

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF HUNTSVILLE
HOSPITAL FOR 2013 AND 2014**

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May 2016
A-04-15-00107

Office of Inspector General

<http://oig.hhs.gov>

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EXECUTIVE SUMMARY

Huntsville Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated overpayments of at least \$203,000 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 (CYs) 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 Huntsville Hospital (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.

The Hospital, which is part of Huntsville Hospital Health System, is a 941-bed acute care teaching hospital located in Huntsville, Alabama. Medicare paid the Hospital approximately \$366 million for 25,978 inpatient and 332,238 outpatient claims with dates of payment from January 1, 2013, through August 31, 2014, based on CMS's National Claims History data.

Our audit covered \$57,845,939 in Medicare payments to the Hospital for 16,397 claims that were potentially at risk for billing errors. We selected a stratified random sample of 277 claims with payments of \$3,893,152 for review. These 277 claims had payment dates in the period January 1, 2013, through August 31, 2014 (audit period), and consisted of 140 inpatient and 137 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 178 of the 277 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 99 claims, resulting in net overpayments of \$23,757 for the audit period. Specifically, 7 inpatient claims had billing errors, resulting in net overpayments

of \$18,027, and 92 outpatient claims had billing errors, resulting in overpayments of \$5,730. 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 \$203,226 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$203,226 (of which \$23,757 was net overpayments identified in our sample) in estimated overpayments for incorrectly billed services and
- strengthen controls to ensure full compliance with Medicare requirements.

HUNTSVILLE HOSPITAL COMMENTS

In written comments on our draft report, the Hospital agreed with all but one of our findings and, “while not admitting any wrong doing,” concurred with our recommendations. However, the Hospital respectfully disagreed with our finding regarding incorrectly billed outpatient services with modifier -59. The Hospital commented that it “was billing under guidance from the Hospital’s Medicare Administrative Contractor (MAC) that the billing practice was compliant with CMS regulations.” It also commented that Recovery Audit Contractor audits of similar Hospital claims had revealed 90 percent compliance. Despite this disagreement, the Hospital acknowledged the criteria for which it will be accountable in the future, and it agreed to refund the entire overpayment as recommended. Additionally, the Hospital stated that it had strengthened controls to ensure full compliance with Medicare requirements.

OUR RESPONSE

We stand by the MAC medical review staff’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 (CYs) 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 Huntsville Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Medicare Program

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

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

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

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

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

Hospital Claims at Risk for Incorrect Billing

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

- inpatient manufacturer credits for replaced medical devices,
- inpatient claims paid greater than \$150,000,
- 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).

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

Huntsville Hospital

The Hospital, which is part of Huntsville Hospital Health System, is a 941-bed acute care teaching hospital located in Huntsville, Alabama. Medicare paid the Hospital approximately \$366 million for 25,978 inpatient and 332,238 outpatient claims with dates of payment from January 1, 2013, through August 31, 2014, based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$57,845,939 in Medicare payments to the Hospital for 16,397 claims that were potentially at risk for billing errors. We selected a stratified random sample of 277 claims with payments of \$3,893,152 for review. These 277 claims had payment dates in the period January 1, 2013, through August 31, 2014 (audit period), and consisted of 140 inpatient and 137 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 seven claims for medical review by the MAC 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 submitted by the Hospital for Medicare reimbursement.

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

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

FINDINGS

The Hospital complied with Medicare billing requirements for 178 of the 277 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 99 claims, resulting in net overpayments of \$23,757 for the audit period. Specifically, 7 inpatient claims had billing errors, resulting in net overpayments of \$18,027, and 92 outpatient claims had billing errors, resulting in overpayments of \$5,730. 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.

