

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
NORTH MISSISSIPPI MEDICAL CENTER
FOR 2013 AND 2014**

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December 2016
A-04-15-00106

Office of Inspector General

<http://oig.hhs.gov>

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EXECUTIVE SUMMARY

North Mississippi Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated overpayments of at least \$119,000 over nearly 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar years 2013 and 2014, Medicare paid hospitals \$156 billion and \$159 billion, respectively, which represented 45 and 46 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether North Mississippi Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Under section 1128J(d) of the Social Security Act and 42 CFR part 401 subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

The Hospital, which is part of North Mississippi Health Services, is a 650-bed regional referral center located in Tupelo, Mississippi. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$249 million for 19,134 inpatient and 183,066 outpatient claims with dates of payment from January 1, 2013, through August 31, 2014.

Our audit covered \$37,365,314 in Medicare payments to the Hospital for 8,611 claims that were potentially at risk for billing errors. We selected a stratified random sample of 237 claims with payments of \$2,936,866 for review. These 237 claims had payment dates in the period

January 1, 2013, through August 31, 2014 (audit period), and consisted of 110 inpatient and 127 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 158 of the 237 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 79 claims, resulting in overpayments of \$40,849 for the audit period. Specifically, 4 inpatient claims had billing errors, resulting in overpayments of \$11,905, and 75 outpatient claims had billing errors, resulting in overpayments of \$28,944. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$119,365 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$119,365 (of which \$40,849 was overpayments identified in our sample) in estimated overpayments for incorrectly billed services;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

NORTH MISSISSIPPI MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed with all but one of our findings and concurred with our recommendations. Although it disagreed that it incorrectly billed three inpatient claims, the Hospital commented that it was in the process of refunding the extrapolated overpayment of \$119,365. Additionally, the Hospital stated that it had strengthened controls to ensure full compliance with Medicare requirements and had rebilled modifier -59 outpatient services that were within CMS's timely filing frame.

OUR RESPONSE

We stand by the independent medical review contractor's determinations and the auditors' professional judgments that the Hospital did not fully comply with Medicare billing requirements for the disputed claims. Therefore, we maintain that all of our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar years 2013 and 2014, Medicare paid hospitals \$156 billion and \$159 billion, respectively, which represented 45 and 46 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

The objective of this review was to determine whether North Mississippi Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

CMS contracts with Medicare Administrative Contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each

APC group.¹ All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- inpatient manufacturer credits for replaced medical devices,
- inpatient claims paid in excess of charges,
- inpatient claims billed with high-severity-level DRG codes,
- outpatient manufacturer credits for replaced medical devices,
- outpatient claims paid greater than \$25,000, and
- outpatient claims billed with modifier -59.

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

Medicare Requirements for Hospital Claims and Payments

Under the Social Security Act (the Act), 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” (§ 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

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

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

Under section 1128J(d) of the Social Security Act and 42 CFR part 401 subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments

¹ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

within 60 days of identifying those overpayments (42 CFR 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

North Mississippi Medical Center

The Hospital, which is part of North Mississippi Health Services, is a 650-bed regional referral center located in Tupelo, Mississippi. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$249 million for 19,134 inpatient and 183,066 outpatient claims with dates of payment from January 1, 2013, through August 31, 2014.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$37,365,314 in Medicare payments to the Hospital for 8,611 claims that were potentially at risk for billing errors. We selected a stratified random sample of 237 claims with payments of \$2,936,866 for review. These 237 claims had payment dates in the period January 1, 2013, through August 31, 2014 (audit period), and consisted of 110 inpatient and 127 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals and evaluated compliance with selected billing requirements. We submitted 29 claims to an independent medical review contractor to determine whether the services met coding requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims that the Hospital submitted for Medicare reimbursement.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

See Appendix A for the details of our scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 158 of the 237 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 79 claims, resulting in overpayments of \$40,849 for the audit period. Specifically, 4 inpatient claims had billing errors, resulting in overpayments of \$11,905, and 75 outpatient claims had billing errors, resulting in overpayments of \$28,944. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

