



November 30, 2011

**TO:** Peter Budetti  
Deputy Administrator and Director  
Center for Program Integrity  
Centers for Medicare & Medicaid Services

Deborah Taylor  
Director and Chief Financial Officer  
Office of Financial Management  
Centers for Medicare & Medicaid Services

**FROM:** /Brian P. Ritchie/  
Assistant Inspector General for the  
Centers for Medicare & Medicaid Audits

**SUBJECT:** Medicare Compliance Review of Norwood Hospital for the Period July 2008 Through June 2010 (A-01-11-00510) and Medicare Compliance Review of Tallahassee Memorial HealthCare, Inc., for Calendar Years 2009 and 2010 (A-04-11-08003)

Attached, for your information, are advance copies of our final reports for two of our hospital compliance reviews. We will issue these reports to Norwood Hospital and Tallahassee Memorial HealthCare, Inc. within 5 business days.

These reports are part of a series of the Office of Inspector General's hospital compliance initiative, designed to review multiple issues concurrently at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services. The two attached reports are the seventh and eighth reports issued in this initiative.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at [Brian.Ritchie@oig.hhs.gov](mailto:Brian.Ritchie@oig.hhs.gov) or your staff may contact the respective Regional Inspectors General for Audit Services:

Norwood Hospital

Michael J. Armstrong, Regional Inspector General for Audit Services, Region I,  
(617) 565-2689, [Michael.Armstrong@oig.hhs.gov](mailto:Michael.Armstrong@oig.hhs.gov)

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Tallahassee Memorial Hospital

Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV,  
(404) 562-7750, [Lori.Pilcher@oig.hhs.gov](mailto:Lori.Pilcher@oig.hhs.gov)

Attachment



Office of Audit Services, Region IV  
61 Forsyth Street, SW, Suite 3T41  
Atlanta, GA 30303

November 30, 2011

Report Number: A-04-11-08003

Mr. G. Mark O'Bryant  
President & Chief Executive Officer  
Tallahassee Memorial HealthCare, Inc.  
1300 Miccosukee Road  
Tallahassee, FL 32308

Dear Mr. O'Bryant:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Tallahassee Memorial HealthCare, Inc., for Calendar Years 2009 and 2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Truman Mayfield, Audit Manager, at (850) 942-8900, extension 22 or through email at [Truman.Mayfield@oig.hhs.gov](mailto:Truman.Mayfield@oig.hhs.gov). Please refer to report number A-04-11-08003 in all correspondence.

Sincerely,

/Lori S. Pilcher/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 East 12<sup>th</sup> Street, Room 235  
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW  
OF TALLAHASSEE MEMORIAL  
HEALTHCARE, INC., FOR CALENDAR  
YEARS 2009 AND 2010**



Daniel R. Levinson  
Inspector General

November 2011  
A-04-11-08003

# *Office of Inspector General*

<http://oig.hhs.gov>

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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:

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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.

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# *Notices*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
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Section 8L 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**

### **BACKGROUND**

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays 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. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Tallahassee Memorial HealthCare, Inc. (Tallahassee Memorial), is a 770-bed acute care hospital located in Tallahassee, Florida. Medicare paid Tallahassee Memorial approximately \$142.7 million for 7,385 inpatient and 7,277 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$3,448,702 in Medicare payments to Tallahassee Memorial for 167 claims that we judgmentally selected as potentially at risk for billing errors. These 167 claims had dates of service in CYs 2009 and 2010, and consisted of 69 inpatient and 98 outpatient claims.

### **OBJECTIVE**

Our objective was to determine whether Tallahassee Memorial complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### **SUMMARY OF FINDINGS**

Tallahassee Memorial complied with Medicare billing requirements for services on 153 of the 167 claims. However, Tallahassee Memorial did not fully comply with Medicare billing

requirements for 14 inpatient and outpatient claims. Specifically, these 14 claims had billing errors that resulted in overpayments totaling \$129,940 for CYs 2009 and 2010. Overpayments occurred primarily because Tallahassee Memorial did not have adequate controls to prevent incorrect billing of Medicare claims, and its staff did not fully understand the Medicare billing requirements.

## **RECOMMENDATIONS**

We recommend that Tallahassee Memorial:

- refund to the Medicare contractor \$129,940,
- strengthen controls to ensure full compliance with Medicare requirements, and
- provide training to its staff members to improve their understanding of Medicare billing requirements.

