

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**BAYLOR SCOTT & WHITE – COLLEGE
STATION: AUDIT OF OUTPATIENT
OUTLIER PAYMENTS**

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**September 2020
A-06-18-04003**

Office of Inspector General

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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.

Report in Brief

Date: September 2020
Report No. A-06-18-04003

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Medicare makes supplemental payments to hospitals, known as outlier payments, which are designed to protect hospitals from significant financial losses resulting from patient-care cases that are extraordinarily costly. Unlike predetermined payment amounts for most Medicare hospital claims, outlier payments are directly influenced by hospital charges. We selected Baylor Scott & White-College Station (College Station) based on outpatient outlier payments increasing from \$82,555 in 2015 to \$2.6 million in 2016.

Our objective was to determine whether outpatient outlier payments received by College Station were based on properly billed claims.

How OIG Did This Audit

Our audit covered 669 outpatient outlier payments totaling \$2.1 million to College Station for services rendered January 1, 2016, through December 31, 2017. We selected a stratified random sample of 100 outlier payments totaling \$552,221 for review. Because outlier payments are based on total charges, we retrieved the claim detail related to each outlier payment. We submitted the claims related to the 100 outlier payments to College Station for them to review. We requested that College Station verify that charges and codes on the claim were correct. Additionally, OIG reviewed outlier claim data for inconsistencies and claim support documentation for billing errors.

Baylor Scott & White – College Station: Audit of Outpatient Outlier Payments

What OIG Found

College Station properly billed the claims for 18 of the 100 sampled outlier payments totaling \$77,939. However, College Station did not properly bill the claims related to the remaining 82 outlier payments which resulted in improper outlier payments during our audit period. These 82 claims, which had outliers totaling \$474,282, contained 174 billing errors. The billing errors primarily occurred because College Station did not have adequate controls to prevent errors related to overcharged observation time, charge errors, and coding errors.

What OIG Recommends and College Station's Comments

We recommend that College Station refund to the Medicare contractor \$189,276 in estimated overpayments for incorrectly billed claims that are within the reopening period. We also recommended that College Station improve procedures, provide education, and implement changes to their billing system to ensure claims billed to Medicare are accurate.

In written comments on our draft report, College Station did not indicate concurrence or nonconcurrence with our recommendations; however, it described actions that it has taken or plans to take to address them. These actions include reviewing claims with less than 24 hours of observation services, updating its systems to appropriately identify and report self-administered drugs, providing education to Cardiology Department staff, and refunding the remaining portion of the \$189,276 in estimated overpayments for incorrectly billed claims. College Station has also undertaken an internal review of any liability outside of our audit; if any overpayments are identified, it will make refunds.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare makes supplemental payments to hospitals, known as outlier payments, which are designed to protect hospitals from significant financial losses resulting from patient-care cases that are extraordinarily costly. Unlike predetermined payment amounts for most Medicare hospital claims, outlier payments are directly influenced by hospital charges.

A prior Office of Inspector General (OIG) audit focusing on inpatient outlier payments found that a hospital's high charges, unrelated to cost, led to excessive inpatient outlier payments.¹ Additionally, prior OIG audits focusing on outpatient outlier payments² found that billing errors led to increased outlier payments. Therefore, we are performing multiple audits of hospital outpatient outlier payments.³

We selected Baylor Scott & White-College Station (College Station) based on outpatient outlier payments increasing from \$82,555 in 2015 to \$2.6 million in 2016.

OBJECTIVE

The objective of this audit was to determine whether outpatient outlier payments received by College Station were based on properly billed 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 (MACs) to, among other things, process and pay claims submitted by hospitals.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) which was effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS,

¹ OIG *Medicare Hospital Outlier Payments Warrant Increased Scrutiny*, November 2013, (OEI-06-10-00520).

² See Appendix D for related work.

³ Additional audits are ongoing.

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.⁴ All services and items within an APC group are comparable clinically and require comparable resources. In this respect, some services, such as anesthesia, supplies, certain drugs, and use of recovery and observation rooms (packaged services) are included in APCs and are not paid separately.

Outpatient Outlier Payments

Section 1833(t)(5) of the Social Security Act (the Act) provides that a payment adjustment (outlier payment) will be made for covered services whose costs exceed a given threshold. OPSS provides outlier payments to hospitals to help mitigate the financial risk associated with high-cost and complex procedures, when a very costly service could present a hospital with significant financial loss.

