Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT SURGERIES BILLED BY HAZEL HAWKINS MEMORIAL HOSPITAL

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

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Office of Inspector General

https://oig.hhs.gov

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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

Hazel Hawkins Memorial Hospital did not comply with Medicare requirements for billing outpatient surgeries, resulting in overpayments of approximately $366,000 over more than 2 years.

WHY WE DID THIS REVIEW

For calendar year (CY) 2012, Medicare paid hospitals $148 billion, which represented 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. Using computer matching, data mining, and data analysis techniques, we identified hospital claims for outpatient surgeries that were at risk for noncompliance with Medicare billing requirements because they were billed with units of service greater than one, indicating that the surgeries may have been performed multiple times.

Our objective was to determine whether Hazel Hawkins Memorial Hospital (the Hospital) complied with Medicare requirements for billing outpatient surgeries on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification. 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: "The definition of service units … is the number of times the service or procedure being reported was performed" (chapter 4, § 20.4).

The Hospital is an acute-care hospital located in Hollister, California. Medicare paid the Hospital approximately $6.3 million for 37,092 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012.

Our audit covered $650,217 in Medicare payments to the Hospital for 141 outpatient claims for surgeries billed with units greater than 1. Initially, we judgmentally selected 92 claims as potentially at risk for billing errors. On the basis of our finding, the Hospital identified an additional 49 claims for our review. Of the 141 claims, 134 claims had dates of service in CYs 2011 or 2012, and 7 claims had dates of service in CY 2013.

WHAT WE FOUND

The Hospital did not comply with Medicare billing requirements for all 141 of the outpatient surgery claims that we reviewed, resulting in overpayments of $366,054. Specifically, the Hospital billed Medicare with an incorrect number of units for cataract and other surgeries. These errors occurred because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare for service units on outpatient surgery claims.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor $366,054 in overpayments for the 141 incorrectly billed outpatient claims and

- strengthen controls to ensure full compliance with Medicare requirements for billing outpatient surgeries.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our finding and provided information on actions that it had taken to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

For calendar year (CY) 2012, Medicare paid hospitals $148 billion, which represented 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. Using computer matching, data mining, and data analysis techniques, we identified hospital claims for outpatient surgeries that were at risk for noncompliance with Medicare billing requirements because they were billed with units of service greater than one, indicating that the surgeries may have been performed multiple times.

OBJECTIVE

Our objective was to determine whether Hazel Hawkins Memorial Hospital (the Hospital) complied with Medicare requirements for billing outpatient surgeries on selected claims.

BACKGROUND

The Medicare Program

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.

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, payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)).

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

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). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Hazel Hawkins Memorial Hospital

The Hospital is an acute-care hospital located in Hollister, California. Medicare paid the Hospital approximately $6.3 million for 37,092 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $650,217 in Medicare payments to the Hospital for 141 outpatient claims for surgeries billed with units greater than 1. Initially, we judgmentally selected 92 claims as potentially at risk for billing errors. On the basis of our finding, the Hospital identified an additional 49 claims for our review. Of the 141 claims, 134 claims had dates of service in CYs 2011 or 2012, and 7 claims had dates of service in CY 2013.

We limited our review to the line items on the 141 claims for which the Hospital billed outpatient surgeries. We evaluated compliance with selected billing requirements but did not use medical review to determine whether the services were medically necessary. This report 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 audit scope and methodology.

FINDING

The Hospital did not comply with Medicare billing requirements for all 141 of the outpatient surgery claims that we reviewed, resulting in overpayments of $366,054. Specifically, the Hospital billed Medicare with an incorrect number of units for cataract and other surgeries. These errors occurred because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare for service units on outpatient surgery claims.

THE HOSPITAL BILLED THE INCORRECT NUMBER OF UNITS FOR OUTPATIENT SURGERIES

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 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). In addition, the Manual states: "The definition of service units … is the number of times the service or procedure being reported was performed" (chapter 4, § 20.4).

For all 141 claims that we reviewed, the Hospital billed Medicare with an incorrect number of units for outpatient surgeries:[2]

- For 108 claims, the Hospital billed cataract surgeries with multiple units per beneficiary visit.

- For 33 claims, the Hospital billed other surgical procedures, such as joint surgeries, with multiple units per beneficiary visit.

However, in each case, only one unit of service was performed. As a result of these errors, the Hospital received overpayments of $366,054.[3]

THE HOSPITAL DID NOT HAVE ADEQUATE CONTROLS TO PREVENT INCORRECT BILLING

The billing errors occurred because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare for service units on outpatient surgery claims. Specifically, the Hospital stated that it relied on edits in its claims processing system to identify potential billing errors for review. The claims processing system lacked edits to identify outpatient surgeries billed with the incorrect number of units. As a result, the Hospital submitted these claims to Medicare for processing without review and revision by the billing department.