## **TALLAHASSEE MEMORIAL COMMENTS**

In written comments on our draft report, Tallahassee Memorial concurred with our recommendations. Tallahassee Memorial stated that it has implemented stronger internal controls and it will continue to monitor its documentation and billing control process to better comply with Medicare requirements. Furthermore, Tallahassee Memorial has corrected the claims identified as being in error in this report and has submitted amended Medicare claims. Tallahassee Memorial's comments are included in their entirety as the Appendix.

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# INTRODUCTION

## BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.<sup>1</sup>

### **Hospital Inpatient Prospective Payment System**

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays 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, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. For beneficiary stays involving extraordinarily high costs, section 1886(d)(5)(A) of the Act provides for additional payments (called outlier payments) to Medicare-participating hospitals.

### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>2</sup> The OPPS is effective for services furnished on or after August 1, 2000. 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

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<sup>1</sup> Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

<sup>2</sup> In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

identify and group the services within each APC group.<sup>3</sup> All services and items within an APC group are comparable clinically and require comparable resources.

### **Hospital Payments at Risk for Incorrect Billing**

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. The types of payments identified included payments for claims billed for:

- inpatient transfers,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- outpatient claims with payments greater than \$25,000,
- outpatient services billed during skilled nursing facility stays,
- outpatient surgeries billed with units of service greater than one,
- inpatient and outpatient claims paid in excess of hospital charged amounts, and
- inpatient and outpatient claims involving manufacturer credits for replaced medical devices.

For purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.”

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

### **Medicare Requirements for Hospital Claims and Payments**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member. In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

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<sup>3</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

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

### **Tallahassee Memorial HealthCare, Inc.**

Tallahassee Memorial HealthCare, Inc. (Tallahassee Memorial), is a 770-bed acute care hospital located in Tallahassee, Florida. According to CMS's National Claims History data, Medicare paid Tallahassee Memorial approximately \$142.7 million for 7,385 inpatient and 7,277 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether Tallahassee Memorial complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### **Scope**

Our audit covered \$3,448,702 in Medicare payments to Tallahassee Memorial for 167 claims that we judgmentally selected as potentially at risk for billing errors. These 167 claims had dates of service in CYs 2009 and 2010 and consisted of 69 inpatient and 98 outpatient claims.

We focused our review on the risk areas identified during, and as a result of, prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not use medical review to determine whether the services were medically necessary. We limited our review of Tallahassee Memorial's internal controls to those applicable to the inpatient and outpatient risk areas 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 select risk areas and does not represent an overall assessment of all claims submitted by Tallahassee Memorial for Medicare reimbursement.

We performed fieldwork at Tallahassee Memorial from March through June 2011.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- extracted Tallahassee Memorial's inpatient and outpatient paid claims data from CMS's National Claims History file for CYs 2009 and 2010;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2009 through 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 167 claims (69 inpatient and 98 outpatient) for detailed review;
- 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 Tallahassee Memorial to support the sampled claims;
- requested that Tallahassee Memorial conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed Tallahassee Memorial'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; and
- discussed the results of our review with Tallahassee Memorial 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 objective.

## **FINDINGS AND RECOMMENDATIONS**

Tallahassee Memorial complied with Medicare billing requirements for services on 153 of the 167 claims. However, Tallahassee Memorial did not fully comply with Medicare billing requirements for 14 inpatient and outpatient claims. Specifically, these 14 claims had billing errors that resulted in overpayments totaling \$129,940 for CYs 2009 and 2010. Overpayments occurred primarily because Tallahassee Memorial did not have adequate controls to prevent incorrect billing of Medicare claims, and its staff did not fully understand the Medicare billing requirements.

Of 69 sampled inpatient claims, 11 claims had billing errors resulting in overpayments totaling \$89,223.

- For eight claims, Tallahassee Memorial submitted claims to Medicare with incorrect DRGs.
- For one claim, Tallahassee Memorial incorrectly billed Medicare for a patient discharge that should have been billed as a transfer to another facility.
- For one claim, Tallahassee Memorial incorrectly billed Medicare Part A for a beneficiary stay that should have been billed as outpatient services. Additionally, this claim did not have a valid physician order to admit the beneficiary to inpatient care.
- For one claim, Tallahassee Memorial submitted the claim to Medicare with incorrect charges that resulted in an incorrect outlier payment.