CMS's *Provider Reimbursement Manual* (PRM) defines charges as the regular rates established by the hospital for services rendered to both beneficiaries and to other paying patients.⁵ Generally, charges do not affect the current APC payment amounts. However, the total charges for the packaged services are used to calculate outlier payments.

A service or group of services becomes eligible for outlier payments when the cost of the service or group of services estimated using the hospital's most recent overall cost-to-charge ratio separately exceeds each relevant threshold. The current hospital outlier payment is calculated on a service basis using both fixed-dollar and multiple thresholds to determine outlier eligibility.⁶

Medicare Requirements for Hospital Claims and Payments

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."⁷ In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.⁸

⁴ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

⁵ Pub. No. 15-1, part 1, § 2202.4.

⁶ 42 CFR § 419.43(d).

⁷ The Act § 1862(a)(1)(A).

⁸ The Act § 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.⁹

The *CMS Medicare Claims Processing Manual* (the Manual) requires claims to be completed accurately so that Medicare contractors may process them correctly and promptly.¹⁰ Under the hospital OPPS, Medicare payment is based upon predetermined amounts for designated services identified by HCPCS codes.¹¹

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.¹²

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.¹³

Hospital Charge Structure

The PRM states that each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program.¹⁴

National Correct Coding Initiative and Procedure-to-Procedure Claim Processing Edits

To promote correct coding by providers and to prevent Medicare payments for improperly coded services, CMS developed the National Correct Coding Initiative (NCCI). MAC contractors

⁹ 42 CFR § 424.5(a)(6).

¹⁰ Pub. No. 100-04, chapter 1, § 80.3.2.2.

¹¹ 42 CFR § 419.2(a).

¹² The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (February 12, 2016).

¹³ 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); PRM—part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

¹⁴ PRM, Pub. No. 15-1, part 1, § 2203 and § 2202.4.

implemented NCCI edits within their claim processing systems for dates of service on or after January 1, 1996.¹⁵

The NCCI edits include procedure-to-procedure edits that define pairs of HCPCS codes and current procedural terminology (CPT) codes (i.e., code pairs) that generally should not be reported together for the same beneficiary on the same date of service.

Baylor Scott & White-College Station

College Station is a 142-bed acute care hospital, located in College Station, Texas. The hospital originally opened in 2013 and subsequently in 2013 merged with Baylor Health Care System.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 669 outpatient outlier payments totaling \$2.1 million to College Station for services rendered January 1, 2016, through December 31, 2017 (audit period).¹⁶ We selected a stratified random sample of 100 outlier payments totaling \$552,221 for review. Because outlier payments are based on total charges, we retrieved the claim detail related to each outlier payment. We submitted the claims related to the 100 outlier payments to College Station for them to review. We requested that College Station verify that charges and codes on the claim were correct. Additionally, OIG reviewed outlier claims data for inconsistencies and claim support documentation for billing errors.

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 A contains the details of our audit scope and methodology.

FINDINGS

College Station properly billed the claims for 18 of the 100 sampled outlier payments totaling \$77,939. However, College Station did not properly bill the claims related to the remaining 82 outlier payments, resulting in improper outlier payments during our audit period. These 82 claims, which had outliers totaling \$474,282, contained 174 billing errors. The billing errors

¹⁵ An edit is programming within the standard claim processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, takes action on the claims, by either paying them in full, paying them in part, denying payment for them, or suspending them for manual review.

¹⁶ The audit period encompassed the most current data available at the time we initiated our audit.

primarily occurred because College Station did not have adequate controls to prevent errors related to overcharged observation time, charge errors, and coding errors.

College Station has amended the 82 claims based on our audit findings, which lowered the outlier payments by \$79,636. Based on the sample results, we estimated that College Station received overpayments of at least \$189,276 during our audit period. As of the publication of this report, these overpayments include some claims that are outside the 4-year period for reopening for good cause (the 4-year reopening period).¹⁷ Notwithstanding, College Station can request that a Medicare contractor reopen those claims for the purpose of reporting and returning overpayments under the 60-day rule. Appendix B contains the details of our statistical sampling methodology, and Appendix C contains the sample results and estimates.

MEDICARE REQUIREMENTS

No payment may be made under part A or part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.¹⁸

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider.¹⁹ Claims must be completed accurately so that Medicare contractors may process them correctly and promptly.²⁰

Observation services are a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.²¹ Hospitals should not report as observation care services that are part of another Part B service; nor should they bill observation services concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure.²²

¹⁷ 42 CFR § 405.980(b)(2) (permitting a contractor to reopen within 4 years for good cause) and 42 CFR § 405.980(c)(2) (permitting a party to request that a contractor reopen within 4 years for good cause).

