Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF GREENVILLE MEMORIAL HOSPITAL

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

Lori S. Pilcher
Regional Inspector General
for Audit Services

February 2016
A-04-15-03082

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

Greenville Memorial Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately $83,000 over nearly 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2013, Medicare paid hospitals $156 billion, which represents 45 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 our review was to determine whether Greenville Memorial Hospital (the Hospital), complied with Medicare requirements for billing inpatient and outpatient services on selected types of 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, which is part of the Greenville Health System, is a 746-bed hospital located in Greenville, South Carolina. According to CMS's National Claims History data, Medicare paid the Hospital approximately $370 million for 21,476 inpatient and 223,623 outpatient claims paid from January 2013 through September 2014 (audit period).

Our audit covered $17,264,798 in Medicare payments to the Hospital for 1,998 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 281 paid claims with payments totaling $3,562,100. These claims consisted of 125 inpatient and 156 outpatient claims with claims paid dates during the audit period.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 257 of the 281 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 24 claims, resulting in overpayments of $83,217 for the audit period. Specifically, 4 inpatient claims had billing errors resulting in overpayments of $24,171, and 20 outpatient claims had billing errors resulting in overpayments of $59,046.

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 program $83,217 consisting of $24,171 in overpayments for incorrectly billed inpatient claims and $59,046 in overpayments for incorrectly billed outpatient claims for the audit period, and

- strengthen controls to ensure full compliance with Medicare requirements.

GREENVILLE MEMORIAL HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital partially agreed with our first recommendation and discussed actions that it had taken or planned to take regarding our second recommendation.

In regard to our first recommendation, the Hospital concurred that it billed 23 of 24 claims incorrectly and said that it would refund $34,269 to Medicare for these 23 claims. However, the Hospital did not concur that one claim, totaling $48,948, was incorrectly billed because the patient's medical record did not sufficiently document that the patient actually received chemotherapy.

However, nothing in the Hospital's comments caused us to change our finding that the one claim was not sufficiently documented. Consequently, we continue to recommend that the Hospital refund to the Medicare program $48,948, for this claim.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2013, Medicare paid hospitals $156 billion, which represents 45 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 Greenville Memorial Hospital (the Hospital), complied with Medicare requirements for billing inpatient and outpatient services on selected types of 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

Under the inpatient prospective payment system (IPPS), 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 billed with high-severity-level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims paid in excess of charges,
- outpatient claims with payments greater than $25,000,
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day),
- outpatient claims billed with evaluation and management (E&M) services, and
- outpatient Herceptin.

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 and 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.

Greenville Memorial Hospital

The Hospital is a 746-bed acute care hospital located in Greenville, South Carolina. According to CMS's National Claims History data, Medicare paid the Hospital approximately $370 million for 21,476 inpatient and 223,623 outpatient claims paid from January 2013 through September 2014 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our audit covered $17,264,798 in Medicare payments to the Hospital for 1,998 claims paid during the audit period that were potentially at risk for billing errors. We selected for review a stratified random sample of 281 paid claims with payments totaling $3,562,100. These claims consisted of 125 inpatient and 156 outpatient claims that had claims paid dates during the audit period.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. 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 audit scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 257 of the 281 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 24 claims, resulting in overpayments of $83,217 for the audit period. Specifically, 4 inpatient claims had billing errors resulting in overpayments of $24,171, and 20 outpatient claims had billing errors resulting in overpayments of $59,046. 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.

See Appendix B for sample design and methodology, Appendix C for sample results and estimates, and Appendix D for the results of our review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 4 of 125 sampled inpatient claims, which resulted in overpayments of $24,171.

Incorrectly Billed Diagnosis-Related-Group Codes

Medicare payments may not be made for items and 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)). Additionally, the Manual requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (chapter 1, § 80.3.2.2).

