Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF SAINT ANTHONY'S MEDICAL CENTER 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

May 2015
A-07-14-05059

Office of Inspector General

http://oig.hhs.gov/

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EXECUTIVE SUMMARY

Saint Anthony's Medical Center did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately $309,000 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 Saint Anthony's Medical Center (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

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

The Hospital is a 767-bed acute care hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately $195 million for 158,777 outpatient and 18,441 inpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered $4,598,820 in Medicare payments to the Hospital for 262 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 40 outpatient and 222 inpatient claims. Of the 262 claims, 251 claims had dates of service in CY 2011 or CY 2012, and 11 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 209 of the 262 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 53 claims, resulting in overpayments of $308,853 for CYs 2011 and 2012 (49 claims) and CY 2010 (4 claims). Specifically, 30 outpatient claims had billing errors, resulting in overpayments of $190,805, and 23 inpatient claims had billing errors,

resulting in overpayments of $118,048. 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 $308,853, consisting of $190,805 in overpayments for 30 incorrectly billed outpatient claims and $118,048 in overpayments for 23 incorrectly billed inpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

Prompted by our review, the Hospital has initiated or completed claims adjustments or cancellation on certain claims.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital described corrective actions that it had taken, including correcting and rebilling claims, to implement our recommendations. The Hospital also described corrective actions that it had taken to further enhance and strengthen its controls.

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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 Saint Anthony's Medical Center (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

The Medicare Program

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

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

Hospital Outpatient Prospective Payment System

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

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

[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 claims billed with Herceptin,
- outpatient claims billed with modifiers,
- outpatient and inpatient claims paid in excess of charges,
- outpatient claims with payments greater than $25,000,
- outpatient claims with surgeries billed with units greater than one,
- inpatient DRG verification,
- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims billed with kyphoplasty services,
- inpatient claims with payments greater than $150,000, and
- inpatient claims billed with cancelled elective surgical procedures.

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).

Saint Anthony's Medical Center

The Hospital is a 767-bed acute care hospital located in Saint Louis, Missouri. Medicare paid the Hospital approximately $195 million for 158,777 outpatient and 18,441 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 $4,598,820 in Medicare payments to the Hospital for 262 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 40 outpatient and 222 inpatient claims. Of the 262 claims, 251 claims had dates of service in CY 2011 or CY 2012, and 11 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 13 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 209 of the 262 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 53 claims, resulting in overpayments of $308,853 for CYs 2011 and 2012 (49 claims) and CY 2010 (4 claims). Specifically, 30 outpatient claims had billing errors, resulting in overpayments of $190,805, and 23 inpatient claims had billing errors, resulting in overpayments of $118,048. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

[2] We selected these 11 claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 30 of 40 selected outpatient claims that we reviewed. These errors resulted in overpayments of $190,805.

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 8 out of 40 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 eight claims, one had a date of service in CY 2010, four had dates of service in CY 2011, and three had dates of service in CY 2012.) The Hospital said that these overpayments occurred because of a weakness in its controls, specifically with the communication of information on medical device credits to the departments that should have ensured that claims were appropriately billed and adjusted. As a result of these errors, the Hospital received overpayments of $118,522.

Incorrect Number of Units

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

The Manual states: "It is … of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug … that was used in the care of the patient" (chapter 17, § 90.2.A). If the provider is billing for a drug, according to the Manual, "[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4.…" (chapter 17, § 70). The Manual also states: "Multi-use vials are not subject to payment for discarded amounts of drug…." (chapter 17, § 40).

[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 20 out of 40 selected claims, the Hospital billed Medicare for incorrect numbers of units of an administered medication (Herceptin).[4] These overpayments occurred because the Hospital's electronic billing system incorrectly assigned charges for entire vials of this medication instead of charging for just the actual administered doses. As a result of these errors, the Hospital received overpayments of $52,149.

Insufficiently Documented Modifier

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 1 out of 40 selected claims, the Hospital submitted the claim to Medicare with an unnecessary modifier. The Hospital attributed the overpayment to coder error. As a result of this error, the Hospital received an overpayment of $17,739.

Insufficiently Documented Procedure

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 1 out of 40 selected claims, the Hospital submitted the claim to Medicare with a procedure code that was unsupported in the medical record. The Hospital attributed the overpayment to coder error. As a result of this error, the Hospital received an overpayment of $2,395.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 23 of 222 selected inpatient claims that we reviewed. These errors resulted in overpayments of $118,048.