¹⁸ The Act § 1862(a)(1)(A).

¹⁹ The Act § 1833(e).

²⁰ The Manual, chapter 1 § 80.3.2.2.

²¹ The Manual, chapter 4, § 290.1.

²² 80 Fed. Reg. 70298, 70335 (Nov. 13, 2015); see also, the Manual, chapter 4, § 290.2.2.

The term “medical and other health services” means hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians’ services rendered to outpatients.²³

The Medicare program provides limited benefits for outpatient prescription drugs. The program covers drugs that are furnished “incident to” a physician’s or nonphysician practitioner’s service provided that the drugs are not usually self-administered by the patients who take them.²⁴

The NCCI Policy Manual for Medicare Services states that many procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesia practitioner. Since these services are integral to the procedure, they are not separately reportable. Examples of these services include cardiac monitoring, pulse oximetry, and ventilation management.²⁵

COLLEGE STATION OVERCHARGED OBSERVATION TIME

Payments to Medicare providers should not be made unless the provider has furnished information necessary to the MAC to determine the amount owed to the provider.²⁶ Claims must be completed accurately so that Medicare contractors may process them correctly and promptly.²⁷ Additionally, hospitals should not report as observation care, services that are part of another Part B service; nor should they bill observation services concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure. In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time.²⁸ According to College Station’s observation services policy, an order is required to be entered for observation services and observation services are not used as a substitution for outpatient care.

Of the 100 claims reviewed, 30 errors of overcharged time were identified for 30 claims.

- Twenty-four cardiology claims with less than 24 hours of observation services were billed when extended recovery was ordered by the physician and not observation,

²³ The Act § 1861(s)(2)(B).

²⁴ 42 CFR § 410.27(a).

²⁵ NCCI Policy Manual for Medicare Services, January 1, 2016, chapter 1, (C)(4).

²⁶ The Act § 1833(e).

²⁷ Pub. No. 100-04, chapter 1, § 80.3.2.2.

²⁸ 80 Fed. Reg. 70298, 70335 (Nov. 13, 2015); see also, the Manual, Pub. No. 100-04, chapter 4, § 290.2.2.

increasing charges by \$8,053. College Station stated that it does not perform utilization review for observation services less than 24 hours.

- Six claims had observation services billed for time spent on another outpatient service, e.g., a diagnostic test. College Station stated that its billing system did not have the ability to reduce observation time while the patient was receiving another Part B service. College Station informed us that the issue has been corrected.

COLLEGE STATION HAD CHARGE ERRORS

Payments to Medicare providers should not be made unless the provider has furnished information necessary to the MAC to determine the amount owed to the provider.²⁹

The term “medical and other health services” means hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians’ services rendered to outpatients.³⁰ The Medicare program provides limited benefits for outpatient prescription drugs. The program covers drugs that are furnished “incident to” a physician’s or nonphysician’s service provided that the drugs are not usually self-administered by the patients who take them.³¹

The NCCI Policy Manual for Medicare Services states that many procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesia practitioner. Since these services are integral to the procedure, they are not separately reportable. Examples of these services include cardiac monitoring, pulse oximetry, and ventilation management.³²

Of the 100 claims reviewed, 127 errors related to charges were identified for 77 claims.

- Sixty-three claims contained charges for non-covered, self-administered drugs, increasing charges by \$5,677. College Station stated that its billing system was not set-up to appropriately classify and bill for self-administered drugs.
- Twenty-seven claims contained charges for medical supplies or devices (i.e., tubing or guidewires) that were not used in the procedures performed, increasing charges by \$211,174. College Station stated that its controls over billing of medical supplies or devices, specifically the documentation of supplies used during the procedure, were not

²⁹ The Act § 1833(e).

³⁰ The Act § 1861(s)(2)(B).

³¹ 42 CFR 410.27(a).

³² NCCI Policy Manual for Medicare Services, January 1, 2016, chapter 1, (C)(4).

adequate to prevent these errors; however, the hospital implemented additional controls and processes prior to the start of our audit.

- Twenty-three claims contained charges for monitoring that is already included in the payment for the procedures, increasing charges by \$7,253. College Station stated that the charge errors were caused by human error.