For 3 of 125 inpatient claims, the Hospital submitted claims to Medicare with incorrect DRG codes. For these claims, the Hospital used a diagnosis code that was incorrect or unsupported by the medical record. The Hospital agreed that these three claims lacked documentation to support the secondary diagnosis. The Hospital attributed these errors to improper application of *Official Guidelines for Coding and Reporting* by coding staff. In addition, the audit process in place did not identify these accounts, and the software did not flag them. As a result of these errors, the Hospital received overpayments of $20,471.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require reduction 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 condition code 49 or 50 combined with value code "FD" (chapter 3 § 100.8).

For 1 of 125 inpatient claims, the Hospital did not provide an invoice for the replacement cost of the implanted device. The Hospital stated that it had not followed the warranty credit process as it is related to implantable cardiac devices; specifically, the lead from the device was under recall, but the Hospital did not return it to the vendor. As a result of these errors, the Hospital received an overpayment of $3,700.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 20 of 156 sampled outpatient claims, which resulted in overpayments of $59,046.

Insufficiently Documented Services

Medicare payments may not be made for items and 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)). In addition, 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 of the 156 outpatient claims, the Hospital incorrectly billed Medicare for services that were not adequately documented. Specifically, the administration of the drug, Yervoy, was not

sufficiently supported in the medical record. The Hospital attributed this lack of support to two human errors: (1) a nurse did not document the treatment in the medical record and (2) pharmacy staff verbally confirmed treatment instead of verifying the documentation. As a result of these errors, the Hospital received an overpayment of $48,948.

Incorrectly Billed Services with Modifier -59

Medicare payments may not be made for items and 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)). Additionally, the Manual requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (chapter 1, § 80.3.2.2). In chapter 23, § 20.9.1.1, the Manual further defines the use of the -59 modifier to indicate a distinct procedural service that may represent a different session or patient encounter, a different procedure or surgery, a different site, a different organ system, a separate incision or excision, or a separate injury (or area of injury in extensive injuries).

For 9 of the 156 outpatient claims, the Hospital incorrectly billed Medicare for HCPCS codes that did not require modifier -59. The Hospital attributed these errors to staff improperly applying the *Official Guidelines for Coding and Reporting*. Furthermore, this issue was not identified by the internal audit process and software in place at the Hospital. As a result, the Hospital received overpayments of $5,296.

Manufacturer Credits for Replaced Medical Devices Not Obtained

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, 2014, the Manual states that when a hospital furnishes a new replacement device received without cost or with a credit of 50 percent or more of the cost of a new replacement from a manufacturer, due to warranty, recall, or field action, the hospital must report the amount of the device credit in the amount portion for value code "FD" and report either condition code 49 or 50. Medicare will reduce the payment by the amount of the device credit for specified procedure codes reported with value code "FD."

For 1 of the 156 outpatient claims, the Hospital did not report the "FD" modifier code. The Hospital stated that, in this case, its staff did not follow the warranty credit process, as it is related to implantable cardiac devices; specifically, because of the condition of the patient, the staff determined that a different device was warranted. Finally, the Hospital explained that the communication between the revenue integrity, accounts payable, and patient billing offices was not effective in this case, and the staff did not provide appropriate patient accounting. As a result, the Hospital received overpayments of $3,100.

Incorrectly Billed Evaluation and Management Services

The Manual states that a Medicare contractor pays an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure (chapter 12, § 30.6.6 B). 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)).

For 9 of the 156 outpatient claims, the Hospital incorrectly billed Medicare for E&M services. For all 9 claims, the E&M services were not significant, separately identifiable, or above and beyond the usual preoperative and postoperative work of the procedure. The Hospital attributed the errors to a lack of education and training of staff regarding when E&M charges should be billed with a procedure. As a result of these errors, the Hospital received overpayments of $1,702.

OVERALL OVERPAYMENTS

On the basis of our results, the Hospital received overpayments of $83,217 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program $83,217 consisting of $24,171 in overpayments for incorrectly billed inpatient claims and $59,046 in overpayments for incorrectly billed outpatient claims for the audit period and

- strengthen controls to ensure full compliance with Medicare requirements.

GREENVILLE MEMORIAL HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Greenville Memorial Comments

In written comments on our draft report, the Hospital partially agreed with our first recommendation and discussed actions that it had taken or planned to take regarding our second recommendation.