Of 98 sampled outpatient claims, 3 claims had billing errors resulting in overpayments totaling \$40,717.

- For two claims, Tallahassee Memorial either did not obtain a credit for a replaced device that was available under the terms of the manufacturer's warranty (1 error) or it received full credit for a replaced device but did not report the "FB" modifier or reduced charges on its claim (1 error).
- For one claim, Tallahassee Memorial billed Medicare using an incorrect HCPCS code.

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

Tallahassee Memorial incorrectly billed Medicare for 11 of the 69 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$89,223.

### **Incorrect Diagnosis-Related Groups**

The Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

However, for 8 of 69 sampled inpatient claims, Tallahassee Memorial submitted claims to Medicare with incorrect procedure codes, which resulted in incorrect DRGs. For example, one incorrectly coded claim generated DRG 468 (revision of hip or knee replacement) based on a secondary diagnosis code of V43.65 (knee joint replaced by other means). However, the medical records indicated that the surgical procedure was cancelled. The appropriate coding would have resulted in DRG 561 (aftercare, musculoskeletal system and connective tissue) based on a secondary diagnosis code V64.3 (procedure not carried out for other reasons).

Tallahassee Memorial stated that the procedure coding errors occurred because of coder errors in applying the rules or interpreting the documentation. As a result, Tallahassee Memorial received overpayments totaling \$73,683.

### **Incorrect Discharge Status**

Federal Regulations (42 CFR § 412.4(c)) state that a discharge of a hospital inpatient is considered a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to a home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge. A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 1 of 69 sampled inpatient claims, Tallahassee Memorial incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. For this claim, Tallahassee Memorial should have coded the discharge status to a home under a written plan of care for the provision of home health services, instead of as a discharge to home. Accordingly, Tallahassee Memorial should have received the per-diem payment instead of the full DRG payment. Tallahassee Memorial stated that this error occurred because documentation found in the physician's discharge summary differed from the case management notes found within the medical record. As a result, Tallahassee Memorial received an overpayment totaling \$7,937.

### **Incorrectly Billed as Inpatient**

Section 1862(a)(1)(A) of the Act states that no Medicare payment may be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member. Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if, "with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment ...."

For 1 of 69 sampled inpatient claims, Tallahassee Memorial incorrectly billed Medicare Part A for a beneficiary stay that should have been billed as outpatient services. Additionally, the medical records did not have a valid physician order to admit the beneficiary to inpatient care. Tallahassee Memorial stated that the missing orders were due to clerical error. The patient type was incorrectly assigned as inpatient rather than outpatient by the medical record coder. As a result, Tallahassee Memorial received an overpayment totaling \$7,363.

### **Incorrect Charges Resulting in Outlier Overpayment**

The Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. In addition, chapter 3, section 10 states that a hospital may bill only for services provided.

For 1 of 69 sampled inpatient claims, Tallahassee Memorial submitted a claim to Medicare with incorrect charges that resulted in an outlier overpayment. The incorrect charges were for drug, pharmacy, and pulmonary function revenue codes. Tallahassee Memorial stated that this error occurred because its edits did not appropriately preclude charging more than one item per day in this circumstance. In this case, the extra charges resulted in a higher outlier payment on the claim. As a result, Tallahassee Memorial received an overpayment totaling \$240.

## **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

Tallahassee Memorial incorrectly billed Medicare for 3 of 98 sampled outpatient claims, resulting in overpayments totaling \$40,717.

### **Incorrect Reporting of Medical Device Credits**

Federal regulations (42 CFR § 419.45) 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.

#### *Prudent Buyer Principle*

Pursuant to 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services ...” CMS’s *Provider Reimbursement Manual*, part 1, section 2102.1, states, “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.” Section 2103 of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example:

Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment supplied.

#### *Billing Requirements for Medical Device Credits*

CMS guidance in *Transmittal 1103*, dated November 3, 2006, and the Manual explain how a provider should report no-cost and reduced-cost devices under the OPPS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduce charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device.

For 2 of the 98 sampled outpatient claims, Tallahassee Memorial either did not obtain a credit for a replaced device that was available under the terms of the manufacturer's warranty (1 error) or it received full credit for a replaced device but did not report the "FB" modifier or reduced charges on its claim (1 error).

Tallahassee Memorial stated that these errors were caused by the need for human intervention in processing credits for replaced medical devices. As a result, Tallahassee Memorial received overpayments totaling \$39,400.