COLLEGE STATION HAD CODING ERRORS

Payments to Medicare providers should not be made unless the provider has furnished information necessary to the MAC to determine the amount owed to the provider.³³ Furthermore, claims must be completed accurately so that Medicare contractors may process them correctly and promptly.³⁴

Of the 100 claims reviewed, 17 coding errors were identified for 15 claims.

- Three claims contained incorrect codes for separately billed drugs in which a HCPCS code had not been assigned, which caused improper outlier payments of \$20,442.
- Twelve claims contained errors for inaccurate coding. When claims were reviewed by reviewers at College Station, it was determined that other coding better described the services provided. For some of these claims, the coding change increased the overall APC payment. Overall, the inaccurate coding increased charges by \$13,574.

College Station stated that these coding errors were caused by human error.

COLLEGE STATION'S PROCEDURES DID NOT ALWAYS ENSURE COMPLIANCE WITH FEDERAL REQUIREMENTS

Payments to Medicare providers should not be made unless the provider has furnished information necessary to the MAC to determine the amount owed to the provider.³⁵ Furthermore, claims must be completed accurately so that Medicare contractors may process them correctly and promptly.³⁶

College Station did not have adequate controls or billing system capabilities in place to ensure claims billed to Medicare are accurate, especially in the cardiology department. We identified

³³ The Act § 1833(e).

³⁴ The Manual, Pub. No. 100-04, chapter 1, § 80.3.2.2.

³⁵ The Act § 1833(e).

³⁶ The Manual, Pub. No. 100-04, chapter 1, § 80.3.2.2.

billing errors on 82 of the 100 claims in our sample (82 percent). We noted 174 billing errors with most claims having more than one error.

RECOMMENDATIONS

We recommend that Baylor Scott & White-College Station:

- refund to the Medicare contractor the portion of the \$189,276³⁷ in estimated overpayments for incorrectly billed claims that are within the 4-year reopening period;³⁸
- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule³⁹ and identify any of those returned overpayments as having been made in accordance with this recommendation;
- improve procedures and provide education to ensure claims billed to Medicare are accurate; and
- implement changes to billing system to ensure claims billed to Medicare are accurate.

OTHER MATTERS

College Station's pricing policy states that "Supplies will be priced utilizing the mark-up formula based on the actual cost of the item." Furthermore, Medicare expects that charges are "consistently related to cost."⁴⁰

College Station did not follow its own policy for calculating the cost of medical supplies and devices (supplies). We judgmentally selected 10 supply code charges from our 100 sampled outlier claims and found that 6 were not calculated using the actual cost of the item(s).

³⁷ \$79,636 has already been recovered.

³⁸ OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

³⁹ This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

⁴⁰ The Manual, Pub. No. 15-1, part 1, § 2203.

College Station did not have procedures in place to ensure that the charges billed by the hospital for supplies were calculated using actual costs.

We suggest that College Station educate staff about the appropriate cost support for supply charge calculation and implement controls to ensure charges billed to Medicare are accurate.

COLLEGE STATION COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, College Station did not indicate concurrence or nonconcurrence with our recommendations; however, it described actions that it has taken or plans to take to address them. These actions include reviewing claims with less than 24 hours of observation services, updating its systems to appropriately identify and report self-administered drugs, providing education to Cardiology Department staff, and refunding the remaining portion of the \$189,276 in estimated overpayments for incorrectly billed claims. College Station has also undertaken an internal review of any liability outside of our audit; if any overpayments are identified, it will make refunds to OIG. College Station also provided technical comments on our draft report that we have incorporated into this report as appropriate.

We commend the actions College Station is taking, but any additional overpayments that are identified should be returned to the MAC, not to OIG.

College Station's comments appear in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 669 outpatient outlier payments, totaling \$2,086,197 paid to College Station for services rendered during our audit period (January 1, 2016, through December 31, 2017). The claims data was obtained from the CMS National Claims History file on the OIG Data Warehouse. We excluded claims with a claim payment of \$0, claims where Medicare was the secondary payer, claims for outpatient services longer than 1 day, and claims where the outlier payment was less than 40 percent of claim payment. We selected a stratified random sample of 100 outlier payments to review.

We did not perform an overall assessment of College Station's internal control structure. Rather, we reviewed only the internal controls that related directly to our objective. Our audit allowed 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.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance,
- obtained outpatient outlier payments from National Claims History file,
- selected a stratified random sample of 100 outpatient outlier payments from the sampling frame,
- reviewed codes and charges on the claims related to our 100 selected outlier payments to look for possible errors,
- sent the claims with questions on possible errors related to our 100 selected outlier payments to College Station,
- requested College Station review the documentation supporting these claims to verify that an outlier should have been paid,
- reviewed documentation obtained from College Station to determine if billing errors contributed to outlier payments,
- requested College Station send the corrected claims to the Medicare contractor for rebilling,

- used the results of the sample review to calculate the estimated Medicare overpayment to College Station, and
- discussed the results of our audit with College Station.