In regard to our first recommendation, the Hospital concurred that it billed 23 of 24 claims incorrectly and said that it would refund $34,269 to Medicare for these 23 claims. However, the Hospital did not concur that one claim, totaling $48,948, was incorrectly billed because the patient's medical record did not sufficiently document that the patient actually received chemotherapy. To provide additional evidence to document this claim, the Hospital included several anecdotal statements and one testimonial statement that it believed sufficiently documented that the patient actually received the chemotherapeutic drug for which the Hospital billed Medicare. For example, to support that the patient actually received the chemotherapeutic

drug, the Hospital produced a signed statement from the registered nurse who attested, more than 2 years after the fact, that she administered the drug to the patient but failed to document the medical record.

In regard to our second recommendation to strengthen its controls, the Hospital described several corrective actions that it would take, including:

- conducting internal audits to determine that Coding Staff is performing at 95 percent or greater accuracy,
- re-educating staff and requiring them to confirm that they have read and understand the current coding guidelines,
- assigning to the Hospital's Electrophysiology Lab staff the responsibility for the return of the explanted medical devices to the manufacturer by following a vendor-provided process for return of the device,
- holding education sessions for the nurses and Medical Assistants to address when it is appropriate to bill an E&M (Facility Charge) with a procedure, and
- conducting random bi-monthly audits to confirm Modifier 25 compliance.

The Hospital's comments are included in their entirety as Appendix E.

Office of Inspector General Response

Section 1833 (e) of the Social Security Act precludes payment to a provider of services without information necessary to determine the amount due. In addition, the Medicare Claims Processing Manual requires that the Hospital document a patient's medical record before billing Medicare for services. The statements that the Hospital provided do not constitute sufficient documentation that the chemotherapeutic drug was actually administered. Consequently, we continue to recommend that the Hospital refund to the Medicare program $48,948 for this claim.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $17,264,798 in Medicare payments to the Hospital for 1,998 claims paid from January 2013 through September 2014 (audit period) that were potentially at risk for billing errors. We selected for review a stratified random sample of 281 paid claims with payments totaling $3,562,100. These claims consisted of 125 inpatient and 156 outpatient claims that had claims paid dates during the audit period.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals.

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 (NCH) 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 at the Hospital in Greenville, South Carolina, from May through October 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's NCH file for claims paid during the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and other analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- identified and removed claims under review by Recovery Audit Contractors from our high-risk claims population;
- selected a stratified random sample of 281 claims (125 inpatient and 156 outpatient) for detailed review (Appendix B),

- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation that the Hospital provided 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 personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustment;
- used the results of the sample review to calculate the total Medicare overpayments to the Hospital (Appendix C); 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: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population contained inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during the audit period.

SAMPLING FRAME

According to CMS's NCH data, Medicare paid the Hospital $370,036,195 for 21,476 inpatient and 223,623 outpatient claims for services provided to beneficiaries during the audit period.

Inpatient Claims

According to CMS's NCH data, Medicare paid the Hospital $288,536,401 for 21,476 inpatient claims in 13 high-risk areas during the audit period for services provided to beneficiaries.

From these 13 high-risk areas, we selected 3 areas consisting of 3,467 claims totaling $55,267,673 for further refinement. We performed data filtering and analyses of the claims within each of the 3 high risk areas. The specific filtering and analyses steps performed varied depending on the Medicare issue, but included such procedures as removing claims with certain patient discharge status codes and revenue codes. We also took into consideration such things as certain vulnerable diagnosis codes, and procedure codes. We also removed all $0 paid claims, claims under review by the Recovery Audit Contractor as of May 4, 2015, and all duplicated claims within individual high risk areas.

This filtering and analyzing resulted in a sampling frame of 1,058 unique Medicare claims totaling $11,697,501.

Outpatient Claims

According to CMS's NCH data, Medicare paid the Hospital $81,499,794 for 223,623 outpatient claims in 16 high-risk areas during the audit period for services provided to beneficiaries.

