Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF HENNEPIN COUNTY MEDICAL CENTER FOR 2012 AND 2013

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Office of Inspector General

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EXECUTIVE SUMMARY

Hennepin County Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated overpayments of at least $1.6 million 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 certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 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 this review was to determine whether Hennepin County Medical Center (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 inpatient rehabilitation services at a predetermined rate according to the distinct case-mix group (CMG). The CMG is based on the beneficiary's clinical characteristics and expected resource needs. 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 455-bed acute care teaching hospital located in Minneapolis, Minnesota. Medicare paid the Hospital approximately $213 million for 9,635 inpatient and 206,717 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

Our audit covered $10,471,175 in Medicare payments to the Hospital for 3,237 claims that were potentially at risk for billing errors. We selected a stratified random sample of 211 claims with payments totaling $2,600,836 for review. These 211 claims had dates of service in CY 2012 or CY 2013 and consisted of 110 inpatient and 101 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 134 of the 211 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 77 claims, resulting in overpayments of $537,724 for CYs

2012 and 2013 (audit period). Specifically, 34 inpatient claims had billing errors, resulting in overpayments of $514,803, and 43 outpatient claims had billing errors, resulting in overpayments of $22,921. 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.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $1,664,961 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor $1,664,961 (of which $537,724 was overpayments identified in our sample) in estimated overpayments for incorrectly billed services, and

- strengthen controls to ensure full compliance with Medicare requirements.

HENNEPIN COUNTY MEDICAL CENTER COMMENTS AND OUR RESPONSE

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

After considering the Hospital's comments, we continue to recommend that the Hospital refund to the Medicare contractor $1,664,961 in estimated overpayments and strengthen controls to ensure full compliance with Medicare requirements.

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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 certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 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 Hennepin County Medical Center (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 Administrative Contractors (MAC) to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Inpatient Rehabilitation Facility Prospective Payment System

Inpatient rehabilitation facilities provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for inpatient rehabilitation facilities. CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the payment system, CMS established a Federal prospective

payment rate for each of the distinct case-mix groups (CMG). The assignment to a CMG is based on the beneficiary's clinical characteristics and expected resource needs. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

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 rehabilitation,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims paid in excess of charges,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed with modifier -59,
- 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 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)). 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)).

[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).

Hennepin County Medical Center

The Hospital, which is part of Hennepin Healthcare System, Inc., is a 455-bed acute care teaching hospital located in Minneapolis, Minnesota. Medicare paid the Hospital approximately $213 million for 9,635 inpatient and 206,717 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 $10,471,175 in Medicare payments to the Hospital for 3,237 claims that were potentially at risk for billing errors. We selected a stratified random sample of 211 claims with payments totaling $2,600,836 for review. These 211 claims had dates of service in CY 2012 or CY 2013 and consisted of 110 inpatient and 101 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 120 claims to focused medical review to determine whether the services met medical necessity and coding requirements. 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 134 of the 211 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 77 claims, resulting in overpayments of $537,724 for CYs 2012 and 2013 (audit period). Specifically, 34 inpatient claims had billing errors, resulting in overpayments of $514,803, and 43 outpatient claims had billing errors, resulting in overpayments of $22,921. 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.