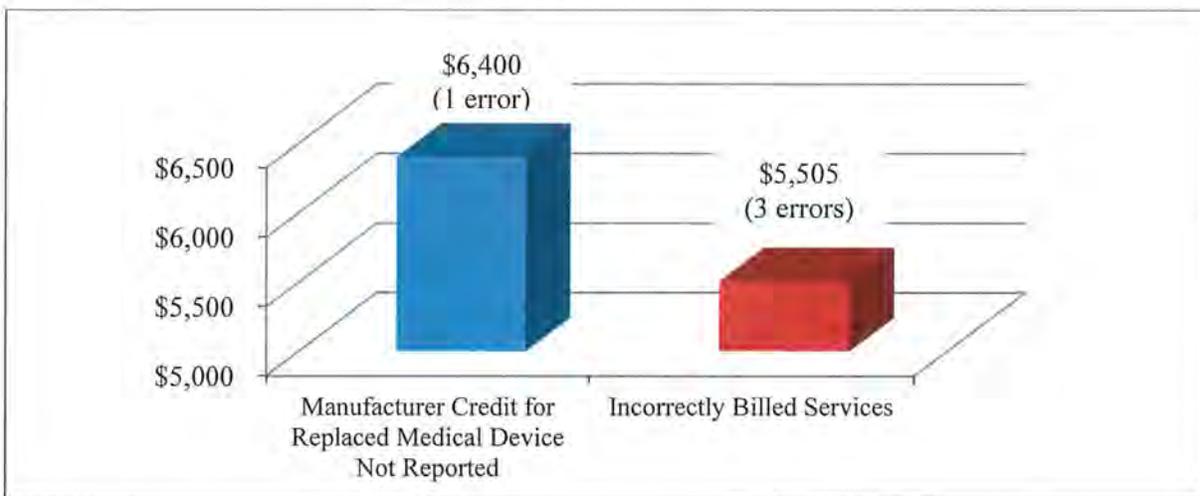
On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$119,365 for the audit period.

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

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 4 of 110 sampled inpatient claims, which resulted in overpayments of \$11,905 as shown in Figure 1 below.

Figure 1: Inpatient Billing Errors



Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of the device, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89(a)). The Manual states that to correctly bill for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50 (which identifies the replacement device) and value code FD (which identifies the amount of the credit or cost reduction received by a hospital for the replaced device) (chapter 3, § 100.8).

Federal regulations state: “All payments to providers of services must be based on the reasonable cost of services ...” (42 CFR § 413.9). The CMS *Provider Reimbursement Manual* (PRM), Pub. No. 15-1, reinforces these requirements in additional detail.²

For 1 of the 110 sampled claims, the Hospital received a reportable medical device credit from manufacturers but did not adjust its inpatient claim with the proper condition and value code to reduce payment as required. Hospital officials stated that this error occurred because the Hospital was not aware that it had received the medical device credit.

As a result of this error, the Hospital received an overpayment of \$6,400.

Incorrectly Billed Services

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(a)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 3 of the 110 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary services. Hospital officials disagreed with our determination that the Hospital had billed these claims incorrectly.

As a result of these errors, the Hospital received overpayments of \$5,505.

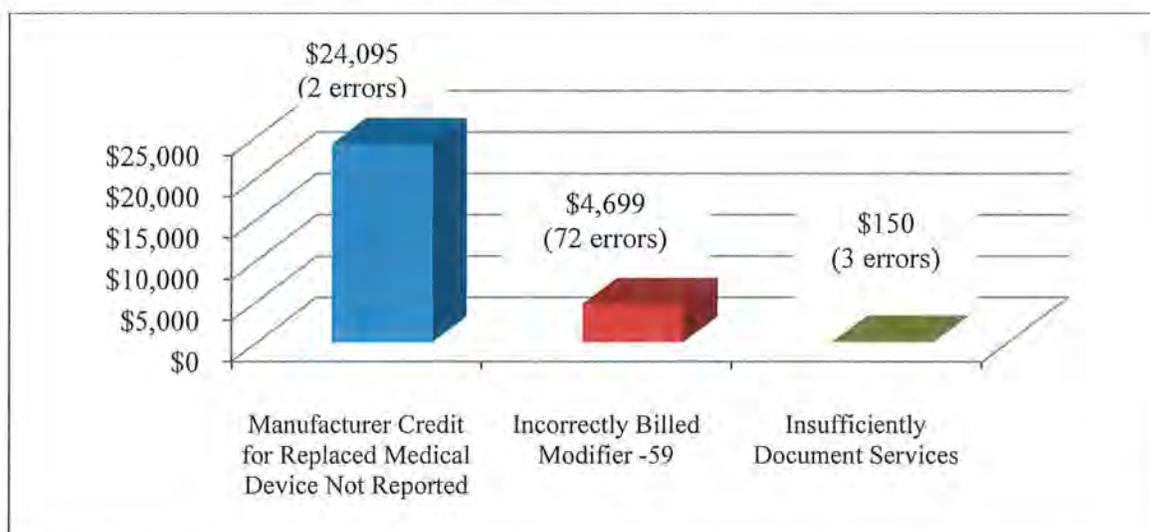
BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 75³ of 127 sampled outpatient claims, which resulted in overpayments of \$28,944 as shown in Figure 2 below.