Insufficiently Documented Procedures

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 14 out of 222 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain procedure and diagnosis codes were not supported in the medical records. The Hospital attributed the overpayments to coder errors. As a result of these errors, the Hospital received overpayments of $60,607.

[4] Herceptin, also known as trastuzumab, is a Medicare-covered drug used to treat breast cancer that has spread to other parts of the body.

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 5 out of 222 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 stated that these overpayments occurred because of a weakness in the process of reviewing inpatient orders prior to patient discharge, a process that should have ensured that beneficiary stays that were billed as impatient claims in fact qualified for inpatient status. As a result of these errors, the Hospital received estimated overpayments of $40,641.[5]

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 4 out of 222 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 four claims, three had dates of service in CY 2010 and one had a date of service in CY 2011.) The Hospital said that these overpayments occurred because of a weakness in its controls, specifically with the communication of information on

[5] 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.

medical device credits to the departments that should have ensured that claims were appropriately billed and adjusted. As a result of these errors, the Hospital received overpayments of $16,800.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $308,853, consisting of $190,805 in overpayments for 30 incorrectly billed outpatient claims and $118,048 in overpayments for 23 incorrectly billed inpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

Prompted by our review, the Hospital has initiated or completed claims adjustments or cancellation on certain claims.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital described corrective actions that it had taken, including correcting and rebilling claims, to implement our recommendations. The Hospital also described corrective actions that it had taken to further enhance and strengthen its controls. The Hospital's comments appear in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $4,598,820 in Medicare payments to the Hospital for 262 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 40 outpatient and 222 inpatient claims. Of the 262 claims, 251 claims had dates of service in CY 2011 or CY 2012, and 11 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010 (footnote 2).

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 13 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 February 2014 to January 2015.

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 262 claims (40 outpatient and 222 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 Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether 13 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 January 8, 2015.

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	10	$144,331	8	$118,522
Claims Billed With Herceptin	20	231,189	20	52,149
Claims Billed With Modifiers	5	90,715	1	17,739
Claims Paid in Excess of Charges	3	16,550	1	2,395
Claims With Payments Greater Than $25,000	1	35,755	0	0
Surgeries Billed With Units Greater Than One	1	3,491	0	0
Outpatient Totals	**40**	**$522,031**	**30**	**$190,805**
Inpatient				
Diagnosis-Related-Group Verification	109	$1,827,106	9	$40,493
Short Stays	12	117,650	4	33,159
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	75	1,271,820	5	20,114
Manufacturer Credits for Replaced Medical Devices	10	103,859	4	16,800
Claims Billed With Kyphoplasty Services	1	7,482	1	7,482
Claims With Payments Greater Than $150,000	3	621,882	0	0
Claims Paid in Excess of Charges	6	81,195	0	0
Claims Billed With Cancelled Elective Surgical Procedures	6	45,795	0	0
Inpatient Totals	**222**	**$4,076,789**	**23**	**$118,048**
Outpatient and Inpatient Totals	**262**	**$4,598,820**	**53**	**$308,853**

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

ST. Anthony's

April 8, 2015

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

Subject: **OIG Report Number: A-07-14-05059**
St. Anthony's Medical Center, St. Louis

Dear Mr. Cogley:

We are in receipt of the Office of Inspector General's (OIG) draft report titled *Medicare Compliance Review of Saint Anthony's Medical Center for 2011 and 2012* dated March 2015.

St. Anthony's response to the identified claims and corresponding plans of correction are detailed below.

* * * * *

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Manufacturer Credits for Replaced Medical Devices Not Reported

OIG Findings: For 8 out of 40 selected claims, the Hospital received a full credit for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims. As a result of these errors, the Hospital received overpayments of $118,522.

Hospital Response:

- St. Anthony's did not include the FB modifiers and adjust outpatient claims with the appropriate value and condition codes to reduce payment for medical device credits. The claims were resubmitted with the correct modifier upon identification of the error.
- St. Anthony's identified a weakness in its communications regarding medical device credits to the proper departments in order to ensure claims are appropriately billed and adjusted. A process to strengthen controls and ensure communication and proper billing of medical device claims and credits has been implemented. St. Anthony's is reviewing medical device credits to ensure they were correctly billed and adjusted.