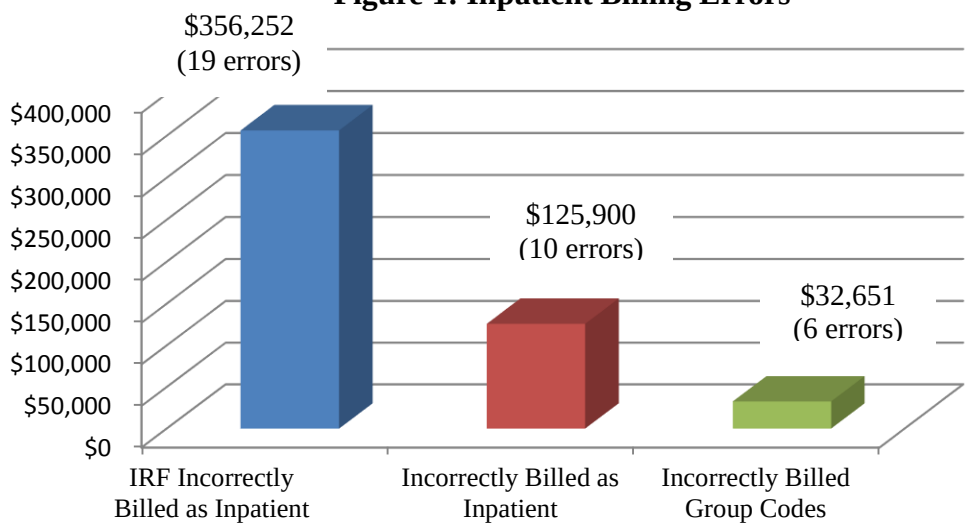
On the basis of our sample results, we estimated that the Hospital received overpayments totaling at least $1,664,961 for the audit period.

See Appendix B for our sample design and methodology, Appendix C for our 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 34[2] of 110 sampled inpatient claims, which resulted in overpayments of $514,803 as shown in Figure 1 below.

Figure 1: Inpatient Billing Errors



Inpatient Rehabilitation Facility (IRF) Services 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)).

The *Medicare Benefit Policy Manual* states the IRF benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. (Pub. No. 100-02, chapter 1, § 110).

[2] Of the 34 inpatient claims with errors, 1 had more than 1 type of error for a total of 35 errors.

In addition, the *Medicare Benefit Policy Manual* states that in order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record must demonstrate a reasonable expectation that at the time of admission to the IRF the patient 1) required the active and ongoing therapeutic intervention of multiple therapy disciplines, 2) generally required an intensive rehabilitation therapy program, 3) actively participated in, and benefited significantly from, the intensive rehabilitation therapy program, 4) required physician supervision by a rehabilitation physician, and 5) required an intensive and coordinated interdisciplinary approach to providing rehabilitation. (Pub. No. 100-02, chapter 1, § 110.2).

Furthermore, the *Medicare Benefit Policy Manual* states that a primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs. (Pub. No. 100-02, chapter 1, § 110.2.2).

For 19[3] of the 110 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation services. To the extent that the Hospital concurs with the incorrectly billed claims, the Hospital believed certain documentation deficiencies related to the patients' condition and a severely understaffed rehabilitation facility may have contributed to the errors.

As a result of these errors, the Hospital received overpayments of $356,252.[4]

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)).

The *Medicare Benefit Policy Manual* states:

> An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later

[3] Five of the 19 claims partially met Medicare coverage requirements for acute inpatient rehabilitation. The guidance that CMS has given providers about this particular issue (when an IRF patient needs to remain in the IRF for the few days past the date at which they have completed their course of IRF treatment) is to record the remaining days as "non-covered" using occurrence code 76. Occurrence code 76 indicates to the Pricer to ignore the charges for those days, and not factor them in to any outlier calculations.

[4] The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status). 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 prior to the issuance of our draft report.

> develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.
>
> The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark. . . . (T)he decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.
>
> Factors to be considered when making the decision to admit include such things as: 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. (Pub. No. 100-02, chapter 1, § 10).

For 10 of the 110 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services. To the extent that the Hospital concurs with the incorrectly billed claims, the Hospital attributed the errors to miscommunication between its utilization management department and its revenue cycle management department after a patient's status was changed during a utilization management review.

As a result of these errors, the Hospital received overpayments of $125,900.[5]

Incorrectly Billed Group Codes

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(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).

[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 prior to the issuance of our draft report.