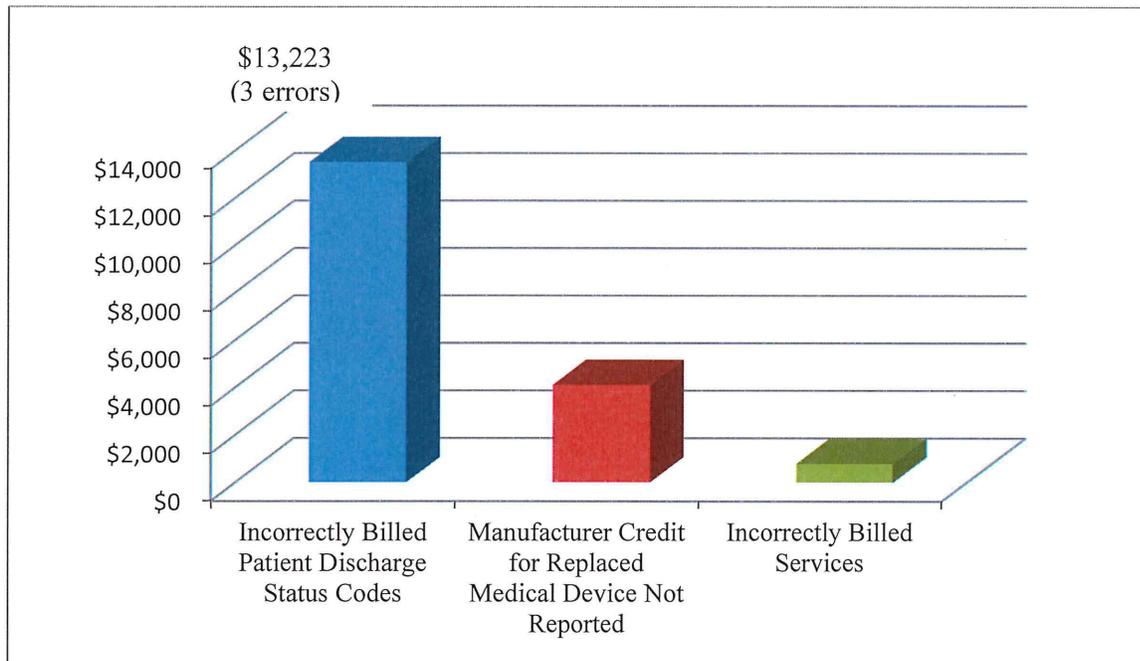
On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$203,226 for the audit period.

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 7 of 140 sampled inpatient claims, which resulted in net overpayments of \$18,027 as shown in Figure 1 below.

Figure 1: Inpatient Billing Errors



Incorrectly Billed Patient Discharge Status Codes

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

For 3 of the 140 sampled claims, the Hospital billed Medicare with an incorrect discharge status code. The Hospital billed these three claims as discharge to home (status code “01”). However, after discharge, the patient received home health care services related to the inpatient admitting diagnosis (status code “06”). Therefore, these were incorrectly billed as routine discharges instead of post-acute care transfers.² The Hospital stated that these errors occurred primarily because it did not gather sufficient information from patients to properly determine the discharge disposition.

As a result of these errors, the Hospital received overpayments of \$13,223.

² Under Medicare’s transfer policy, DRG payments are reduced when a patient is transferred to home with home health care services and receives clinically related care that begins within 3 days of hospital discharge.

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 the 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.³

For 1 of the 140 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. The Hospital stated that this error occurred because it misunderstood the application of the regulations applying to this billing circumstance.

As a result of this error, the Hospital received an overpayment of \$4,018.

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 140 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary services. The Hospital stated that these errors occurred primarily because of human error.

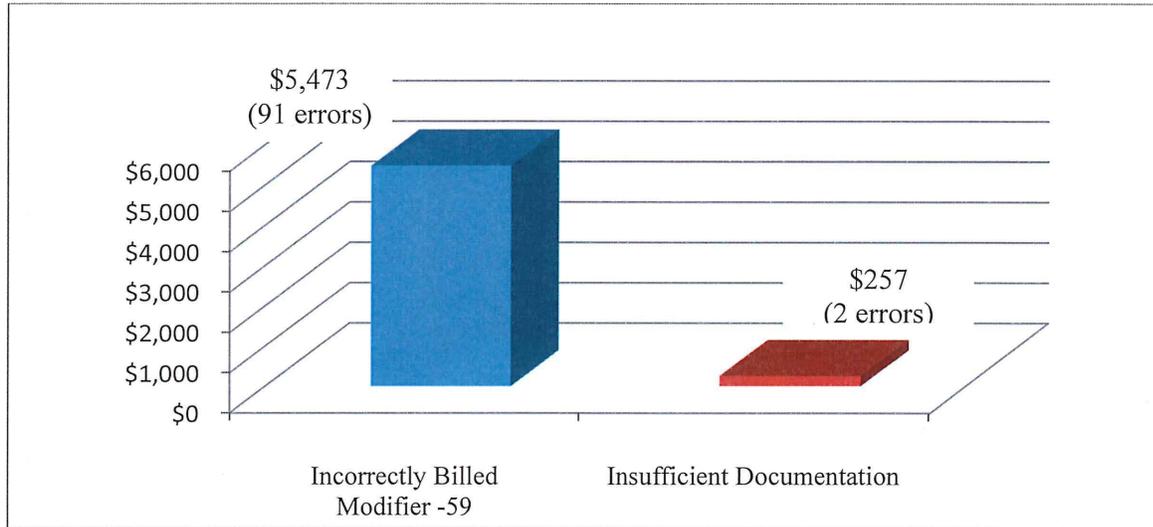
As a result of these errors, the Hospital received net overpayments of \$786.

