



September 21, 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 Baystate Medical Center for Calendar Years 2008 and 2009 (A-01-11-00500); and Medicare Compliance Review of University of California, San Francisco, Medical Center for Calendar Years 2008 and 2009 (A-09-11-02034)

Attached, for your information, are advance copies of our final reports for two of our hospital compliance reviews. We will issue these reports to Baystate Medical Center and the University of California, San Francisco, Medical Center within 5 business days.

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

Baystate Medical Center

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

Page 2 – Peter Budetti, Deborah Taylor

University of California, San Francisco, Medical Center

Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX  
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Attachment

cc:

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



Office of Audit Services, Region I  
John F. Kennedy Federal Building  
Room 2425  
Boston, MA 02203

September 26, 2011

Report Number: A-01-11-00500

Mr. Peter A. Lyons  
Vice President, Finance Support Services  
Baystate Health System  
280 Chestnut Street  
Springfield, MA 01199

Dear Mr. Lyons:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Baystate Medical Center for Calendar Years 2008 and 2009*. 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](mailto:David.Lamir@oig.hhs.gov). Please refer to report number A-01-11-00500 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 12<sup>th</sup> Street, Room 235  
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF BAYSTATE MEDICAL  
CENTER FOR CALENDAR YEARS  
2008 AND 2009**



Daniel R. Levinson  
Inspector General

September 2011  
A-01-11-00500

# *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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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 inpatient hospital 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.

Baystate Medical Center (the Hospital) is a 659-bed acute care hospital located in Springfield, Massachusetts. The Hospital was paid approximately \$397 million for 28,542 inpatient and 415,255 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2008 and 2009 based on CMS's National Claims History data.

Our audit covered \$3.5 million in Medicare payments to the Hospital for 86 inpatient and 102 outpatient claims that we identified as potentially at risk for billing errors. These 188 claims had dates of service in CYs 2008 and 2009.

### **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 138 of the 188 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for

selected inpatient and outpatient claims. Specifically, of the 188 claims, 50 claims had errors, resulting in overpayments totaling \$325,120 for CYs 2008 and 2009. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims and did not fully understand Medicare billing requirements.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$325,120, consisting of \$282,455 in overpayments for 23 incorrectly billed inpatient claims and \$42,665 in overpayments for 27 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **BAYSTATE 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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### BAYSTATE MEDICAL CENTER COMMENTS

# 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 inpatient hospital 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.

### **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 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.

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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, requires 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.

<sup>3</sup> 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 same-day discharges and readmissions,
- inpatient short stays,
- inpatient claims paid in excess of charges,
- inpatient claims with payments greater than \$150,000,
- outpatient claims billed during an inpatient stay,
- outpatient evaluation and management service claims billed with surgical services,
- outpatient claims billed with modifier -59,
- outpatient claims paid in excess of charges, and
- outpatient and inpatient manufacturer credits for replaced medical devices.

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 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 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.

## **Baystate Medical Center**

Baystate Medical Center (the Hospital) is a 659-bed acute care hospital located in Springfield, Massachusetts. Medicare paid the Hospital approximately \$397 million for 28,542 inpatient and 415,255 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 and 2009 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 \$3,533,077 million in Medicare payments to the Hospital for 86 inpatient and 102 outpatient claims that we identified as potentially at risk for billing errors. These 188 claims had dates of service in CYs 2008 and 2009.

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 based our review on selected billing requirements and did not include a focused 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 from January through March 2011.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2008 and 2009;
- obtained information on known credits for replacement cardiac medical devices from selected device manufacturers for CYs 2008 and 2009;
- 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 188 claims (86 inpatient and 102 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 the 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 138 of the 188 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, of the 188 claims, 50 claims had billing errors that resulted in overpayments totaling \$325,120 for CYs 2008 and 2009. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims and did not fully understand Medicare billing requirements.

Of 86 sampled inpatient claims, 23 claims had billing errors resulting in overpayments totaling \$282,455:

- For inpatient claims with short stays, the Hospital incorrectly billed Medicare for inpatient stays that lacked valid physician orders to admit beneficiaries for inpatient care, should have been billed as outpatient observation hours, or had a miscoded DRG (13 claims totaling \$148,193 in overpayments).
- For inpatient claims with same-day discharges and readmissions, the Hospital billed Medicare separately for related discharges and readmissions within the same day (eight errors totaling \$110,371 in overpayments).
- For inpatient claims with payments greater than \$150,000, the Hospital billed Medicare for an incorrect DRG (one error resulting in a \$19,496 overpayment).
- For inpatient claims involving manufacturer credits for replaced medical devices, the Hospital did not properly report a device credit received from a manufacturer on its Medicare claim (one error resulting in a \$4,395 overpayment).