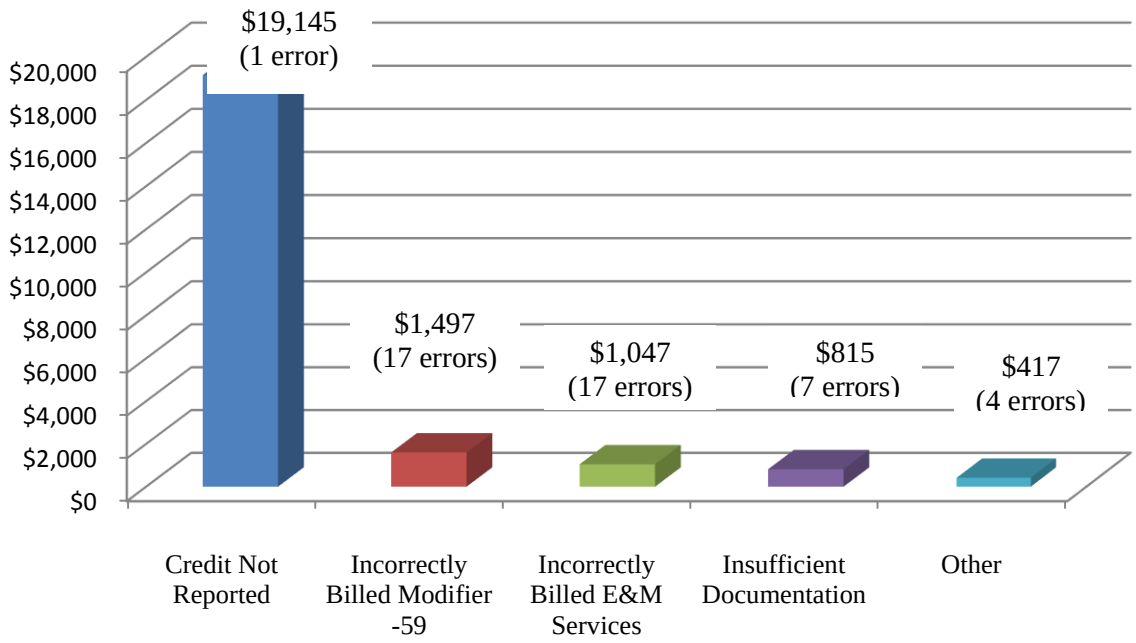
For 6[6] of the 110 sampled claims, the Hospital billed Medicare with either incorrect DRG codes or CMG code. The Hospital stated that these errors occurred primarily because the medical record documentation did not clearly document the patient's clinical indicators and because the coding staff did not query the physician for clarification.

As a result of these errors, the Hospital received overpayments of $32,651.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 43[7] of 101 sampled outpatient claims, which resulted in overpayments of $22,921 as shown in Figure 2 below.

Figure 2: Outpatient Billing Errors



Manufacturer Credit for Replaced Medical Device 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(a)). 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

[6] Five of the 6 errors relate to incorrectly billed DRG codes and 1 relates to an incorrectly billed CMG code.

[7] Of the 43 outpatient claims, 3 had more than 1 type of error for a total of 46 errors.

insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device.[8]

For 1 of the 101 sampled claims, the Hospital received full credit for a replaced device but did not properly report the "FB" modifier and reduced charges on its claim. The Hospital stated that the error occurred because the Hospital didn't receive the credit until several months after the date of service and inadvertently failed to send in a corrected claim to reflect the credit.

As a result of this error, the Hospital received an overpayment of $19,145.

Incorrectly Billed Outpatient Services with Modifier -59

The Manual states: "The '-59' modifier is used to indicate a distinct procedural service…. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)" (chapter 23, § 20.9.1.1). 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 17 of the 101 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes, appended with modifier -59, which were already included in the payments for other services billed on the same claim or did not require modifier -59. The Hospital attributed some of the errors to coding staff relying too heavily on the encoder system and not consistently using their coding knowledge to determine whether the suggested modifier was actually appropriate based on the documentation.

As a result of these errors, the Hospital received overpayments of $1,497.

Incorrectly Billed Evaluation and Management Services

The Manual states that a Medicare contractor pays for 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)).

