Service Insurance Corporation (the 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 September 19, 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				
Diagnosis-Related-Group Verification	49	$1,021,509	9	$66,366
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	65	1,660,735	9	59,830
Same-Day Discharges and Readmissions	12	165,313	10	33,908
Short Stays	8	76,886	3	24,418
Manufacturer Credits for Replaced Medical Devices	8	174,207	7	15,923
Claims Billed With Cancelled Elective Surgical Procedures	3	16,494	1	4,102
Claims With Payments Greater Than $150,000	11	2,580,285	1	1,504
Claims Paid in Excess of Charges	7	86,447	0	0
Inpatient Totals	**163**	**$5,781,876**	**40**	**$206,051**
Outpatient				
Manufacturer Credits for Replaced Medical Devices	15	$200,655	10	$121,108
Claims Billed With Dental Services	9	17,958	4	$1,895
Claims Billed With Doxorubicin Hydrochloride	16	57,147	0	$0
Claims With Payments Greater Than $25,000	1	26,085	0	$0
Claims Billed With Modifiers	1	12,667	0	$0
Outpatient Totals	**42**	**$314,512**	**14**	**$123,003**
Inpatient and Outpatient Totals	**205**	**$6,096,388**	**54**	**$329,054**

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

Mercy

Tony M. Krawat
Vice President – Chief Compliance & Privacy Officer
Mercy
14528 S. Outer Forty
Suite 100
Chesterfield, MO 63017

January 30, 2015

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

Re: Audit Number A-07-14-05057

Dear Mr. Cogley:

Mercy Hospital St. Louis ("MHSL") appreciates the 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 Mercy Hospital in Saint Louis for 2011 and 2012".*

The objective of this review was to determine whether MHSL complied with Medicare requirements for billing inpatient and outpatient services on selected claims. The audit covered $6,096,388 in Medicare payments to MHSL for 205 claims that the OIG judgmentally selected as potentially at risk for billing errors. These claims consisted of 163 inpatient and 42 outpatient claims. Of the 205 claims, 196 claims had dates of service in CY 2011 or CY 2012, and nine claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010 or CY 2013.

Of these claims sampled, the OIG had findings related to 54 claims where it indicates MHSL received $329,054 in overpayments for CYs 2011 and 2012 (48 claims) and CYs 2010 and 2013 (6 claims). Specifically, there are 40 inpatient claims where the OIG indicates billing errors resulted in an overpayment of $206,051, and 14 outpatient claims where the OIG indicates billing errors resulted in an overpayment of $123,003.

MHSL responds to the OIG's Compliance Review report as follows:

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Unsupported Codes

The OIG audit reviewed 49 claims to validate the appropriate assignment of the DRG (Sample Items "I"). Of these 49 claims reviewed, the OIG reports findings with nine. Additionally, the OIG Audit reviewed 65 claims to validate the appropriate coding of MCCs or CCs (Sample Items "J"), which impact the determination of the assigned DRG. Of these 65 claims reviewed the OIG reports findings with nine. We agree with these findings which resulted in an overpayment of $126,196. In addition to our previously established controls, MHSL has taken the following corrective action:

- Our coders are now required to route all Medicare accounts with only one CC or MCC to a "second review" work queue. During this second review process, a select group of coders with specialized training and experience review the account to verify that the CC or MCC is supported by the documentation in the medical record.
- Our coders are also now required to route all Medicare accounts with DRGs 981 (Extensive O.R. Procedure Unrelated to Principal Diagnosis w MCC) or 982 (Extensive O.R. Procedure Unrelated to Principal Diagnosis w CC) to the same "second review" work queue discussed above.
- We are also exploring the potential within our electronic medical record system to automate the routing of these accounts to the "second review" work queue.
- We continue to refresh our on-going coding education.

Incorrectly Billed as Separate Inpatient Stays

The OIG audit reviewed 12 claims for services provided to patients who were discharged and readmitted to MHSL on the same day (Sample Items "G"). The OIG notes that the *Medicare Claims Processing Manual* states:

> When a patient is discharged/transferred from an acute care Prospective Payment System ("PPS") hospital and is readmitted to the same acute care PPS on the same day for the same symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For ten of these 12 selected claims, the OIG reports findings that MHSL billed Medicare separately for related discharges and readmissions that occurred within the same day, resulting in an overpayment of $33,908. MHSL agrees with this finding. In addition to our previously established controls, MHSL has taken the following corrective action:

- Established new logic in our electronic medical record that routes any patient with a discharge and same day readmission to a work queue for review. A co-worker from the Care Management Department reviews the two claims, determines if they are related and if so the claims are combined. A physician advisor assists in the review as necessary and appropriate to support an accurate determination.
- Centralized and reorganized our Utilization Review/Management functions to improve access to resources and optimize support for front-line staff.
- Expanded use of third-party physician reviewers who are experts in the Medicare regulations and who are available to assist and guide front-line co-workers making billing determinations.

Incorrectly Billed as Inpatient

The OIG audit selected eight Short Stay claims (Sample Items "H") and requested these be reviewed by the Medicare Audit Contractor ("MAC"). For four of these eight claims, the MAC found that MHSL incorrectly billed Medicare Part A for a beneficiary stay that should have been billed as outpatient or outpatient with observation services. The OIG finds that as a result, MHSL received estimated overpayments of $28,520. The OIG notes that MHSL 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. Additionally, the OIG notes that they

are 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 MAC before the issuance of this draft report.