Of 102 sampled outpatient claims, 27 claims had billing errors, resulting in overpayments totaling \$42,665:

- For outpatient claims involving manufacturer credits for replaced medical devices, the Hospital did not properly report device credits received from manufacturers on its Medicare claims (12 errors totaling \$36,547 in overpayments).
- For outpatient claims paid in excess of charges, the Hospital submitted claims to Medicare with incorrect HCPCS codes (two errors totaling \$4,777 in overpayments).
- For outpatient claims billed during an inpatient stay, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays that should have been included on the Hospital's inpatient (Part A) bills to Medicare (12 errors totaling \$1,265 in overpayments).
- For outpatient evaluation and management service claims billed with surgical services, the hospital incorrectly billed Medicare for a service that was not documented in the medical record (one error resulting in a \$76 overpayment).

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

The Hospital incorrectly billed Medicare for 23 of 86 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$282,455.

## **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 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 ....”

The Manual, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

For 13 of 30 sampled claims, the Hospital incorrectly billed Medicare Part A for inpatient claims that lacked a valid physician’s order in the medical record to admit beneficiaries to inpatient care (10 errors), incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient services (2 errors), and billed with an incorrect DRG (1 error).

The inpatient claims we identified as lacking physician orders contained “bed reservations,” which, according to the Hospital, represented physician orders. We reviewed the “bed reservation” documentation provided to us and found that these reports did not meet the criteria of a physician order (i.e., physician signature) to admit patients to inpatient status. The Hospital subsequently agreed and has implemented a Web-based training program for physicians on proper inpatient admitting procedures. Two claims were billed as inpatient services, but should have been billed under outpatient observation status. The remaining claim involved an incorrect DRG assignment, resulting from an erroneously applied procedure code. The Hospital agreed with the status of these three claims. As a result of these errors, the Hospital received overpayments totaling \$148,193.

## **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 8 out of 16 sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. In each of these instances, the original claim and the claim(s) involving subsequent readmission were related to the same medical condition(s) and should have been billed as a continuous stay. However, in each of these cases, the Hospital did not adjust the original claim by combining the original and subsequent stays onto a single claim. These errors occurred because the Hospital did not have an additional level of review in place to

determine whether the stays were related. As a result of these errors, the Hospital received overpayments totaling \$110,371.

### **Inpatient Claims With Payments Greater Than \$150,000**

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For one out of six sampled claims, the Hospital billed Medicare with an incorrect DRG. For this claim, the Hospital stated that it included an erroneous surgical procedure code that resulted in the inaccurate DRG. This error occurred because of a lack of proper oversight of coding/billing decisions. As a result of this error, the Hospital received overpayments totaling \$19,496.

### **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.

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.”

For one of the four sampled claims, the Hospital received a reportable medical device credit for a replaced cardiac pacemaker from a manufacturer. However, the Hospital did not adjust its inpatient claim with the proper value and condition codes to reduce payment as required. This error was due to the Hospital’s lack of controls to report the appropriate billing codes. As a result, the Hospital received an overpayment of \$4,395.

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

The Hospital incorrectly billed Medicare for 27 of 102 sampled outpatient claims, which resulted in overpayments totaling \$42,665.

### **Outpatient Manufacturer Credits for Replaced Medical Devices**

Federal regulations (42 CFR § 419.45) require reductions in the OPPS payments 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.

CMS guidance in Transmittal 1103, dated November 3, 2006, and in the Manual explains 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. 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 (the Manual, chapter 4, section 61.3.1). If the provider receives full credit from the manufacturer for a replaced device that is less expensive than the replacement device, the provider must report a charge that represents the difference between its usual charge for the device being implanted and its usual charge for the device for which it received credit (the Manual, chapter 4, section 61.3.2).

For services furnished on or after January 1, 2008, CMS requires the provider to report the modifier “FC” on a claim that includes a procedure code for the insertion of a replacement device if the provider receives a credit from the manufacturer of 50 percent or more of the cost of the replacement device. Partial credits for less than 50 percent of the cost of a replacement device need not be reported with any modifier.

For 12 out of 24 sampled claims, the Hospital did not comply with Medicare requirements for reporting the appropriate billing codes and charges to reflect the credits it received from medical device manufacturers. Specifically, for nine of these claims, the Hospital received full credits from manufacturers but used the partial credit modifier “FC” to report the credit on its claim instead of the appropriate full credit “FB” modifier. For the remaining three claims, the Hospital received full credits from manufacturers but did not report the required “FB” modifier nor reduce its charges on the claims. In these instances, the Hospital misunderstood the Medicare billing requirements for device credits. As a result of these errors, the Hospital received overpayments totaling \$36,547.