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Incorrect Number of Units

OIG Findings: For 20 of 40 selected claims, the Hospital billed Medicare for incorrect numbers of units of an administered medication (Herceptin). As a result of these errors, the Hospital received overpayments of $52,149.

Hospital Response:

- In 2011 and 2012, the Hospital's electronic billing system incorrectly assigned charges for entire vials of the medication instead of charging only for the actual administered doses. The claims were resubmitted upon identification of the error.

- Since that time, the Hospital implemented a new software program that correctly assigns a charge based upon the dose administered. St. Anthony's is reviewing Herceptin claims submitted before and after the software change to ensure they were correctly billed.

Insufficiently Documented Modifier

OIG Findings: For 1 out of 40 selected claims, the Hospital submitted the claim to Medicare with an unnecessary modifier. As a result of this error, the Hospital received an overpayment of $17,739.

Hospital Response:

- This random error resulted from the inadvertent assigning an unnecessary modifier.

- This claim was corrected and resubmitted once the error was identified. All coders receive comprehensive education and training on proper coding procedures upon hire and periodically throughout their employment. Claims are subject to periodic internal and external audits, and any errors identified are corrected and the claims rebilled. Based upon the results of these audits, the coders receive specific and tailored education and training.

Insufficiently Documented Procedure

OIG Findings: For 1 out of 40 selected claims, the Hospital submitted the claim to Medicare with a procedure code that was unsupported in the medical record. As a result of this error, the Hospital received an overpayment of $2,395.

Hospital Response:

- This random error resulted from the inadvertent assigning of an incorrect code.

- This claim was corrected and resubmitted once the error was identified. All coders receive comprehensive education and training on proper coding procedures upon hire and periodically throughout their employment. St. Anthony's claims are subject to periodic internal and external audits, and any errors identified are corrected and the claims

rebilled. Based upon the results of these audits, the coders receive specific and tailored education and training.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Insufficiently Documented Procedures

OIG Findings: For 14 out of 222 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain procedure and diagnosis codes were not supported in the medical records. As a result of these errors, the Hospital received overpayments of $60,607.

Hospital Response:

- These random errors resulted from incorrectly coding secondary diagnoses.
- The claims identified as incorrect were corrected and resubmitted upon identification of the error. All coders receive comprehensive education and training on proper coding procedures upon hire and periodically throughout their employment. St. Anthony's claims are subject to periodic internal and external audits, and any errors identified are corrected and the claims rebilled. Based upon the results of these audits, the coders receive specific and tailored education and training.

Incorrectly Billed as Inpatient

OIG Findings: For 5 out of 222 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. As a result of these errors the Hospital received overpayments of $40,641.

Hospital Response:

- St. Anthony's has had controls in place to review inpatient orders prior to patient discharge to ensure inpatient claims qualified for inpatient status. As weaknesses in that process were identified, improvements were made, including concurrent on-site physician review. These claims were corrected and resubmitted once the errors were identified. 100% of inpatient claims with a length of stay less than 48 hours are audited for clinical documentation to support inpatient status. Claims that do not meet criteria for inpatient status are billed as outpatient.

Manufacturer Credits for Replaced Medical Devices Not Reported

OIG Findings: For 4 out of 222 selected claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate condition and value codes to reduce payment as required. As a result of these errors, the Hospital received overpayments of $16,800.

Hospital Response:

- St. Anthony's did not include the FB modifiers and adjust inpatient claims with the appropriate value and condition codes to reduce payment for medical device credits. The claims were resubmitted with the correct modifier upon identification of the error.

- St. Anthony's identified a weakness in its communications regarding medical device credits to the proper departments in order to ensure claims are appropriately billed and adjusted. A process to strengthen controls and ensure communication and proper billing of medical device claims and credits has been implemented. St. Anthony's is reviewing medical device credits to ensure they were correctly billed and adjusted.

St. Anthony's is committed to a culture of ethics and integrity, in which compliance with all Medicare standards is a priority. We will continue to provide ongoing education, auditing and monitoring to ensure adherence to the appropriate processes and standards. If you have any questions regarding the information contained herein, please do not hesitate to contact me.

Respectfully submitted,

Kelly M. Schmidt

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