From these 16 high-risk areas, we selected 5 areas consisting of 43,619 claims totaling $61,784,306 for further refinement. We performed data filtering and analyses of the claims within each of the 5 high risk areas. The specific filtering and analyses steps performed varied depending on the Medicare issue, but included such procedures as removing claims with certain patient discharge status codes and revenue codes. We also took into consideration such things as certain vulnerable diagnosis codes, and procedure codes. We also removed all $0 paid claims, claims under review by the Recovery Audit Contractor as of May 4, 2015, and all duplicated claims within individual high risk areas.

This filtering and analyzing resulted in a sample frame of 940 unique Medicare claims totaling $5,567,297.

Table 1 contains the combined inpatient and outpatient sample frame by risk area.

Table 1: Sample Frame Detail by Risk Area

Risk Area	Number of Claims	Amount of Payments
Inpatient Manufacturer Credits for Replaced Medical Devices	25	$657,047
Inpatient Claims Billed With High-Severity-Level Diagnosis-Related-Group Codes (Low)	700	5,588,838
Inpatient Claims Billed With High-Severity-Level Diagnosis-Related-Group Codes (High)	185	3,772,639
Inpatient Claims Paid in Excess of Charges	148	1,678,978
Outpatient Manufacturer Credits for Replaced Medical Devices	24	310,326
Outpatient Herceptin	13	89,927
Outpatient Claims With Payments Greater Than $25,000	120	3,688,514
Outpatient Claims With Modifier -59 (Low)	529	541,242
Outpatient Claims With Modifier -59 (High)	245	926,807
Outpatient Claims Billed With Evaluation and Management Services	9	10,480
Total	**1,998**	**$17,264,798**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample.

SAMPLE SIZE

We randomly selected 281 claims for review, as shown in Table 2.

Table 2: Stratum, Risk Area, Frame, and Sample Detail

Stratum	Risk Area	Claims in Sample Frame	Claims in Sample
1	Inpatient Manufacturer Credits for Replaced Medical Devices	25	25
2	Inpatient Claims Billed With High-Severity-Level Diagnosis-Related-Group Codes (Low)	700	40
3	Inpatient Claims Billed With High-Severity-Level Diagnosis-Related-Group Codes (High)	185	30

Stratum	Risk Area	Claims in Sample Frame	Claims in Sample
4	Inpatient Claims Paid in Excess of Charges	148	30
5	Outpatient Manufacturer Credits for Replaced Medical Devices	24	24
6	Outpatient Herceptin	13	13
7	Outpatient Claims With Payments Greater Than $25,000	120	35
8	Outpatient Claims With Modifier -59 (Low)	529	45
9	Outpatient Claims With Modifier -59 (High)	245	30
10	Outpatient Claims Billed With Evaluation and Management Services	9	9
	Total	**1,998**	**281**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata 2, 3, 4, 7, 8, and 9. After generating the random numbers for these strata, we selected the corresponding claims in each stratum. We selected all claims in strata 1, 5, 6, and 10.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments paid to the Hospital for the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	25	$657,047	25	$657,047	1	$3,700
2	700	5,588,838	40	353,615	1	2,807
3	185	3,772,639	30	569,696	2	17,664
4	148	1,678,978	30	379,798	0	0
5	24	310,326	24	310,326	1	3,100
6	13	89,927	13	89,927	0	0
7	120	3,688,514	35	1,045,201	1	48,948
8	529	541,242	45	45,532	4	1,271
9	245	926,807	30	100,478	5	4,025
10	9	10,480	9	10,480	9	1,702
Total	**1,998**	**$17,264,798**	**281**	**$3,562,100**	**24**	**$83,217**

Table 4: Estimates of Overpayments for the Audit Period

Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	$382,179
Lower Limit	83,217[2]
Upper Limit	755,277

[2] We set the lower limit to the actual error value identified in the sample.