### **Outpatient Claims Paid in Excess of Charges**

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. The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For 2 out of 19 sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes. For example, for one claim, the Hospital billed for shoulder arthroscopy while the patient’s medical records showed knee arthroscopy. The Hospital attributed these errors to clerical oversights. As a result of these errors, the Hospital received overpayments totaling \$4,777.

### **Outpatient Claims Billed During an Inpatient Stay**

The Manual, chapter 3, section 10.4, states that certain items and nonphysician services furnished to inpatients are covered under Part A and consequently are covered by the inpatient prospective payment rate.

For 12 out of 15 sampled claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays that should have been included on the Hospital’s

inpatient (Part A) bills to Medicare. Most of these outpatient claims billed in error were for laboratory, chemotherapy, audiology, and radiology services. The Hospital attributed these errors to its patient accounting system, which was not designed to identify outpatient charges entered after the Hospital submitted the inpatient claim to Medicare. As a result, the Hospital received overpayments totaling \$1,265.

### **Outpatient Evaluation and Management Service Claims Billed With Surgical Services**

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. The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For 1 out of 18 sampled claims, the Hospital incorrectly billed Medicare for an outpatient evaluation and management service that was not documented in the medical record. The Hospital attributed this overpayment to a clerical error. As a result of this error, the Hospital received an overpayment of \$76.

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$325,120, consisting of \$282,455 in overpayments for 23 incorrectly billed inpatient claims and \$42,665 in overpayments for 27 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

### **BAYSTATE 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**

Sent Via Certified Mail



# Baystate Medical Center

A Member of Baystate Health System  
Springfield, Massachusetts 01199  
413-794-0000

August 11, 2011

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

Re: Report Number A-01-11-00500

Dear Mr. Armstrong:

Baystate Medical Center (BMC) has received a draft report from the Department of Health & Human Services, Office of the Inspector General entitled, "*Medicare Compliance Review of Baystate Medical Center for Calendar Years 2008 and 2009*". Baystate Medical Center has had an opportunity to review the report and is in general agreement with the findings.

As the report states, the OIG originally selected for review certain inpatient and outpatient claims submitted by BMC for dates of services January 1, 2008 through December 31, 2009, covering ten audit areas. Eighty-six inpatient and 102 outpatient claims were reviewed and 23 inpatient and 27 outpatient claims errors were identified. The auditors concluded that BMC had received \$325,120 in overpayments for calendar years 2008 and 2009 and recommends that these accounts are refunded to the Medicare contractor.

BMC concurs with the OIG's findings regarding the overpayments and has begun rebilling claims as appropriate. To date \$146,835.44 has been refunded and the remaining refunds are being processed.

In addition the OIG recommends that BMC strengthen controls aimed at reducing the risk of these types of errors from occurring in the future.

- Beginning in fiscal year 2010, Baystate Medical Center had performed audits on inpatient stays and identified the problem with inpatient one day stays. We had found most of the problems happened on weekends and holidays. Corrected rebilling has taken place for short inpatient stays identified during our internal audit process. Our Case Management Department put changes in place to correct

August 11, 2011

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Re: Report Number A-01-11-00500

the process and updated their policies and procedures. These processes and procedures are reviewed annually in coordination with CMS rules and regulations.

- The OIG identified inpatients with same day discharges and readmissions. We have created a new report to identify these types of inpatients. The Patient Accounting and Health Information Management departments have established a process for the evaluation of the inpatient discharge and readmission on the same day. This process is working and accounts are being reviewed by Health Information Management and Patient Accounting prior to billing.
- One inpatient claim paid in excess of \$150,000 with an incorrect DRG was identified by the OIG. This particular account was a highly unusual case for BMC. Education and training to coders is in place and is an ongoing function within Health Information Management.
- With respect to inpatient and outpatient claims involving manufacturer credits for medical devices, the hospital relied on the device vendors for device credits. BMC has since changed its internal process and initiated a tracking system of the original device and replacement devices to properly determine any credit. A new procedure is in place to make sure correct value and condition codes and modifiers are included on claims when a credit is received.
- Outpatient claims with incorrect HCPCS on two claims and one claim with incorrect modifier 25 were identified. The Health Information Management department has implemented reviews for education and training with coders.
- The OIG found outpatient claims billed during DRG payment windows. BMC discovered a problem with our internal reports that identified charges within the 72 hour window but missed charges during the inpatient stay that were incorrectly charged and billed as outpatient. Patient Accounting has implemented a new process to identify and correct any related outpatient charges during an inpatient stay.

BMC will continue to monitor all of the audited areas and will update its controls as necessary.

BMC takes its compliance obligations very seriously. Please feel free to call me if you have any questions about the hospital's effort in this regard or if you require additional information.

Sincerely,



Peter A. Lyons

Vice President, Finance Support Services