² The PRM 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” (part I, § 2102.1). Section 2103 further defines prudent buyer principles and 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.”

³ Of the 75 outpatient claims, 2 had more than 1 type of error for a total of 77 errors.

Figure 2: Outpatient Billing Errors



Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of a replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45(a)). As described in footnote 2 of this report, the PRM reinforces these requirements in additional detail.

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. 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.

For 2 of the 127 sampled claims, the Hospital received full credit for a replaced device but did not report the -FB modifier and reduce charges on its claim. Hospital officials stated that these errors occurred because the Hospital was not aware it had received the medical device credits.

As a result of these errors, the Hospital received overpayments of \$24,095.

Incorrectly Billed Outpatient Services With Modifier -59

The Manual states: “The ‘-59’ modifier is used to indicate a distinct procedural service.... This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)” (chapter 23, § 20.9.1.1). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 72 of the 127 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes appended with modifier -59, which either were already included in the payments for other services billed on the same claim or did not require modifier -59. Hospital officials stated that the Hospital relied on prior appeals experience when billing claims with modifier -59. Additionally, the Hospital has changed its billing processes pertaining to the use of modifier -59 as a result of our review.

As a result of these errors, the Hospital received overpayments of \$4,699.

Insufficiently Documented Services

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

For 3 of the 127 sampled claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record. Hospital officials attributed the incorrectly billed services to human error.

As a result of these errors, the Hospital received overpayments of \$150.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$119,365 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$119,365 (of which \$40,849 was overpayments identified in our sample) in estimated overpayments for incorrectly billed services;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

NORTH MISSISSIPPI MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

NORTH MISSISSIPPI MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed with all but one of our findings and concurred with our recommendations. Although it disagreed that it incorrectly billed three inpatient claims, the Hospital commented that it was in the process of refunding the extrapolated overpayment of \$119,365. Additionally, the Hospital stated that it had strengthened controls to ensure full compliance with Medicare requirements and had rebilled modifier -59 outpatient services that were within CMS's timely filing frame.

OUR RESPONSE

We stand by the independent medical review contractor's determinations and the auditors' professional judgments that the Hospital did not fully comply with Medicare billing requirements for the disputed claims. Therefore, we maintain that all of our findings and recommendations are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$37,365,314 in Medicare payments to the Hospital for 8,611 claims that were potentially at risk for billing errors. We selected a stratified random sample of 237 claims with payments totaling \$2,936,866 for review. These 237 claims had payment dates in the period January 1, 2013, through August 31, 2014, and consisted of 110 inpatient and 127 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals and evaluated compliance with selected billing requirements. We submitted 29 claims to an independent medical review contractor to determine whether the services met coding requirements.

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

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

We conducted our fieldwork from July 2015 through September 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 237 claims (110 inpatient and 127 outpatient) totaling \$2,936,866 for detailed review (Appendix B and C);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for submitting Medicare claims;
- used an independent medical review contractor to determine whether 29 claims met coding requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample review to calculate the estimated Medicare overpayments to the Hospital (Appendix C); and
- discussed the results of our review with Hospital officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

TARGET POPULATION

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

SAMPLING FRAME

Inpatient Claims

According to CMS's National Claims History data, Medicare paid the Hospital approximately \$187 million for 19,134 inpatient claims from January 1, 2013, through August 31, 2014, for services provided to beneficiaries. Our Advanced Audit Techniques Staff (AATS) provided us with a database of claims totaling \$105 million for 8,985 claims in 12 high-risk areas.

From these 12 risk areas, we selected 3 areas consisting of 4,819 claims totaling \$59,282,933 for further refinement. The high-risk areas were:

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

We performed data filtering and analysis of the claims within each of the three high-risk areas. The specific filtering and analysis steps performed varied, depending on the risk area, but included such procedures as removing:

- claims with certain patient discharge status codes;
- \$0 paid claims;
- claims duplicated within individual risk areas by assigning each inpatient claim that appeared in multiple risk areas to just one category on the basis of the following hierarchy:
 - inpatient manufacturer credits for replaced medical devices,
 - inpatient claims paid in excess of charges, and
 - inpatient claims billed with high-severity-level DRG codes; and
- claims under review by the Recovery Audit Contractor as of April 13, 2015.