[2] For one claim, in addition to billing the incorrect number of units, the Hospital billed for an outpatient surgery when the beneficiary was not entitled to outpatient benefits. The incorrect billing resulted in an overpayment of $2,457.

[3] Initially, we judgmentally selected 92 claims for review and identified overpayments of $132,582. On the basis of our finding, the Hospital identified an additional 49 claims for our review. We reviewed the 49 claims and identified additional overpayments of $233,472.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $366,054 in overpayments for the 141 incorrectly billed outpatient claims and

- strengthen controls to ensure full compliance with Medicare requirements for billing outpatient surgeries.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our finding and provided information on actions that it had taken to address our recommendations. The Hospital's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $650,217 in Medicare payments to the Hospital for 141 outpatient claims for surgeries billed with units greater than 1. Initially, we judgmentally selected 92 claims as potentially at risk for billing errors. On the basis of our finding, the Hospital identified an additional 49 claims for our review. Of the 141 claims, 134 claims had dates of service in CYs 2011 or 2012, and 7 claims had dates of service in CY 2013.

We limited our review to the line items on the 141 claims for which the Hospital billed outpatient surgeries. We evaluated compliance with selected billing requirements but did not use 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 line items for outpatient surgeries 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 CMS's National Claims History file, but we did not assess the completeness of the file.

This report does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork from February 2013 to January 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient paid claim data from CMS's National Claims History file for CYs 2011 and 2012;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected for detailed review 141 outpatient claims for surgeries billed with units greater than 1, consisting of 92 claims that we initially selected as potentially at risk for billing errors and 49 claims that the Hospital identified on the basis of our finding;[4]
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;

[4] The 92 claims that we initially selected had dates of service in CYs 2011 and 2012. The 49 claims that the Hospital identified had dates of service in CYs 2011, 2012, and 2013.

- 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;

- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;

- discussed the incorrectly billed claims with Hospital officials to determine the underlying causes of noncompliance with Medicare requirements;

- calculated the correct payments for all 141 claims; and

- discussed the results of our review with Hospital officials.

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: HOSPITAL COMMENTS

Hazel Hawkins
MEMORIAL HOSPITAL
SKILLED NURSING FACILITIES
HOME HEALTH AGENCY
San Benito Health Care District

San Benito Health Care District
A Public Agency
911 Sunset Drive
Hollister, CA 95023-5695
(831) 637-5711

FROM: Kristen templeton
Director of Patient Accounting
Hazel Hawkins Memorial Hospital
911 Sunset Drive
Hollister, CA 95023

TO: Lori A Ahlstrand
Regional Inspector General for Audit services
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

RE: Review of Outpatient Surgeries Billed by Hazel Hawkins Memorial Hospital
Report Number: A-09-13-02053

Lori Ahlstrand:

This is in response to your letter dated June 17, 2014 pertaining to the draft report titled Review of Outpatient Surgeries Billed by Hazel Hawkins Memorial Hospital.

Summary of Findings:

The OIG audited 92 claims with possible billing errors of units on surgery claims. Hazel Hawkins Memorial Hospital identified an additional 49 claims with possible billing error of units on surgery claims. Out of the total 141 outpatient surgery the hospital concurs that all outpatient surgeries were billed with the incorrect units of service.

Recommendation #1:

The hospital refund Medicare $366,054.00 in over payments for the 141 outpatient claims incorrectly billed. Hazel Hawkins Memorial Hospital has already rebilled Medicare the corrected claim and Medicare has recouped all of the $366,054.00 owed to them.

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Recommendation #2:

Hazel Hawkins Memorial Hospital strengthen controls to ensure full compliance with Medicare requirements for billing outpatient surgeries. The hospital has already put controls in place.

Corrective Action Plan:

The following are the controls Hazel Hawkins Memorial Hospital has put in place on February 2013 to monitor correct units billed for all outpatient surgical procedures:

1.) The hospital is having the third party vender flag all outpatient surgery claims with a 360 revenue code greater than 1 unit.
2.) The units on the outpatient surgery claim will be reviewed for correct units before the claim is billed to Medicare.
3.) The hospital will do ongoing internal audits to make sure that all outpatient surgery claims are billed with the correct units.

If you have any questions regarding our response please contact me at 831-636-2626 or E-mail me at ktempleton@hazelhawkins.com.

Sincerely,

Kristen Templeton

Kristen Templeton,
Director of Patient Accounting
Hazel Hawkins Memorial Hospital

CC: Mark Robinson, CFO, Hazel Hawkins Memorial Hospital