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
High Dollar Claims Billed With High Severity Level DRG Codes	30	$569,696	2	$17,664
Manufacturer Credits for Replaced Medical Devices	25	657,047	1	3,700
Low Dollar Claims Billed With High Severity Level DRG Codes	40	353,615	1	2,807
Inpatient Claims Paid in Excess of Charges	30	379,798	0	0
Inpatient Totals	**125**	**$1,960,156**	**4**	**$24,171**
Outpatient				
Claims With Payments Greater Than $25,000	35	$1,045,201	1	$48,948
High Dollar Claims Billed With Modifier -59	30	100,478	5	4,025
Manufacturer Credits for Replaced Medical Devices	24	310,326	1	3,100
Claims Billed With Evaluation and Management Services	9	10,480	9	1,702
Low Dollar Claims Billed With Modifier -59	45	45,532	4	1,271
Herceptin	13	89,927	0	0
Outpatient Totals	**156**	**$1,601,944**	**20**	**$59,046**
Inpatient and Outpatient Totals	**281**	**$3,562,100**	**24**	**$83,217**

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 E: GREENVILLE MEMORIAL HOSPITAL COMMENTS

GREENVILLE
HEALTH SYSTEM

January 6, 2016

Ms. Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Re: Draft Report, *Medicare Compliance Report of Greenville Memorial Hospital,* dated December 9, 2015. [Report Number: A-04-15-03082].

Dear Ms. Pilcher:

This submission is made on behalf of Greenville Memorial Hospital (GMH) in response to your letter dated December 9, 2015, addressed to Greenville Health System (GHS), and enclosing and requesting comments to the above referenced draft report. The draft report identifies compliance with Medicare billing requirements for 257 of the 281 inpatient and outpatient claims reviewed. The report indicates GMH did not fully comply with Medicare billing requirements for the remaining 24 claims, resulting in overpayments of $83,217 for the audit period. Specifically, the report identifies 4 unallowable inpatient claims resulting in overpayments of $24,171, and 20 unallowable outpatient claims resulting in overpayments of $59,046. The report states the overpayments were the result of errors which occurred primarily because GMH did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

A. GMH submits and concurs that the proposed disallowances and requested refunds listed below are appropriate:

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

1) Incorrectly Billed Diagnostic-Related Group Codes

For 3 of the 125 Inpatient claims tested, GMH agrees these 3 claims lacked documentation to support the secondary diagnosis due to the following:

- Improper application of Official Guidelines for Coding and Reporting by coding staff.
- Account was not identified by the audit process in place and was not flagged by the PwC Smart software.

As a result of this error GMH concurs an overpayment of $20,471 was received.

The corrective action measures GMH is taking to address the control deficiencies are as follows:

300 E. McBee Avenue Greenville, SC 29601 P: 864-797-7726 F: 864-797-7728

- A detailed coding audit criteria has been developed and implemented, resulting in more robust auditing and is in place today.

- Coding Staff is expected to perform at 95% or greater accuracy as evidenced by internal audits. External audits are also conducted (both random and targeted) on a quarterly basis.

- Failure to meet the 95% quality expectation will result in additional education, monitoring of coding practices and possible disciplinary action.

- Re-educate staff and require them to update their Health Information Management (HMI) Coding Statement as confirmation that they have read and understand the current coding guidelines.

- Remind coding staff of the in-house resources available (i.e. 2nd level reviews prior to final coding).

2) Manufacturer Credits for Replaced Medical Devices Not Reported

For 1 of the 125 inpatient claims tested, GMH agrees it did not provide an invoice for the replacement cost of the implanted device.

As a result of this error GMH concurs an overpayment of $3,700 was received.

The corrective action measures GMH is taking to address the control deficiencies are as follows:

- GMH Electrophysiology (EP) Lab staff has assumed responsibility for the return of the explant to the manufacturer by following a vendor-provided process for return of the device.

- A Device Warranty Form, an internal GMH document formerly known as an Explant Return Form, is completed by the vendor at the time of the repeat procedure as an internal tracking guide for Warranty Credits.

- The Device Warranty Form as completed by the vendor is given to the EP Lab staff and recorded onto a log of repeat daily procedures kept in the EP Lab, to track and assure accuracy of those procedures.