This data filtering resulted in a sampling frame of 2,363 unique Medicare claims totaling \$17,968,728.

Outpatient Claims

According to CMS's National Claims History data, Medicare paid the Hospital approximately \$62 million for 183,066 outpatient claims from January 1, 2013, through August 31, 2014, for services provided to beneficiaries. Our AATS provided us with a database of claims totaling \$31 million for 72,557 claims in 17 high-risk areas.

From these 17 risk areas, we selected 3 areas consisting of 30,040 claims totaling \$23,079,514 for further refinement. The high-risk areas were:

- outpatient manufacturer credits for replaced devices,
- outpatient claims paid in excess of \$25,000, and
- outpatient claims billed with modifier -59.

We performed data filtering and analysis of the claims within each of the three high-risk areas. The specific filtering and analysis steps performed varied depending on the risk area, but included such procedures as removing:

- claims with certain patient discharge status codes and revenue codes;
- \$0 paid claims;
- claims duplicated within individual risk areas by assigning each inpatient claim that appeared in multiple risk areas to just one category on the basis of the following hierarchy:
 - outpatient manufacturer credits for replaced medical devices,
 - outpatient claims paid in excess of \$25,000, and
 - outpatient claims billed with modifier -59; and
- claims under review by the Recovery Audit Contractor as of April 13, 2015.

This data filtering resulted in a sample frame of 6,248 unique Medicare claims totaling \$19,396,586.

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into six strata on the basis of risk area and split two risk areas on the basis of dollar value. The split risk areas were: Inpatient Claims Billed With High-Severity-Level DRG Codes (low and high), and Outpatient Claims Billed With Modifier -59 (low and high).

SAMPLE SIZE

We selected 237 claims for review as shown in Table 1.

Table 1: Stratum, Risk Area, Frame, and Sample Detail

Stratum	Risk Area	Frame Size	Value of Frame	Sample Size
1	Inpatient Manufacturer Credits for Replaced Medical Devices	10	\$242,027	10
2	Inpatient Claims Paid in Excess of Charges	324	3,067,104	30
3	Low-Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes	1,556	8,364,833	40
4	High-Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes	473	6,294,764	30
5	Outpatient Manufacturer Credits for Replaced Medical Devices	27	525,729	27
6	Outpatient Claims Paid Greater Than \$25,000	162	4,624,091	30
7	Low-Dollar Outpatient Claims Billed With Modifier -59	4,960	5,108,848	30
8	High-Dollar Outpatient Claims Billed With Modifier -59	1,099	9,137,918	40
	Total	8,611	\$37,365,314	237

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments paid to the Hospital during the audit period. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1*	10	\$242,027	10	\$242,027	1	\$6,400
2	324	3,067,104	30	294,018	3	5,505
3	1,556	8,364,833	40	216,368	0	0
4	473	6,294,764	30	422,422	0	0
5*	27	525,729	27	525,729	17	26,143
6	162	4,624,091	30	868,418	16	487
7	4,960	5,108,848	30	34,393	9	226
8	1,099	9,137,918	40	333,491	33	2,088
Total	8,611	\$37,365,314	237	\$2,936,866	79	\$40,849

*We reviewed all claims in this stratum.

ESTIMATES

**Table 3: Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval**

Point Estimate	\$189,361
Lower Limit	\$119,365
Upper Limit	\$259,358

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Inpatient Manufacturer Credits for Replaced Medical Devices	10	\$242,027	1	\$6,400
Inpatient Claims Paid in Excess of Charges	30	294,018	3	5,505
Low-Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes	40	216,368	0	0
High-Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes	30	422,422	0	0
Inpatient Totals	110	\$1,174,835	4	\$11,905
Outpatient				
Outpatient Manufacturer Credits for Replaced Medical Devices	27	\$525,729	17	\$26,143
Outpatient Claims Paid Greater Than \$25,000	30	868,418	16	487
Low-Dollar Outpatient Claims Billed With Modifier -59	30	34,393	9	226
High-Dollar Outpatient Claims Billed With Modifier -59	40	333,491	33	2,088
Outpatient Totals	127	\$1,762,031	75	\$28,944
Inpatient and Outpatient Totals	237	\$2,936,866	79	\$40,849

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX E: NORTH MISSISSIPPI MEDICAL CENTER COMMENTS



**NORTH MISSISSIPPI
MEDICAL CENTER**

December 6, 2016

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

Subject: Report Number A-04-15-00106
Medicare Compliance Review of North Mississippi Medical Center for 2013 and 2014

Dear Ms. Pilcher,

North Mississippi Medical Center (NMMC) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) Draft Report titled **Medicare Compliance Review of North Mississippi Medical Center for 2013 and 2014, Report Number: A -04-15-00106** Report.