³ 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.”

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 92⁴ of 137 sampled outpatient claims, which resulted in overpayments of \$5,730 as shown in Figure 2 below.

Figure 2: Outpatient Billing Errors



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 90 of the 137 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes, appended with modifier -59, which were already included in the payments for other services billed on the same claim or did not require modifier -59. For all of these claims, the Hospital billed modifier -59 on electrocardiogram tracing (HCPCS code 93005) either before or after a surgical procedure. However, electrocardiogram tracing was an inherent service normally provided before or after these surgical procedures; therefore, using modifier -59 was incorrect. Hospital officials stated that they relied on prior appeals experience when processing claims for outpatient services with modifier -59 and that the Hospital billed these claims correctly.

As a result of these errors, the Hospital received overpayments of \$5,473.

⁴ Of the 92 outpatient claims, 1 had more than 1 type of error for a total of 93 errors.

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 2 of the 137 sampled claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record. The Hospital stated that the incorrect billings occurred primarily because of human error.

As a result of these errors, the Hospital received overpayments of \$257.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$203,226 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$203,226 (of which \$23,757 was net overpayments identified in our sample) in estimated overpayments for incorrectly billed services and
- strengthen controls to ensure full compliance with Medicare requirements.

HUNTSVILLE HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

HUNTSVILLE HOSPITAL COMMENTS

In written comments on our draft report, the Hospital agreed with all but one of our findings and, “while not admitting any wrong doing,” concurred with our recommendations. However, the Hospital respectfully disagreed with our finding regarding incorrectly billed outpatient services with modifier -59. The Hospital commented that it “was billing under guidance from the Hospital’s Medicare Administrative Contractor (MAC) that the billing practice was compliant with CMS regulations.” It also commented that Recovery Audit Contractor audits of similar Hospital claims had revealed 90 percent compliance. Despite this disagreement, the Hospital acknowledged the criteria for which it will be accountable in the future, and it agreed to refund the entire overpayment as recommended. Additionally, the Hospital stated that it had strengthened controls to ensure full compliance with Medicare requirements. The Hospital’s comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

We stand by the MAC medical review staff'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 \$57,845,939 in Medicare payments to the Hospital for 16,397 claims that were potentially at risk for billing errors. We selected a stratified random sample of 277 claims with payments totaling \$3,893,152 for review. These 277 claims had payment dates in the period January 1, 2013, through August 31, 2014, and consisted of 140 inpatient and 137 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 seven claims for medical review by the MAC 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 through December 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 277 claims (140 inpatient and 137 outpatient) totaling \$3,893,152 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;
- submitted seven claims (two post-acute transfer claims and five outpatient claims billed with modifier -59) for medical review by the MAC to corroborate our determinations regarding coding requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample review to calculate the estimated Medicare overpayments to the Hospital (Appendix C); and
- discussed the results of our review with Hospital officials.

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

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

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

SAMPLING FRAME

Inpatient Claims

According to CMS's National Claims History data, Medicare paid the Hospital approximately \$253 million for 25,978 inpatient claims during 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 \$130 million for 11,621 claims in 13 high-risk areas.

From these 13 risk areas, we selected 4 areas consisting of 7,852 claims totaling \$93,096,284 for further refinement. The high-risk areas were:

- inpatient manufacturer credits for replaced medical devices,
- inpatient claims paid greater than \$150,000,
- 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 four 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 greater than \$150,000,
 - 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 July 21, 2015.