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.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

College Station received \$3,727,030 in outpatient outlier payments for 1,493 claims for services rendered January 1, 2016 through December 31, 2017. We excluded claims with a payment of \$0, claims where Medicare was the secondary payer, claims for outpatient services longer than one day, and claims where the outpatient outlier payment was less than 40 percent of the claim amount. The resulting sampling frame consisted of 669 outpatient outlier payments totaling \$2,086,197.

SAMPLE UNIT

The sample unit was an outpatient outlier payment.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. The sample frame was divided into three strata based on outlier payment amounts.

Stratum #	Dollar Range of Frame Units Within Each Stratum	Number of Frame Units	Sample Size	Dollar Value of Frame Units
1	≥ \$1,016.62 and ≤ \$2,629.25	443	34	\$737,714
2	≥ \$2,634.79 and ≤ \$6,962.82	165	33	671,455
3	≥ \$6,990.05 and ≤ \$21,483.98	61	33	677,027
TOTALS		669	100	\$2,086,197*

* Total may not equal sum of subtotals due to rounding.

SOURCE OF RANDOM NUMBERS

We generated Random numbers using the HHS-OIG Office of Audit Services RAT-STATS 2010 Version 4 statistical software package.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the frame. After the statistical specialist generated the random numbers for each stratum, we selected the corresponding sample units.

ESTIMATION METHODOLOGY

Using the OIG/OAS RAT-STATS Variable Appraisal Program for a stratified sample, we estimated the total dollar value of any inappropriate outlier payments in our sampling frame.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size (Claims)	Frame Value	Sample Size	Sample Value	Number of Incorrectly Billed Claims	Net Value of Incorrect Payments in Sample
1	443	\$737,714	34	\$59,486	27	\$7,745
2	165	671,455	33	121,183	26	15,931
3	61	677,027	33	371,553	29	54,367
Totals*	669	\$2,086,197	100	\$552,221	82	\$78,043

* Totals may not equal sum of subtotals due to rounding.

ESTIMATES

**Estimated Value of Unsupported Claim Amounts
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$281,063
Lower limit	189,276
Upper limit	372,850

APPENDIX D: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>CHI St. Vincent Infirmiry: Audit of Outpatient Outlier Payments</i>	<u>A-06-16-01002</u>	2/25/2020
<i>Review of Medicare Outpatient Prospective Payment System Outlier Payments made to Rush-Presbyterian-St. Luke's Medical Center Chicago, Illinois</i>	<u>A-05-03-00033</u>	7/31/2003
<i>Review of Outlier Payments Made to Eastern Maine Medical Center Under the Outpatient Prospective Payment System for Period August 1, 2000 Through June 30, 2001</i>	<u>A-01-02-00507</u>	1/15/2003

APPENDIX E: COLLEGE STATION COMMENTS



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July 28, 2020

VIA SECURE E-MAIL PORTAL

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region VI
1100 Commerce Street, Room 632 Dallas, TX 75242

Re: Office of Audit Services Audit A-06-18-04003

Dear Ms. Wheeler:

Baylor Scott & White Medical Center- College Station understands and takes seriously its obligation to bill Medicare appropriately for hospital outlier services rendered to program beneficiaries and appreciates the opportunity to provide comments to the Office of Inspector General (OIG), Office of Audit Services draft report dated April 2020.

Baylor Scott & White Medical Center – College Station (BSWMC-CS) is a 5 story, 142 bed acute care hospital located on a 98-acre campus in College Station, Texas. BSWMC-CS is a nationally accredited Chest Pain Center, advanced Primary stroke Center and Level III Trauma Center. The hospital opened in 2013 and subsequently in 2013 merged with Baylor Health Care System. (page 4 of the report includes an incorrect date and bed count).

I. OIG Findings

A. Observation Services

Of the 100 claims reviewed, 30 errors of overcharged observation time were identified for 30 claims.

