



February 7, 2012

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 Services Audits

SUBJECT: Medicare Compliance Review of St. Vincent's Medical Center for Calendar Years 2009 and 2010 (A-01-11-00517) and Medicare Compliance Review of Riverside Methodist Hospital for Calendar Years 2008 Through 2010 (A-05-11-00058)

Attached, for your information, are advance copies of our final reports for two of our hospital compliance reviews. We will issue these reports to St. Vincent's Medical Center and Riverside Methodist Hospital 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.

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, or your staff may contact the respective Regional Inspectors General for Audit Services:

St. Vincent's Medical Center

Michael J. Armstrong, Regional Inspector General for Audit Services, Region I
(617) 565-2689, email – Michael.Armstrong@oig.hhs.gov

Riverside Methodist Hospital

Sheri L. Fulcher, Regional Inspector General for Audit Services, Region V
(312) 353-2618, email – Sheri.Fulcher@oig.hhs.gov

Attachment

cc:
Jacquelyn White, Director
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

February 9, 2012

Report Number: A-01-11-00517

Mr. John Gleckler
Senior Vice President/CFO
St. Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606

Dear Mr. Gleckler:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of St. Vincent's Medical Center 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 David Lamir, Audit Manager, at (617) 565-2704 or through email at David.Lamir@oig.hhs.gov. Please refer to report number A-01-11-00517 in all correspondence.

Sincerely,

/Michael J. Armstrong/
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 12th Street, Room 235
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
ST. VINCENT'S MEDICAL CENTER FOR
CALENDAR YEARS 2009 AND 2010**



Daniel R. Levinson
Inspector General

February 2012
A-01-11-00517

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.

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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 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.

St. Vincent's Medical Center (the Hospital) is a 473-bed acute care hospital located in Bridgeport, Connecticut. Medicare paid the Hospital approximately \$187 million for 18,657 inpatient and 51,715 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 approximately \$3.7 million in Medicare payments to the Hospital for 198 claims that we judgmentally selected as potentially at risk for billing errors. These 198 claims had dates of service in CYs 2009 and 2010 and consisted of 138 inpatient and 60 outpatient claims.

OBJECTIVE

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

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 157 of the 198 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 41 selected inpatient and outpatient claims, resulting in overpayments totaling \$284,773 for CYs 2009 and 2010. Specifically, 38 inpatient claims had billing errors, resulting in overpayments totaling \$265,279, and 3 outpatient claims had billing errors, resulting in overpayments totaling \$19,494. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand Medicare billing requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$284,773, consisting of \$265,279 in overpayments for 38 incorrectly billed inpatient claims and \$19,494 in overpayments for 3 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

ST. VINCENT'S MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations. The Hospital'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 employs Medicare contractors to, among other things, process and pay claims submitted by hospitals.¹

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.

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).² 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 identify and group the services within each APC group.³ All services and items within an APC group are comparable clinically and require comparable resources.

¹ 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 the purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

² In 2009, SCHIP was formally renamed the Children's Health Insurance Program.

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

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 to hospitals reviewed by this and related audits included payments for claims billed for:

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims with payments greater than \$150,000,
- inpatient claims with high severity level DRG codes,
- inpatient and outpatient claims involving manufacturer credits for replaced medical devices,
- inpatient claims paid in excess of charges,
- outpatient claims billed with modifier -59, and
- outpatient claims billed during an inpatient stay.

For the 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 the diagnosis or treatment of illness or injury or to improve 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 the payment.

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.

St. Vincent's Medical Center

St. Vincent's Medical Center (the Hospital) is a 473-bed acute care hospital located in Bridgeport, Connecticut. Medicare paid the Hospital approximately \$187 million for 18,657 inpatient and 51,715 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit covered \$3,695,040 in Medicare payments to the Hospital for 198 claims that we judgmentally selected as potentially at risk for billing errors. These 198 claims had dates of service in CYs 2009 and 2010 and consisted of 138 inpatient and 60 outpatient claims.

We focused our review on the risk areas that we had 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 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. Our review enabled us to establish 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 at the Hospital during June and July 2011.

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 National Claims History file for CYs 2009 and 2010;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2009 and 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 198 claims (138 inpatient and 60 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 the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of selected sampled 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 adjustments; 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 objective.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 157 of the 198 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 41 selected inpatient and outpatient claims, resulting in overpayments totaling \$284,773 for CYs 2009 and 2010. Specifically, 38 inpatient claims had billing errors, resulting in overpayments totaling \$265,279, and 3 outpatient claims had billing errors, resulting in overpayments totaling \$19,494. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 38 of the 138 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$265,279.

Inpatient Short Stays

Section 1862(a)(1)(A) of the Act states that 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.” 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 21 of the 45 sampled claims, the Hospital incorrectly billed Medicare Part A for inpatient claims that did not have valid physician orders to admit beneficiaries for inpatient care (13 errors) or that should have been billed as outpatient or outpatient-with-observation services (8 errors).

The Hospital attributed the lack of valid physician orders to its failure to adhere to Hospital admission-order policies and its need to strengthen procedures to review physician admission orders to confirm the presence of the physician signature. In addition, the Hospital attributed those claims not meeting the inpatient level of care to its inconsistency in applying Hospital standards for determining the admission status of a patient. As a result, the Hospital received overpayments totaling \$151,905.⁴

Inpatient Manufacturer Credits for Replaced Medical Devices

Federal regulations (42 CFR § 412.89) require reductions in the inpatient prospective payment 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 cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

Billing Requirements for Medical Device Credits

The Manual, chapter 3, section 100.8, states that to bill correctly for a replacement device that was provided with a credit, the hospital must code its Medicare claims with a combination of condition codes 49 or 50 along with value code “FD.”