This data filtering resulted in a sampling frame of 2,507 unique Medicare claims totaling \$21,064,556.

Outpatient Claims

According to CMS's National Claims History data, Medicare paid the Hospital approximately \$113 million for 332,238 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 \$92 million for 150,869 claims in 16 high-risk areas.

From these 16 risk areas, we selected 3 areas consisting of 49,896 claims totaling \$83,902,553 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 July 21, 2015.

This data filtering resulted in a sample frame of 13,890 unique Medicare claims totaling \$36,781,383.

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into nine 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 277 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	4	\$65,626	4
2	Inpatient Claims Paid Greater Than \$150,000	6	1,180,106	6
3	Inpatient Claims Paid in Excess of Charges	43	592,046	30
4	Low-Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes	1,979	11,419,842	60
5	High-Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes	475	7,806,936	40
6	Outpatient Manufacturer Credits for Replaced Medical Devices	7	81,974	7
7	Outpatient Claims Paid Greater Than \$25,000	198	5,574,046	30
8	Low-Dollar Outpatient Claims Billed With Modifier -59	11,547	13,767,569	50
9	High-Dollar Outpatient Claims Billed With Modifier -59	2,138	17,357,794	50
	Total	16,397	\$57,845,939	277

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

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

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.

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 Over-payments in Sample
1*	4	\$65,626	4	\$65,626	1	\$4,018
2*	6	1,180,106	6	1,180,106	2	391
3	43	592,046	30	372,789	1	5,200
4	1,979	11,419,842	60	\$334,692	1	2,764
5	475	7,806,936	40	593,797	2	5,654
6*	7	81,974	7	81,974	7	231
7	198	5,574,046	30	812,394	25	709
8	11,547	13,767,569	50	63,241	15	511
9	2,138	17,357,794	50	388,533	45	4,279
Total	16,397	\$57,845,939	277	\$3,893,152	99	\$23,757

*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	\$476,119
Lower Limit	\$203,226
Upper Limit	\$749,013

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	4	\$65,626	1	\$4,018
Inpatient Claims Paid Greater Than \$150,000	6	1,180,106	2	391
Inpatient Claims Paid in Excess of Charges	30	372,789	1	5,200
Low-Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes	60*	334,692	1	2,764
High-Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes	40*	593,797	2	5,654
Inpatient Totals	140	\$2,547,010	7	\$18,027
Outpatient				
Outpatient Manufacturer Credits for Replaced Medical Devices	7	\$81,974	7	\$231
Outpatient Claims Paid Greater Than \$25,000	30*	812,394	25	709
Low-Dollar Outpatient Claims Billed With Modifier -59	50*	63,241	15	511
High-Dollar Outpatient Claims Billed With Modifier -59	50*	388,533	45	4,279
Outpatient Totals	137	\$1,346,142	92	\$5,730
Inpatient and Outpatient Totals	277	\$3,893,152	99	\$23,757

*We submitted seven claims (two post-acute transfer claims and five outpatient claims billed with modifier -59) for medical review by the MAC to corroborate our determinations regarding coding requirements.

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

APPENDIX E: HUNTSVILLE HOSPITAL COMMENTS



101 Sivley Road
Huntsville, AL 35801
(256) 265-1000
huntsvillehospital.org

VIA Email and FedEx

April 21, 2016

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

Subject: **Report Number A-04-15-00107**
Medicare Compliance Review of Huntsville Hospital for 2013 and 2014

Dear Ms. Pilcher:

The Health Care Authority of the City of Huntsville d/b/a Huntsville Hospital (Huntsville Hospital) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) Draft Report titled ***Medicare Compliance Review of Huntsville Hospital for 2013 and 2014, Report Number: A-04-15-00107 (Report)***.

Huntsville Hospital is highly committed to ensuring that the Hospital complies with all Federal healthcare program rules and regulations. To that end, we are committed to having an effective compliance program with internal audits designed to detect and prevent billing errors.

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

Huntsville Hospital Responses:

Billing Errors Associated with Inpatient Claims

Incorrectly Billed Patient Discharge Status Codes

The Report found Huntsville Hospital incorrectly billed three (3) out of one hundred forty (140) Medicare inpatient claims. Huntsville Hospital accepts the findings of the OIG. In these three instances, the Hospital failed to document information from the patient of their status upon admission to the hospital. The medical condition that the patient had was unrelated to the admission condition. (e.g. – a broken leg was not a condition present while in the care of Home Health). We mistakenly discharged

the patient home instead referring back to the pre-hospital care provider. We have reviewed our procedures and upgraded the process to correct the problem. Case Management and Nursing staffs were provided education to correct this process so proper documentation can take place. However, while we agree that we did not have the complete data elements, for two of the claims, we would have been reimbursed at the same rate.