- Twenty-four cardiology claims with less than 24 hours of observation services were billed when extended recovery was ordered by the physician and not observation, increasing charges by \$8,053. College Station stated that it does not perform utilization review for observation services less than 24 hours.
- Six claims had observation services billed for time spent on another outpatient service, e.g., a diagnostic test. College Station stated that its billing system did not have the ability to reduce observation time while the patient was receiving another Part B service. College Station informed us that the issue has been corrected.

BSWMC-CS Response

This issue occurred prior to the system utilization review department taking over utilization review at the facility. The system utilization review department is now reviewing claims with less than 24 hours of observation services.

In addition, the system was corrected on December 12, 2018 to not change the extended recovery orders to observation orders.

In July 2019, a process was implemented to capture any time spent performing diagnostic services and subtract it from the observation time.

B. Charge Errors

Of the 100 claims reviewed, 127 errors related to charges were identified for 77 claims.

- Sixty-three claims contained charges for non-covered, self-administered drugs, increasing charges by \$5,677. College Station stated that its billing system was not set-up to appropriately classify and bill for self-administered drugs.
- Twenty-seven claims contained charges for medical supplies or devices (i.e., tubing or guidewires) that were not used in the procedures performed, increasing charges by \$211,174. College Station stated that its controls over billing of medical supplies or devices, specifically the documentation of supplies used during the procedure, were not adequate to prevent these errors; however, the hospital implemented additional controls and processes prior to the start of our audit.
- Twenty-three claims contained charges for monitoring that is already included in the payment for the procedures, increasing charges by \$7,253. College Station stated that the charge errors were caused by human error.

BSWMC-CS Response

Effective June 2019 Revenue Integrity completed a review of all self-administered drugs (SADs) and updated the Revenue Codes to 637 to appropriately identify and report self-administered drugs.

Revenue Integrity will confirm charge reconciliation processes are in place to enable appropriate documentation and charge capture.

Cardiology Charge Coordinators were provided education on when it was appropriate to drop to the EKG charges.

C. Coding Errors

Of the 100 claims reviewed, 17 coding errors were identified for 15 claims.

- Three claims contained incorrect codes for separately billed drugs in which a HCPCS code had not been assigned, which caused improper outlier payments of \$20,442.
- Twelve claims contained errors for inaccurate coding. When claims were reviewed by reviewers at College Station, it was determined that other coding better described the services provided. For some of these claims, the coding change increased the overall APC payment. Overall, the inaccurate coding increased charges by \$13,574.

College Station state that these coding errors were caused by human error.

BSWMC-CS Response

The HIM Coding auditors provided education to the Coders in December of 2019.

D. College Station's procedures did not always ensure compliance with Federal requirements

College Station did not have adequate controls or billing system capabilities in place to ensure claims billed to Medicare are accurate, especially in the cardiology department. We identified billing errors on 82 of the 100 claims in our sample (82 percent). We noted 174 billing errors with most claims having more than one error.

BSWMC-CS Response

The Cardiology Charge Coordinators and Coders were provided education in December of 2019.

OIG Recommendations

We recommend that Baylor Scott & White-College Station:

- refund to the Medicare contractor the portion of the \$189,276.00 in estimated overpayments for incorrectly billed claims that are within the 4-year reopening period;
- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation;
- improve procedures and provide education to ensure claims billed to Medicare are accurate; and
- implement changes to billing system to ensure claims billed to Medicare are accurate.

BSWMC-CS Response

BSWMC-CS will refund the Medicare Contractor the remaining \$109,640 (which is the remaining amount due since \$79,363 has already been recovered).

BSWMC-CS has undertaken an internal review of any liability outside of the OIG audit and if any overpayments are identified will make refunds to the OIG.

BSWMC-CS believes its policies, procedures and processes were structured for compliance with Federal requirements. Furthermore, BSWMC-CS understands the significance of its responsibility to bill Medicare appropriately and, therefore, BSWMC-CS has updated procedures, revised systems, extended training to its staff to enable continued compliance with Federal requirements.

BSWMC-CS has been implementing changes over a 3-year period to improve the accuracy of charges billed to Medicare including transitioning to a more robust Supply Inventory Software,

modifying our charge posting workflow to include more thorough and consistent cost validation, and providing re-education to staff as of August 2019.

BSWMC-CS takes its responsibility of compliance seriously and takes ownership of billing and coding errors, striving to continually improve processes and outcomes to achieve accuracy in billing practices. We will continue to improve procedures, provide education and implement changes to the billing system as appropriate to enable accurate claims to be billed to Medicare.

Thank you for the opportunity to provide this response.

Sincerely,



Jason Jennings
Senior Vice President, College Station Region