For 17 of the 101 sampled claims, the Hospital incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. The Hospital attributed the errors to coding staff relying too heavily on the encoder system and not always understanding the billing requirements for when E&M services are separately billable due to insufficient training and education.

As a result of these errors, the Hospital received overpayments of $1,047.

[8] 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). 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.

Insufficiently Documented Services

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 7 of the 101 sampled claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record. To the extent that the Hospital concurs with the incorrectly billed claims, the Hospital attributed the errors to coding staff not validating the documentation supporting the billed services and to physicians not always appropriately documenting the services provided.

As a result of these errors, the Hospital received overpayments of $815.

Incorrectly Billed Healthcare Common Procedure Coding System Code

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 of the 101 sampled claims, the Hospital submitted the claim to Medicare with an incorrect HCPCS code. The Hospital stated that this error occurred primarily due to human error.

As a result of this error, the Hospital received an overpayment of $246.

Incorrectly Billed Routine Foot Care

The *Medicare Benefit Policy Manual* states that routine foot care is generally excluded from coverage (Pub. No. 100-02, chapter 15, § 290). However, the *Medicare Benefit Policy Manual* also states: "In certain circumstances, services ordinarily considered to be routine may be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcers, wounds, or infection" (Pub. No. 100-2, chapter 15, § 290(C)).

For 2 of 101 sampled claims, the Hospital incorrectly billed for routine foot care when the patient did not have a diagnosis that allowed for Medicare payment. The Hospital attributed the errors to coding staff not always understanding the routine foot care billing requirements, and to their encoder and claims scrubber systems not flagging these claims as incorrectly coded and billed.

As a result of these errors, the Hospital received overpayments of $120.

Incorrectly Billed Medical Nutrition Therapy Services

The Manual authorizes coverage of medical nutrition therapy services for certain beneficiaries who have diabetes or a renal disease (Pub. No. 100-04, chapter 4, § 300).

For 1 of the 101 sampled claims, the Hospital incorrectly billed for medical nutrition therapy services when the patient did not have a diagnosis that allowed for Medicare payment. The Hospital attributed the error to their encoder and claims scrubber systems not flagging the claim as incorrectly coded and billed.
As a result of this error, the Hospital received an overpayment of $51.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $1,664,961 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $1,664,961 (of which $537,724 was overpayments identified in our sample) in estimated overpayments for incorrectly billed services, and

- strengthen controls to ensure full compliance with Medicare requirements.

HENNEPIN COUNTY MEDICAL CENTER COMMENTS

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

The Hospital generally agreed that 41 of the 77[9] claims identified in our draft report were improperly billed and described its corrective actions taken in response to our recommendations. The Hospital disagreed with our determination that it did not correctly bill the remaining 36 claims and stated that it intends to appeal the denial of these claims. For 29 inpatient claims, the Hospital maintained that the inpatient admissions were appropriate and met Medicare criteria. For seven outpatient claims found to be insufficiently documented, the Hospital stated that the claims were documented and billed correctly.

Finally, the Hospital disagreed with the sampling frame and extrapolation methodology used for the category of errors identified as Incorrectly Billed as Inpatient.

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

[9] Of the 77 claims with errors, 4 had more than 1 type of error for a total of 81 errors.

OFFICE OF INSPECTOR GENERAL RESPONSE

In response to the Hospital's comments, we maintain that all of our findings and the associated recommendations are valid. For the 36 contested claims, we subjected these claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Two clinicians, including a physician reviewed each case that was denied. We stand by those determinations.

The Hospital maintains its appeal rights. In those instances where the Hospital disagrees with the results, the Hospital should first contest these disallowances with the CMS action official, and finally, the last recourse is the appeals process.