North Mississippi Medical Center is highly committed to ensuring that the Hospital complies with all federal healthcare regulations and standards by educating our physicians, Patient Access/Registration, Case Management, and Health Information Management staff. We are committed to having an effective compliance program and internal audits designed to detect and prevent billing errors.

NMMC's response to the OIG's findings and recommendations in the Report are detailed below.

NMMC Responses:

Billing Errors Associated with Inpatient Claims

Manufacturer Credit for Replaced Medical Device Not Reported

The Report found NMMC incorrectly billed one (1) out of one hundred ten (110) inpatient claims to Medicare. NMMC agrees with the OIG finding. NMMC continues to review and strengthen internal controls over this billing process. NMMC believed that the billing for the patient at the time was in compliance with CMS regulations. We have corrected our internal policy and audit measures, and have provided training to staff to ensure full compliance moving forward.

Incorrectly Billed Services

The Report found NMMC incorrectly billed three (3) out of one hundred ten (110) inpatient claims to Medicare. NMMC respectfully disagrees with the OIG findings. NMMC believes its documentation supports the submitted claims.

In 2014, NMMC implemented a robust Clinical Documentation Improvement process (CDI) to ensure proper documentation exists to support billing. For over ten years, NMMC has required: i) all Inpatient coders to have the Certified Coding Specialist (CCS) credentials, ii) employed physician advisors to review patient records for complete and consistent documentation, and finally, iii) NMMC has retained external audit oversight to ensure compliance with coding guidelines and to prevent billing errors.

Billing Errors Associated with Outpatient Claims

Manufacturer Credit for Replaced Medical Device Not Reported

The Report found NMMC incorrectly billed two (2) out of one hundred twenty-seven (127) outpatient claims to Medicare. NMMC agrees with the OIG finding. NMMC continues to review and strengthen internal controls over this billing process. NMMC believed that, at the time, the billing for the patient was in compliance with CMS regulations. We have corrected our internal policy and audit measures, and have provided training to staff to ensure full compliance moving forward.

Incorrectly Billed Outpatient Services with Modifier-59

The Report found NMMC incorrectly billed for HCPCS codes appended with modifier - 59, for seventy-two (72) of one hundred twenty-seven (127) sampled claims. NMMC agrees with the OIG findings. Physician orders and medical necessity were both present for services provided; however, these should not have been separately billed as distinct procedural services. NMMC has taken appropriate action to ensure future compliance. NMMC has also rebilled services which were in the timely filing time frame of CMS.

Insufficiently Documented Services

The Report found NMMC incorrectly billed three (3) out of one hundred twenty-seven (127) outpatient claims to Medicare. NMMC agrees with the OIG findings. NMMC believes that controls are in place to ensure that documentation and coding are appropriate. NMMC believes these were not systemic but random errors.

SUMMARY

We concur to the repayments as stated in this letter. We are in the process of refunding the extrapolated payment of \$119,365.

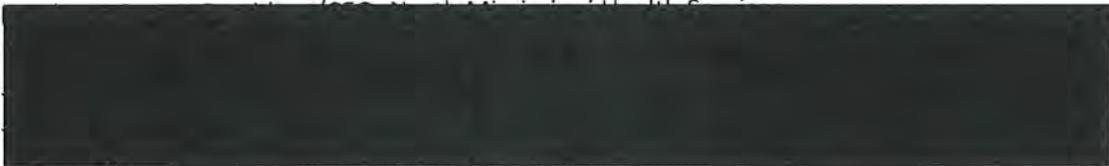
We would like to thank the OIG audit staff who conducted the review of NMMC for their professionalism, courteousness, and willingness to work with our staff. We appreciated the opportunity to have communication to resolve questions and issues in a timely and collaborative manner. NMMC continues to have a strong compliance program to support accurate billing and coding. Our coding department uses extensive internal and external means to support accurate billing. If you have any questions or require further information, please contact us.

Sincerely,



Bruce J. Toppin
VP & General Counsel
Privacy Officer & Secretary
North Mississippi Health Services

CC:



The Office of the Inspector General Note - The deleted text has been redacted because it is personally identifiable.