### **Incorrect Healthcare Common Procedure Coding System Codes**

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. Additionally, the Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 1 of 98 sampled outpatient claims, Tallahassee Memorial billed Medicare using an incorrect HCPCS code. For this claim, Tallahassee Memorial used a code that was not supported by the medical records but was accepted by the coding software. Tallahassee Memorial attributed this error to limitations in its coding software because none of the options available to the coder accurately described the procedure performed. As a result, Tallahassee Memorial received an overpayment totaling \$1,317.

### **RECOMMENDATIONS**

We recommend that Tallahassee Memorial:

- refund to the Medicare contractor \$129,940,
- strengthen controls to ensure full compliance with Medicare requirements, and
- provide training to its staff members to improve their understanding of Medicare billing requirements.

### **TALLAHASSEE MEMORIAL COMMENTS**

In written comments on our draft report, Tallahassee Memorial concurred with our recommendations. Tallahassee Memorial stated that it has implemented stronger internal controls and it will continue to monitor its documentation and billing control process to better comply with Medicare requirements. Furthermore, Tallahassee Memorial has corrected the claims identified as being in error in this report and has submitted amended Medicare claims. Tallahassee Memorial's comments are included in their entirety as the Appendix.

# **APPENDIX**

## APPENDIX: TALLAHASSEE MEMORIAL COMMENTS



**Tallahassee Memorial  
Hospital**

*Tallahassee Memorial HealthCare*

Richard A. Zyski  
Chief Compliance Officer

1300 Miccosukee Road  
Tallahassee, Florida 32308

850 431-5339

October 27, 2011

Mr. John T. Drake, Sr.  
Acting 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: Report Number: A-04-11-08003

Dear Mr. Drake:

On behalf of Tallahassee Memorial HealthCare, Inc. (TMH) and G. Mark O' Bryant, President and Chief Executive Officer of TMH, please accept these comments to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG), draft report entitled *Medicare Compliance Review of Tallahassee Memorial HealthCare, Inc. for Calendar Years 2009 and 2010*.

TMH constantly strives to eliminate billing errors. While TMH would have preferred that no errors were identified, we note that our error rate is extremely low for these types of claims that otherwise have been universally identified by DHHS/OIG as suspected of having high error rates.

We concur with the three report recommendations and note the following with regard to those recommendations:

- 1) We agree that TMH was overpaid as stated in the report by \$129,940. All of the amounts identified as errors in the report have been corrected, and amended claims have been submitted, in accordance with CMS guidelines, to our fiscal intermediary, First Coast Service Options (FCSO). It is our understanding that this process will be completed as soon as the final report related to this examination is issued by the OIG and transmitted to FCSO.
- 2) With regard to the recommendation to strengthen controls, TMH devotes a significant amount of resources to maintain accurate and effective controls. We are constantly making improvements to our documentation and billing processes and related controls. We will continue to do so.

The following corrective actions have been taken to strengthen internal controls:

As a result of this audit, TMH has strengthened its internal processes surrounding explanted medical devices requiring the collaboration of clinical, billing and procurement departments. Additionally, we have revised our internal processes surrounding DRG changes identified internally which will require the collaboration of the medical records, billing, and charge capture departments. Lastly, we have strengthened our Case Management processes in an attempt to ensure that all Inpatient accounts are correctly classified and meet appropriate guidelines for Inpatient admission.

- 3) With regard to the recommendation to provide training to staff members, TMH continuously provides education and training to our colleagues involved in the coding and billing processes. We also provide automated tools and reference resources in order to maintain current knowledge of ever-changing, complex Medicare coding and billing requirements. We will continue to do so.

The following corrective actions have been taken subsequent to the period covered by the OIG audit:

TMH has increased the frequency of external coding reviews in an attempt to enhance the accuracy of its coding practices. Additionally, Case Management personnel have been given additional education in standards for Inpatient admission criteria as well as proper documentation of the correct discharge status for patients.

It has always been and will continue to be our intent to file accurate, complete, and timely Medicare claims with the objective of having no errors or need for adjustments.

Thank you for assisting us by identifying areas for our continuous improvement activities and for the opportunity to provide this commentary.

Sincerely,

/Richard A. Zyski/

Richard A. Zyski  
Chief Compliance Officer

RAZ/svh

cc: G. Mark O'Bryant, President and Chief Executive Officer