- The Device Warranty Form is also scanned and emailed to Revenue Integrity to match to the vendor monthly Credit Reports, as vendors are required to submit monthly Credit Reports (which includes all returned devices – credit or no credit) directly to Revenue Integrity. Revenue Integrity sends the information obtained on the Device Warranty Form and the Credit Report to Accounts Payable.

- Accounts Payable receives the vendor Credit Memos which have patient, device, and date of service identifiers indicated and verifies correct patient accounts for re-bills.

- Accounts Payable and Revenue Integrity reconcile their information to assure proper patient re-billing is identified.

- Revenue Integrity notifies patient accounts for re-billing.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

3) Incorrectly Billed Services with Modifier -59

For 9 of the 156 outpatient claims tested, GMH agrees it incorrectly billed Medicare for HCPCS codes that did not require modifier – 59.

As a result of this error GMH concurs an overpayment of $5,296 was received.

The corrective action measures GMH is taking to address the control deficiencies are as follows:

- A detailed coding audit criteria has been developed and implemented, resulting in more robust auditing and is in place today.
- Coding Staff is expected to perform at 95% or greater accuracy as evidenced by internal audits. External audits are also conducted (both random and targeted) on a quarterly basis.
- Failure to meet the 95% quality expectation will result in additional education, monitoring of coding practices and possible disciplinary action.
- Re-educate staff and require them to update their HIM Coding Statement as confirmation that they have read and understand the current coding guidelines.
- Remind coding staff of the in-house resources available (i.e. 2nd level reviews prior to final coding and online coding).
- Revenue Cycle Integrity has created a Charge Capture Audit Rule to review accounts with Modifier -59 charges to prevent claims from billing out incorrectly.
- Education sessions have been held by Revenue Cycle Integrity with Charge Capture Specialist to update and educate on billing guidelines as well as the Charge Capture Audit Rule created to review those claims.

4) Manufacturer Credits for Replaced Medical Devices Not Obtained

For 1 of the 156 outpatient claims tested, GMH agrees it did not report the FD modifier code.

As a result of this error GMH concurs an overpayment of $3,100 was received.

The corrective action measures GMH is taking to address the control deficiencies are as follows:

- GMH Electrophysiology (EP) Lab staff has assumed responsibility for the return of the explant to the manufacturer by following a vendor-provided process for return of the device.
- A Device Warranty Form, an internal GMH document formerly known as an Explant Return Form, is completed by the vendor at the time of the repeat procedure as an internal tracking guide for Warranty Credits.
- The Device Warranty Form as completed by the vendor is given to the EP Lab staff and recorded onto a log of repeat daily procedures kept in the EP Lab, to track and assure accuracy of those procedures.
- The Device Warranty Form is also scanned and emailed to Revenue Integrity to match to the vendor monthly Credit Reports, as vendors are required to submit monthly Credit Reports (which includes all returned devices – credit or no credit) directly to Revenue Integrity. Revenue Integrity sends the information obtained on the Device Warranty Form and the Credit Report to Accounts Payable.
- Accounts Payable receives the vendor Credit Memos which have patient, device, and date of service identifiers indicated and verifies correct patient accounts for re-bills.

- Accounts Payable and Revenue Integrity reconcile their information to assure proper patient re-billing is identified.

- Revenue Integrity notifies patient accounts for re-billing.

5) **Incorrectly Billed Evaluation and Management (E&M) Services**

For 9 of the 156 outpatient claims tested, GMH agrees it incorrectly billed Medicare for E&M services

As a result of this error GMH concurs an overpayment of $1,702 was received.

The corrective action measures GMH is taking to address the control deficiencies are as follows:

- Cancer Institute Patient Accounts staff reviews accounts that have a facility fee with a procedure and send each account to Revenue Integrity Quality Coding to review and apply Modifier 25 where appropriate.

- Quality Coders have held education sessions for the nurses and Medical Assistant's to address when it is appropriate to bill an E&M (Facility Charge) with a procedure.

- Quality Coders have held education sessions with the Cancer Institute Patient Accounts staff to address compliant use of Modifier 25.

- Random bi-monthly audits will be conducted by Revenue Integrity Quality Coders and Charge Specialist to confirm Modifier 25 compliance. These audits will be specific to sites which perform surgical procedures same day in the office.