Regarding the Hospital's objections to our statistical sampling and extrapolation methodology, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[10] We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

[10] *See Anghel v.Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $10,471,175 in Medicare payments to the Hospital for 3,237 claims that were potentially at risk for billing errors. We selected a stratified random sample of 211 claims with payments totaling $2,600,836 for review. These 211 claims had dates of service in CY 2012 or CY 2013 and consisted of 110 inpatient and 101 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 120 claims to focused medical review to determine whether the services met medical necessity and coding requirements.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork from August 2014 through 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 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 analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 211 claims (110 inpatient and 101 outpatient) totaling $2,600,836 for detailed review (Appendix B and C);
- 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 provided by the Hospital to support the sampled claims;

- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;

- reviewed the Hospital's procedures for submitting Medicare claims;

- used an independent medical review contractor to determine whether 120 sampled claims met medical necessity and coding 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;

- used the results of the sample review to calculate the estimated 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: SAMPLE DESIGN AND 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

Medicare paid Hennepin County Medical Center $213,139,520 for 9,635 inpatient and 206,717 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

We downloaded a database of claims from CMS's National Claims History database totaling $116,688,317 for 4,974 inpatient and 53,561 outpatient claims in 29 risk areas. From these 29 areas, we selected 8 consisting of 47,289 claims totaling $60,225,632 for further review.

We performed data analysis of the claims within each of the eight risk areas. For risk area one, we removed claims with payment amounts less than $3,000. For risk area three, we removed claims with claim lines containing Modifier -59 with payment amounts less than $50. For risk area four, we removed claims with claim lines containing an evaluation and management HCPCS with payment amounts less than $60.

We then removed the following:

- all $0 paid claims,
- all claims under review by the Recovery Audit Contractor, and
- all duplicated claims within individual risk areas.

We assigned each claim that appeared in multiple risk areas to just one category based on the following hierarchy: Inpatient MCC/CC, Inpatient Rehabilitation, Outpatient Claims Billed with Modifier 59, Outpatient Claims Billed with Evaluation & Management Services, Inpatient Claims Billed in Excess of Charges, Inpatient Medical Devices, Outpatient Medical Devices, and then Outpatient Herceptin. This resulting database contained 3,237 unique Medicare claims in 8 risk areas totaling $10,471,175 from which we drew our sample.

Risk Area	Number of Claims	Amount of Payments
Inpatient Claims Billed with High-Severity-Level DRG Codes	416	$5,714,417
Inpatient Rehabilitation	92	2,166,133
Outpatient Claims Billed with Modifier -59	1,565	1,003,233
Outpatient Claims Billed with Evaluation & Management Services	1,113	237,989
Inpatient Claims Paid in Excess of Charges	39	1,200,000
Inpatient Manufacturer Credits for Replaced Medical Devices	1	57,144
Outpatient Manufacturer Credits for Replaced Medical Devices	3	69,197
Outpatient Herceptin	8	23,062
Total	**3,237**	**$10,471,175**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into eight strata based on the risk area.

SAMPLE SIZE

We selected 211 claims for review as follows:

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Claims Billed with High-Severity-Level DRG Codes	416	40
2	Inpatient Rehabilitation	92	30
3	Outpatient Claims Billed with Modifier -59	1,565	50
4	Outpatient Claims Billed with Evaluation & Management Services	1,113	40
5	Inpatient Claims Paid in Excess of Charges	39	39
6	Inpatient Manufacturer Credits for Replaced Medical Devices	1	1
7	Outpatient Manufacturer Credits for Replaced Medical Devices	3	3
8	Outpatient Herceptin	8	8
	Total	**3,237**	**211**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata one through four. After generating the random numbers for these strata, we selected the corresponding frame items. We selected all claims in strata five through eight.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software, RAT-STATS to estimate the total amount of overpayments paid to the hospital during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Over-payments in Sample
1	416	$5,714,417	40	$457,628	11	$84,270
2	92	2,166,133	30	759,110	19	358,177
3	1,565	1,003,233	50	26,288	25	2,610
4	1,113	237,989	40	8,407	17	1,166
5*	39	1,200,000	39	1,200,000	4	72,356
6*	1	57,144	1	57,144	0	0
7*	3	69,197	3	69,197	1	19,145
8*	8	23,062	8	23,062	0	0
Total	**3,237**	**$10,471,175**	**211**	**$2,600,836**	**77**	**$537,724**

*We reviewed all claims in this stratum.