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

⁴ The Hospital may bill Medicare Part B for a limited range of services related to some of these 21 incorrect Medicare Part A short-stay claims. 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 or adjudicated by the MAC prior to the issuance of our report.

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.

Appropriate Level of Care

Section 1862(a)(1)(A) of the Act states that 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.”

For 11 of the 21 sampled claims, the Hospital (1) received a reportable medical device credit for a replaced cardiac pacemaker from a manufacturer but did not adjust its inpatient claim with the proper value and condition codes to reduce payment as required (7 errors), (2) was eligible for a medical-device credit but did not request it (2 errors), or (3) should have billed the device replacement surgery as outpatient or outpatient-with-observation services (2 errors). The Hospital stated that these errors occurred because the Hospital did not have controls in place to report the appropriate value code and charges to reflect the credits received from the manufacturers or to obtain credits available under the terms of manufacturers’ warranties. In addition, the Hospital did not have adequate procedures for coordinating functions among various departments to ensure claims were submitted correctly. The claims identified with erroneous inpatient level of care occurred because of inconsistency in the application of Hospital standards for determining admission status. As a result, the Hospital received overpayments of \$65,535.

Inpatient Same-Day Discharges and Readmissions

The Manual, chapter 3, section 40.2.5, states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay on a single claim.

For 5 of the 30 sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that these errors occurred because of narrow interpretations of the readmission-related principal diagnosis. According to the Hospital,

interpretations have broadened over time with education and better understanding of applicable standards. As a result, the Hospital received overpayments totaling \$30,129.

Inpatient Claims Paid in Excess of Charges

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 the 20 sampled claims, the Hospital incorrectly billed Medicare Part A for a beneficiary stay that did not have a valid physician order to admit the beneficiary for inpatient care. The Hospital attributed the lack of a valid physician order to its failure to adhere to Hospital admission order policies and its need to strengthen procedures to review physician admission orders to confirm the presence of the physician signature. As a result, the Hospital received an overpayment of \$17,710.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 3 of 60 sampled outpatient claims, which resulted in overpayments totaling \$19,494.

Outpatient Manufacturer Credits for Replaced Medical Devices

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.

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 reduced 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.

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.

For 3 of the 20 sampled claims, the Hospital (1) was eligible for a medical device credit but did not request one (2 errors) and (2) received full credit for a replaced device but did not report the “FB” modifier (1 error). The Hospital stated that these errors occurred because the Hospital did not have controls in place to report the appropriate modifiers and charges to reflect the credits received from the manufacturers or to obtain credits available under the terms of manufacturers’ warranties. In addition, the Hospital did not have adequate procedures for coordinating functions among various departments to ensure claims were submitted correctly. As a result, the Hospital received overpayments totaling \$19,494.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$284,773, consisting of \$265,279 in overpayments for 38 incorrectly billed inpatient claims and \$19,494 in overpayments for 3 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

ST. VINCENT’S MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations. The Hospital’s comments are included in their entirety as the Appendix.

APPENDIX



Via UPS

January 5, 2012

Mr. Michael J. Armstrong
 Regional Inspector General for Audit Services
 Department of Health and Human Services
 Office of Audit Services, Region I
 John F. Kennedy Federal Building
 Boston, Massachusetts 02203

Re: Report Number A-01-11-00517

Dear Mr. Armstrong:

This letter provides comments on behalf of St. Vincent's Medical Center ("St. Vincent's") to the draft report entitled "Medicare Compliance Review of St. Vincent's Medical Center for Calendar Years 2009 and 2010" (the "Draft Report"). St. Vincent's appreciates the opportunity to respond to the Draft Report.

As noted in the Draft Report, the Office of Inspector General (the "OIG") reviewed certain payments in nine audit areas determined to be at risk for noncompliance with Medicare billing requirements based on prior OIG audits, investigations and inspections of payments to hospitals. The OIG's audit covered 198 claims and approximately \$3,695,040 in Medicare payments to St. Vincent's.

St. Vincent's concurs with the OIG's findings that of the 198 sampled claims, 41 claims had billing errors that resulted in overpayments totaling \$284,773. The OIG's recommendations and the nature of the corrective action taken or planned is set forth below:

1. The OIG recommends that St. Vincent's refund to the Medicare contractor \$284,773, consisting of \$265,279 in overpayments for 38 incorrectly billed inpatient claims and \$19,494 in overpayments for 3 incorrectly billed outpatient claims.

St. Vincent's will refund these amounts to its Medicare contractor and appropriate secondary payors and, to the extent permitted by Medicare rules, rebill claims as appropriate.

2. The OIG recommends that St. Vincent's strengthen controls to ensure full compliance with Medicare requirements.

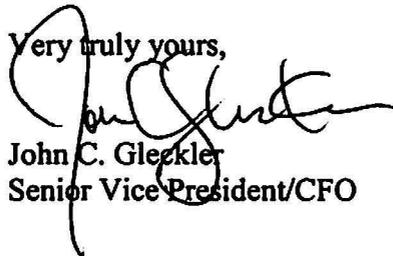
To address the issues raised by the OIG's findings, St. Vincent's has implemented several measures, including the following:

- Revised policies and procedures, and conducted additional education and auditing, regarding inpatient admission requirements and process.
- Implementing a revised process to identify when medical device credits are available, and conducting additional education and auditing with respect to coding and billing of device credits.
- Revised policies and procedures, and conducted additional education, with respect to identification and processing of claims where discharge date and subsequent readmission date are the same.

St. Vincent's takes its compliance obligations very seriously and appreciates the assistance and guidance provided by OIG staff in the review process. We will continue to monitor and audit claims, and institute additional controls and procedures, in the above areas as necessary.

Please contact the undersigned if you need any additional information.

Very truly yours,



John C. Glekler
Senior Vice President/CFO