MHSL agrees with two out of the four findings and disagrees with the findings on the remaining two. Although MHSL continues to disagree with the two findings, in the interest of expeditiously resolving this matter, MHSL has chosen not to further appeal. It is worthy of note that the regulatory requirements pertinent to Short Stay claims has undergone significant evolution since the account service dates involved with this audit. Specifically, implementation of the Two-Midnight Rule occurred subsequent to the submission of these claims. MHSL has undertaken the following steps to comply with the new Two-Midnight Rule regulations:

- Continued engagement of a nationally recognized, third-party physician advisory group to serve as a resource to our co-workers for assistance determining whether or not a patient has met criteria for inpatient admission.
- Enhanced physician education regarding these criteria, including emphasis on documentation requirements.
- Utilization Review/Management Committees meet regularly to provide leadership and guidance to the organization regarding these regulations.
- Enhanced recurring co-worker education.

Manufacturer Credits for Replaced Medical Devices Not Reported

The OIG audit selected eight claims involving medical device credits on inpatient records (Sample Items "L"). The audit finds that for seven of the eight claims, MHSL 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. MHSL contends that its interpretation of the complex regulations surrounding how to calculate these medical device credits is a correct interpretation. However, having now heard OIG's interpretation of the calculation methodology intended by the regulations we acknowledge that the methodology used by the OIG is a reasonable alternative interpretation of how these credits are to be calculated, and we concur with the OIG's findings on this item. In addition to our previously established controls, MHSL has taken the following corrective action:

- Modified the method used to calculate how medical device credits are calculated to be consistent with the guidance recommended by the OIG auditors.
- Established a process with our largest medical device supplier whereby they provide us with a monthly email which lists all the patients who received a device which included a medical device credit provided to MHSL. We are also pursuing this option with other medical device suppliers as a way to supplement our internal processes to accurately identify each time we receive a device credit.

Unsupported Charges

The OIG audit selected 11 claims involving inpatient accounts with reimbursement greater than $150,000 (Sample Items "B"). Regarding one record with a 112 day length of stay the OIG finds two medication charging errors with an overpayment determination of $1504.13. MHSL concurs with this finding. In addition to our previously established controls, MHSL has taken the following corrective action:

- We continue to reinforce our existing processes with nursing staff to support accurate charging.

- Mercy currently has a multi-year project underway whereby all of our hospitals are being converted to a methodology where pharmaceuticals are charged upon administration to the patient versus charged upon dispensing from the pharmacy. Unless a currently unforeseen barrier develops, MHSL should be converted to this method by the end of October 2015.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Manufacturer Credits for Replaced Medical Devices Not Reported

The OIG audit selected 15 claims involving medical device credits on outpatient records (Sample Items "L"). The audit finds that for 10 of the 15 claims, MHSL received reportable medical device credits from manufacturers but did not adjust its outpatient claims with the appropriate modifier and reduce charges as required. MHSL contends that its interpretation of the complex regulations surrounding how to calculate these medical device credits is a correct interpretation. However, having now heard OIG's interpretation of the calculation methodology intended by the regulations we acknowledge that the methodology used by the OIG is a reasonable alternative interpretation of how these credits are to be calculated, and we concur with the OIG's findings on this item. In addition to our previously established controls, MHSL has taken the following corrective action:

- Modified the method used to calculate how medical device credits are calculated to be consistent with the guidance recommended by the OIG auditors.
- Established a process with our largest medical device supplier to provide us with a monthly email which lists all the patients that have received a medical device for which a credit was provided to MHSL. We are also pursuing this option with other medical device suppliers as a way to supplement our internal processes to accurately identify each time we receive a device credit.

Services Not Billable to Medicare

The OIG audit selected nine outpatient dental claims for review (Sample Items "D"). For four claims, the OIG notes findings related to medically unnecessary services billed to Medicare related to teeth removal, resulting in an overpayment of $1,895. We concur with these findings. MHSL determined we need more assistance from a physician advisor (dentist) when determining whether or not these services can be appropriately billed to Medicare. In addition to our previously established controls, MHSL has taken the following corrective action:

- We are now reviewing 100% of MHSL's outpatient dental claims prior to billing.
- We have identified a dentist who is willing to serve as a physician advisor to assist our compliance staff with understanding the clinical complexities related to these services. With this assistance, we believe we can more accurately determine when it is appropriate to bill.

In closing, please know that MHSL has a strong commitment to compliance. We continually work to create and maintain a culture in which all individuals in the MHSL community strive to do the right thing and feel empowered to raise concerns, ask questions, and obtain answers through a collaborative, multi-disciplinary and cooperative process. We have appreciated the opportunity to learn from this audit process as we strive to be in full compliance with CMS

regulations. Please share our thanks with Doug Kelly, Senior Auditor, and his team for their professionalism and assistance provided throughout this audit process.

If you have any questions or need further information, please do not hesitate to contact me.

Sincerely,

Tony M. Krawat
Vice President
Chief Compliance & Privacy Officer
Mercy Health

Mercy continues the tradition of the Sisters of Mercy in meeting community health needs across a seven state area.