Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF DEPAUL HEALTH CENTER FOR 2012 AND 2013

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

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Office of Inspector General

http://oig.hhs.gov/

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EXECUTIVE SUMMARY

DePaul Health Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately $81,000 over 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 DePaul Health Center (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 476-bed hospital located in Bridgeton, Missouri. Medicare paid the Hospital approximately $165 million for 12,004 inpatient and 65,110 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

Our audit covered $3,612,869 in Medicare payments to the Hospital for 204 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 187 inpatient and 17 outpatient claims and had dates of service in CY 2012 or CY 2013.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 190 of the 204 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 14 claims (all of which were inpatient claims), resulting in overpayments of $81,352. The errors that we identified 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 $81,352 in overpayments for 14 incorrectly billed inpatient claims and

- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with all our findings and described corrective actions that it had taken or planned to take, including the processing of refunds, to implement our recommendations.

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INTRODUCTION

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OBJECTIVE

Our objective was to determine whether DePaul Health Center (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. 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 claims paid in excess of charges,
- inpatient claims billed with high severity level DRG codes,
- inpatient DRG verification,
- inpatient claims billed with cancelled elective surgical procedures,
- inpatient claims billed with elective admissions,
- inpatient claims billed with kyphoplasty services, and
- outpatient claims with payments greater than $25,000.

For the purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas." We reviewed these risk areas as part of this review.

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items or services that "… are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Social Security Act (the Act) § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

Federal regulations state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). In addition, the Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

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

DePaul Health Center

The Hospital is a 476-bed hospital located in Bridgeton, Missouri. Medicare paid the Hospital approximately $165 million for 12,004 inpatient and 65,110 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $3,612,869 in Medicare payments to the Hospital for 204 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 187 inpatient and 17 outpatient claims and had dates of service in CY 2012 or CY 2013. 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 did not use 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 190 of the 204 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 14 claims (all of which were inpatient claims), resulting in overpayments of $81,352. The errors that we identified 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 14 of 187 selected inpatient claims that we reviewed. These errors resulted in overpayments of $81,352.

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 14 out of 187 selected claims, the Hospital billed Medicare with incorrectly coded claims. Specifically, certain diagnosis codes or procedure codes were not supported in the medical records. The Hospital stated that these overpayments happened due to human error. As a result of these errors, the Hospital received overpayments of $81,352.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $81,352 in overpayments for 14 incorrectly billed inpatient claims and

- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with all our findings and described corrective actions that it had taken or planned to take, including the processing of refunds, to implement our recommendations.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $3,612,869 in Medicare payments to the Hospital for 204 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 187 inpatient and 17 outpatient claims and had dates of service in CY 2012 or CY 2013.

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 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 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 audit work from October 2014 to October 2015.

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 2012 and 2013;
- obtained information on a known credit for a replacement medical device from the device manufacturer for CY 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 204 claims (187 inpatient and 17 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;

- 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 November 18, 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
Inpatient				
Claims Paid in Excess of Charges	5	$128,088	3	$40,656
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	50	1,045,185	3	21,589
Diagnosis-Related-Group Verification	127	1,772,385	8	19,107
Claims Billed With Cancelled Elective Surgical Procedures	2	22,405	0	0
Claims Billed With Elective Admissions	2	13,063	0	0
Claims Billed With Kyphoplasty Services	1	7,764	0	0
Inpatient Totals	**187**	**$2,988,890**	**14**	**$81,352**
Outpatient				
Claims With Payments Greater Than $25,000	17	$623,979	0	$0
Outpatient Totals	**17**	**$623,979**	**0**	**$0**
Inpatient and Outpatient Totals	**204**	**$3,612,869**	**14**	**$81,352**

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

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January 22, 2016

Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Attention: Patrick Cogley
Regional Inspector General for Audit Services

Subject: Report Number A-07-15-05072
Medicare Compliance Review of SSM DePaul Health Center for 2012 and 2013

SSM DePaul Health Center received the draft report dated January 14, 2016 with a request to provide written comments and corrective actions taken or planned by SSM DePaul Health Center based on the recommendations provided in the report.

As a result of this review, the OIG determined that SSM DePaul Health Center complied with 190 of the 204 inpatient and outpatient claims reviewed. The review did identify 14 claims that the hospital did not fully comply with Medicare billing requirements resulting in overpayments of $81,352 for claim years 2012 and 2013 all of which were inpatient claims.

In response to the audit SSM DePaul Health Center would like to assure you of its commitment to create and maintain robust procedures and controls to minimize risk of billing errors. After review of the audit findings SSM DePaul Health Center agrees with the 14 claims identified with billing errors. We have corrected and rebilled to Medicare for the claims determined by your audit to be billed in error.

SSM DePaul Health Center has reviewed the recommendations in the report and responds as follows:

Inpatient Claims

Unsupported Codes
For 14 out of 187 selected claims, the hospital incorrectly billed Medicare with incorrectly coded claims resulting in an overpayment of $81,352.

Processes are in place for HIM/Coding to review claims prior to claim submission to ensure that we comply with Medicare regulations. The 14 cases found to be non-compliant were a result of human error and were not detected by controls. The claim was incorrectly assigned diagnosis or procedure codes that were not supported within the record. Based on the results of this review the HIM/Coding department have conducted educational sessions with staff on the process for reviewing claims including diagnosis and procedure code selection. After review of the 14 cases the hospital does agree with the findings of this audit and have correct and rebilled the claims to Medicare.

SSM DePaul Health Center is committed to its Corporate Responsibility Process, which is consistent with our Mission and Values. If you have any questions or require further information, please contact me at 314-989-6838.

Respectfully Submitted,

Melissa Shine

Melissa Shine
Manager Corporate Responsibility