Manufacturer Credits for Replaced Medical Devices not reported

The Report found Huntsville Hospital incorrectly billed one (1) out of one hundred forty (140) inpatient claims to Medicare. Huntsville Hospital agrees with the OIG finding. Huntsville Hospital continues to review and strengthen internal controls over this billing process. Huntsville Hospital 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 Huntsville Hospital incorrectly billed three (3) out of one hundred forty (140) inpatient claims to Medicare. Huntsville Hospital agrees with the OIG findings. Our internal review revealed this to be the result of human error. These errors occurred when the medical record indicated one service was performed, but a different service was charged to the patient. Huntsville Hospital has provided education and training to staff in departments where these errors occurred.

Billing Errors Associated with Outpatient Claims

Incorrectly Billed Outpatient Services with Modifier - 59

The Report found Huntsville Hospital incorrectly billed ninety (90) out of one hundred thirty seven (137) outpatient claims to Medicare. Huntsville Hospital respectfully disagrees with this finding from the OIG. Huntsville Hospital was billing under guidance from the Hospital's Medicare Administrative Contractor (MAC) that the billing practice was compliant with CMS regulations. This same guidance was shared with the OIG during the audit. Furthermore, we have had a significant number of claims of a similar nature subjected to Recovery Audit Contractors (RAC). The RAC audits revealed compliance in over 90% of reviewed claims. We appreciate the honest discussion that the audit team was able to help facilitate concerning our position, as well as that of our MAC. Although we continue to respectfully disagree with the report and the current MAC position taken during the audit process, we acknowledge the criteria which the Hospital will be accountable for in the future. We would like to note that in 2014 the Deputy Inspector General acknowledged that modifier 59 has "controversial interpretations." It would be our hope that OIG, CMS and the MACs would take this opportunity to work collaboratively to establish consistent guidance for providers on the acceptable usage of modifier 59. Our remediation plan is to review all claims with a modifier 59 EKG charge and medical record documentation to ensure the charge is properly supported by a change in the patient's medical condition. Any items that do not meet these criteria will not be billed.

Insufficiently Documented Services

The Report found Huntsville Hospital incorrectly billed two (2) out of one hundred thirty seven (137) outpatient claims to Medicare. Huntsville Hospital agrees with the OIG findings. These errors occurred when a service was charged to the patient but medical record documentation did not support the charge. Huntsville Hospital has provided education and training to staff in the areas where these errors occurred.

SUMMARY

We believe we have submitted documentation and support to successfully challenge the \$5,473 in alleged overpayments related to modifier 59 usages. There has been conflicting difference of guidance regarding modifier 59 usages; however, while not admitting any wrong doing in these matters, Huntsville Hospital agrees to resolve this matter in accordance with the OIG findings. We concur to the other repayments as stated in this letter.

We are in the process of refunding the extrapolated payment of \$203,226 to Medicare to resolve each of these matters, including the modifier 59 issue.

Huntsville Hospital would like to thank the OIG audit staff who conducted the compliance review of Huntsville Hospital for their professionalism, collegiality and willingness to work cooperatively with our staff. We appreciated the willingness to have open dialogue in efforts to resolve questions and issues in a timely and collaborative manner. Huntsville Hospital continues to be committed to its Corporate Compliance Process, which is consistent with our Mission and Values. If you have any questions or require further information, please contact us.

Sincerely,



Jeffrey R. Pigott, CIA, CFE, CHC, CHPC, MBA
Corporate Compliance Officer and Director of Internal Audit
Huntsville Hospital



David S. Spillers
Chief Executive Officer
Huntsville Hospital

CC: Jeff Samz, Chief Operating Officer, Huntsville Hospital
Kelli Powers, Chief Financial Officer, Huntsville Hospital
Kenneth Graves, Vice President Legal Services, Huntsville Hospital
Phillip Bentley, Chairman of the Board, The Health Care Authority of the City of Huntsville