ESTIMATES

Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	$2,180,448
Lower Limit	$1,664,961
Upper Limit	$2,695,934

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Rehabilitation	30**	$759,110	19	$358,177
Claims Billed with High-Severity-Level Diagnosis-Related Group Codes	40**	457,628	11	84,270
Claims Paid in Excess of Charges	39	1,200,000	4	72,356
Manufacturer Credits for Replaced Medical Devices	1	57,144	0	0
Inpatient Totals	**110**	**$2,473,882**	**34**	**$514,803**
Outpatient				
Manufacturer Credits for Replaced Medical Devices	3	$69,197	1	19,145
Claims Billed with Modifier -59	50**	26,288	25	2,610
Claims Billed with Evaluation & Management Services	40	8,407	17	1,166
Herceptin	8	23,062	0	0
Outpatient Totals	**101**	**$126,954**	**43**	**$22,921**
Inpatient and Outpatient Totals	**211**	**$2,600,836**	**77**	**$537,724**

** We submitted these claims to a focused medical review to determine whether the services met medical necessity and coding requirements.

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: HENNEPIN COUNTY MEDICAL CENTER COMMENTS

January 13, 2016

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

VIA: US Mail

RE: Report Number A-05-14-00048

Dear Ms. Fulcher:

Thank you for providing Hennepin County Medical Center (HCMC) with the Office of Inspector General's (OIG) November 30, 2015 draft report entitled *Medicare Compliance Review of Hennepin County Medical Center for 2012 and 2013*. We appreciate the opportunity to review the draft report and provide comments prior to its finalization and publication.

During the Compliance Review, the OIG reviewed 211 inpatient and outpatient claims with dates of service in 2012 and 2013. In its draft report, the OIG concluded that HCMC complied with Medicare billing requirements for 134 claims reviewed. However, the OIG concluded that 77 of the reviewed claims contained billing errors, which resulted in identified overpayments of $537,724. Based on these sample results, the OIG used statistical methods to estimate the total amount of overpayment paid to HCMC during the review period to total at least $1,664,961.

HCMC takes these results seriously and assures you of its commitment to create and maintain robust processes and internal controls to minimize the risk of billing errors. This letter sets forth HCMC's concurrence or non-concurrence with each finding contained in the OIG draft report. As requested by the OIG, for each concurrence, HCMC has also described the nature of the corrective actions HCMC has taken in response to the relevant recommendations. For each non- concurrence, HCMC has provided specific reasons for the non-concurrence and a statement regarding alternative corrective action taken.

1. Billing Errors Associated with Inpatient Claims

    1.1 Inpatient Rehabilitation Facility (IRF) Services Incorrectly Billed as Inpatient

The OIG concluded that in 19 of 110 sampled inpatient claims, HCMC incorrectly billed Medicare Part A for beneficiary stays that did not meet criteria for acute inpatient rehabilitation services. These errors resulted in overpayments of $356,252. HCMC does not concur with this finding. HCMC asserts that all 19 claims did meet Medicare billing criteria, and it plans to exercise its right to appeal these claims.

While HCMC does not concur with this finding, it acknowledges that there is an opportunity to improve its documentation for inpatient rehabilitation facility admissions. Since the review period, HCMC has instituted additional internal controls to improve documentation practices. Specifically, HCMC has developed and implemented admission screening and evaluation checklists and templates and strengthened its discharge planning process. Additionally, HCMC recognizes that staffing shortages, including physician and advance practice provider shortages, may contribute to clinical documentation that is not as comprehensive as desired. HCMC has taken reasonably appropriate actions to mitigate the impact of staffing shortages like those that existed during the review period.