- Audit findings will be presented to GHS Corporate Integrity.

B. **GMH does NOT concur that the proposed disallowance and requested refund listed below is appropriate for the specific reason as outlined:**

<u>BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS</u>

1) **Insufficiently Documented Services**

The draft report indicates that for 1 of the 156 outpatient claims tested, GMH incorrectly billed Medicare for services that were not adequately documented, thus the Office of Inspector General (OIG) Auditors concluded the services were *"not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member"* (the Act, § 1862(a)(1)(A)), nor was the bill completed accurately in order to be processed correctly and properly (Medicare Claims Processing Manual, chapter 1, § 80.3.2.2). Specifically, the OIG report states the administration of a known life-saving chemotherapy drug, Yervoy, was "*...not sufficiently supported in the medical record*".

Though GMH acquiesces that the nurse who administered the chemotherapeutic drug and the pharmacy staff member who confirmed the drug was given did not record such activity in the patient's medical record, we respectfully disagree these two errors bring sufficient cause to counter the full weight of the episodic care recorded in the patient medical record, which clearly and completely describes and documents clinical events that when taken into consideration, provides reasonable evidence that the drug Yervoy was indeed administered for the patient's second chemotherapy treatment.

GMH offers the following facts that were shared with the OIG Auditors in support of our position. These facts are undisputed and gleaned from the patient's medical record and support GMH's position that the patient received his chemotherapy upon his second visit:

1) The patient was seen by a nurse practitioner for patient education prior to beginning treatment.
2) The physician prescribed the drug and the treatment plan for three (3) visits.
3) The patient received the first of three (3) chemotherapy regimens and it is well documented.
4) The patient returned for the second chemotherapy treatment. Pre - chemotherapy administration clinical work is well documented. Pharmacy documented that the chemotherapy drug was dispensed. Physician progress notes affirm reason for visit.
5) Third visit records physician documenting patient's second chemotherapy tolerated well. Additional clinical activity and patient progress well documented
6) Signed Attestation by the registered nurse that she administered the second regimen of chemotherapy to patient but failed to document such in medical record, provides further evidence the drug Yervoy was given to the patient.

Accordingly, GMH submits that the weight of supporting documentation in the patient's record affirms there is sufficient evidence surrounding the patient episodes of care to draw but one conclusion – the patient received the second chemotherapy treatment in question. We respectfully request the OIG change its position on this matter and find GMH provided care, billed correctly and is deserving of this paid claim.

RECOMMENDATIONS

In summary, GMH believes its good faith obligation to refund the Medicare program in the amount of $34,269 is derived as follows:

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS		
Incorrectly Billed Diagnostic-Related Group Codes	**3**	**$20,471**
Manufacturer Credits for Replaced Medical Devices Not Reported	**1**	**$ 3,700**
BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS		
Incorrectly Billed Services with Modifier -59	**9**	**$ 5,296**
Manufacturer Credits for Replaced Medical Devices Not Obtained	**1**	**$ 3,100**
Incorrectly Billed Evaluation and Management (E&M) Services	**9**	**$ 1,702**
Total Estimated Overpayments	**23**	**$34,269**

Nothing herein should be deemed an admission by GHS of any regulatory violation; and GHS reserves the right to appeal any and all claims denied by the Medicare Administrative Contractors.

Greenville Health System takes its obligations to comply with all laws and regulations seriously and we will continue remediation efforts to promote continued compliance with Medicare regulations associated with patient billing. Our health system is committed to ensuring follow through and maintenance of these efforts.

Finally, we appreciate the professionalism, openness, cooperation, and collegiality of the OIG Auditors during this review. Please contact my office at 864.797.7726 or smorris@ghs.org with any questions you may have regarding our responses.

Sincerely,

/Calvin M. Morris, Jr./
Executive Director
Office of Corporate Integrity

/Terri Newsom/
Vice President and Chief Financial Officer

Cc: Michael Riordan, President and Chief Executive Officer
J. Scott Pietras, Corporate Compliance Officer