1.2 Incorrectly Billed as Inpatient

The OIG concluded that in 10 of 110 sampled inpatient claims, HCMC incorrectly billed Medicare Part A for beneficiary stays that did not meet criteria for inpatient status. This resulted in overpayments of $125,900. HCMC does not concur with this finding. HCMC asserts that many of these claims met Medicare criteria for inpatient admission, and it plans to exercise its right to appeal these claims. In addition, HCMC disagrees with the OIG extrapolation methodology used for this error category (see Section 3).

To the extent that HCMC concurs with individual OIG claim findings, it attributes the billing errors to communication gaps that existed during the review period. HCMC has developed and implemented a more comprehensive utilization management process, which involves concurrent review of the medical necessity of Medicare admissions. This process also includes referral to a physician for second-level review when appropriate. HCMC is continually making improvements to its utilization management program, including updates to its electronic health record to link and reconcile level of care information and updating the claims process so that claims do not progress until a level of care determination has been made. Level of care determinations remain an area of focus for physician, utilization management, and coding education.

1.3 Incorrectly Billed Group Codes

The OIG concluded that in 6 of the 110 sampled inpatient claims, HCMC billed Medicare with either incorrect Diagnostic Related Group (DRG) or Case-Mix Group (CMG) codes. These errors resulted in identified overpayments of $32,651. HCMC concurs with this finding.

HCMC acknowledges the errors were primarily due to coding staff reliance upon encoder systems and coders not consistently applying coding knowledge during the review period. All coding staff received physician-led targeted training in 2014-2015. HCMC also refined existing controls, increased training for coding staff, and enhanced regular auditing. Since the OIG

review, the results of the review have been discussed with coding leadership and re-education has been provided to coding staff. Additionally, the coding department continues to work with physician liaisons to identify appropriate physician query opportunities and is actively increasing the number of coding auditors on staff. HCMC has targeted its internal auditing practices to high risk areas to produce meaningful results that can be used to further refine documentation and coding practices.

2. Billing Errors Associated with Outpatient Claims

2.1 Manufacturer Credit for Replaced Medical Device Not Reported

The OIG concluded that in 1 of the 101 sampled outpatient claims, HCMC received full credit for a replaced medical device, but it did not properly report the required claim modifier to reduce charges on the claim. This error resulted in an overpayment of $19,145. HCMC concurs with this finding.

HCMC attributes this error to inadvertently failing to send a corrected claim to reflect the credit that was received. HCMC has strengthened its policies to address gaps in its processes for identifying when credits for replacement devices are to be applied to claims. HCMC continues to work with relevant staff to understand the complexities associated with Medicare device credit reporting.

2.2 Incorrectly Billed Outpatient Services with Modifier-59

The OIG concluded that 17 of the 101 sampled outpatient claims contained billing errors for codes appended with modifier -59, which were already included in the payments for other services billed on the same claim or did not require the modifier. These errors resulted in overpayments of $1,497. HCMC generally concurs with this finding. HCMC plans to appeal a small number of these cases.

To the extent HCMC concurs with the findings, it acknowledges that the errors were related to coding staff reliance upon encoder systems and coders not consistently applying coding knowledge to determine whether the suggested modifier was appropriate. HCMC has taken several actions since the audit period to minimize the risk of this error, including contracting with a third party to provide coding education for all coders. This education included content on appropriate application of coding modifiers. HCMC has also increased its regular coding audit resources and increased coder-specific monitoring based upon known coder-specific errors, with focused follow-up education.

2.3 Incorrectly Billed Evaluation and Management (E&M) Services

The OIG concluded HCMC incorrectly billed Medicare for E&M services in 17 of the 101 sampled outpatient claims. These billing inaccuracies resulted in an overpayment of $19,145. HCMC concurs with this finding.

As described in the preceding Section 2.2, HCMC has taken several actions since the audit period to minimize the risk of this error type.

2.4 Insufficiently Documented Services

The OIG concluded HCMC incorrectly billed Medicare in 7 of the 101 sampled claims for services not supported by the outpatient medical record. This resulted in overpayments of $815 dollars. HCMC does not concur with this finding, and it plans to exercise its right to appeal several of these claims because these claims were documented and billed correctly.

To the extent that HCMC concurs with the OIG's individual claim findings, HCMC has increased coder and physician education, increased coding auditor resources, and implemented additional monitoring and targeted education for coding staff to minimize this type of error.

2.5 Incorrectly Billed Healthcare Common Procedure Coding System Code

The OIG concluded that HCMC submitted a claim to Medicare with an incorrect HCPCS code in 1 of the 101 selected outpatient claims. This resulted in an overpayment of $246. HCMC concurs with this finding.

HCMC attributes the inaccuracy to human error, and the error is not indicative of a systematic internal control gap. HCMC internal controls, such as coder education and internal coding audits, adequately protect against this type of error. HCMC continues to refine its internal controls in response to identified errors.

2.6 Incorrectly Billed Routine Foot Care

The OIG concluded HCMC incorrectly billed Medicare for routine foot care when the patient did not have a diagnosis that allowed for Medicare coverage in 2 of the 101 selected outpatient claims. This resulted in overpayments of $120. HCMC concurs with this finding.

HCMC attributes the errors to incomplete knowledge of routine foot care billing requirements among hospital staff, as well as to the inability of the hospital's encoder system to flag these claims as incorrectly coded. In response to this finding, HCMC has updated its coding guidelines to include additional direction for coding staff related to routine foot care and will incorporate this type of coding error into future coding audits. HCMC is reviewing the functionality of it encoder and claims scrubber systems and, where possible, it plans to add
system edits to alert coders to inaccuracies in routine foot care billing. Additionally, HCMC will consider this error when developing future provider training related to covered services.

2.7 Incorrectly Billed Medical Nutrition Therapy Services

The OIG concluded that HCMC incorrectly billed Medicare for medical nutrition therapy services when the patient did not have a diagnosis that allowed for payment in 1 of the 101 sampled outpatient claims. This resulted in an overpayment of $51. HCMC concurs with this finding.

HCMC attributes the error to the hospital's encoder system not flagging these types of claims as incorrectly coded. In this case, the clinical documentation supports the diagnoses coded, but the claim does not meet the coverage standards identified in applicable CMS guidance. In response to this finding, HCMC initiated the request to have an edit built in the encoder system that will identify potential errors of this type. Additionally, HCMC continues to refine its staff education and regular coding audits to mitigate this type of error.

3. Overall Estimate of Overpayments

The OIG used statistical sampling to review eight risk areas. Based upon the sample results, the OIG extrapolated the sample results in four categories and as a result estimated overpayments during the review period to total $1,664,961 (of which $537,724 were overpayments identified in the samples). HCMC disagrees with the extrapolated overpayment estimate.

Specifically, HCMC disagrees with the sampling frame and extrapolation methodology for the category of errors identified as Incorrectly Billed as Inpatient. The OIG randomly selected claims of particular DRG codes. However, the selected sample was disproportionately distributed in favor of short-stay claims (i.e., 1 to 2 day length of stay). None of the denied claims in this error category had lengths of stay exceeding 2 days. Therefore, any resulting extrapolation based upon the identified error rate should be applied only to similarly situated claims (i.e., 1 to 2 day length of stay), rather than applying extrapolation to the entirety of the OIG's sampling frame. In other words, the sample should have been stratified by claim value to result in a more accurate overpayment amount.

HCMC is committed to maintaining a robust compliance program and continued enhancement and refinement of its internal control processes. We would like to thank the OIG's audit staff who conducted the compliance review for their professionalism during the audit and their ongoing open communication. If you have questions or require further information, please contact Mary Myslajek, HCMC Regulatory Review and Analysis Manager, at 612-873-3320.

Respectfully Submitted,

Jon L. Pryor, MD, MBA
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