

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
HEARTLAND REGIONAL
MEDICAL CENTER FOR CALENDAR
YEARS 2010 AND 2011**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Patrick J. Cogley
Regional Inspector General

December 2013
A-07-12-01120

Office of Inspector General

<https://oig.hhs.gov/>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

Heartland Regional Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of approximately \$282,000 over 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 hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 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 Heartland Regional Medical Center (Heartland) complied with Medicare requirements for billing inpatient and outpatient services on selected 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.

Heartland is a 328-bed acute care hospital located in St. Joseph, Missouri. Medicare paid Heartland approximately \$231 million for 17,934 inpatient and 303,627 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$2,886,744 in Medicare payments to Heartland for 194 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 131 inpatient and 63 outpatient claims, with dates of service in CYs 2010 and 2011 (audit period).

WHAT WE FOUND

Heartland complied with Medicare billing requirements for 128 of the 194 inpatient and outpatient claims we reviewed. However, Heartland did not fully comply with Medicare billing requirements for the remaining 66 claims, resulting in net overpayments of \$281,997 for the audit period. Specifically, 42 inpatient claims had billing errors, resulting in overpayments of \$270,037, and 24 outpatient claims had billing errors, resulting in net overpayments of \$11,960.

These errors occurred primarily because Heartland did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that Heartland:

- refund to the Medicare contractor \$281,997, consisting of \$270,037 in overpayments for 42 incorrectly billed inpatient claims and \$11,960 in net overpayments for 24 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Heartland concurred in part with our first recommendation and described actions that it had taken to address our second recommendation.

Heartland disagreed with our findings on 40 inpatient claims, consisting of \$260,787 in questioned costs, in which we found that Heartland should have billed the claims as outpatient or outpatient with observation services. Heartland stated that we (that is, our medical review contractor) "... based their review on the time the [physician's] order was placed in the computer." Heartland also stated that our medical review contractor did not consider individual factors related to the ability to safely care for these patients in an outpatient setting and that we "... did not give sufficient weight to the possibility of adverse events and scarcity of resources in a rural setting."

For the remaining 26 claims, Heartland concurred with our findings and said that it had either refunded or would refund a total of \$21,210.

After reviewing Heartland's comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether the 40 inpatient claims that the Hospital disagreed with met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether Heartland billed the inpatient claims according to Medicare requirements. Based on the contractor's conclusions, we determined, and continue to believe, that the 40 inpatient claims should have been billed as outpatient or outpatient with observation services.

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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 hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 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

Our objective was to determine whether Heartland Regional Medical Center (Heartland) complied with Medicare requirements for billing inpatient and outpatient services on selected 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 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. 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 short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient same-day discharges and readmissions,
- inpatient transfers,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient and outpatient claims paid in excess of charges,
- outpatient claims billed before and during inpatient stays,
- outpatient claims billed with modifiers,
- outpatient claims billed for Doxorubicin Hydrochloride,
- outpatient claims billed for surgeries with units greater than one, and
- outpatient claims billed for Lupron injections.

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

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” (the Social Security Act (the Act), § 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)).

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

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).

Heartland Regional Medical Center

Heartland is a 328-bed acute care hospital located in St. Joseph, Missouri. Medicare paid Heartland approximately \$231 million for 17,934 inpatient and 303,627 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$2,886,744 in Medicare payments to Heartland for 194 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 131 inpatient and 63 outpatient claims with dates of service in CYs 2010 and 2011 (audit period). We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 46 claims to focused medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Heartland 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

Heartland complied with Medicare billing requirements for 128 of the 194 inpatient and outpatient claims we reviewed. However, Heartland did not fully comply with Medicare billing requirements for the remaining 66 claims, resulting in net overpayments of \$281,997 for the audit period. Specifically, 42 inpatient claims had billing errors, resulting in overpayments of \$270,037, and 24 outpatient claims had billing errors, resulting in net overpayments of \$11,960. These errors occurred primarily because Heartland did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Heartland incorrectly billed Medicare for 42 of 131 selected inpatient claims, which resulted in overpayments of \$270,037.

Incorrectly Billed as Inpatient

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" (the Act, § 1862(a)(1)(A)).

According to chapter 1, § 10, of the *CMS Benefit Policy Manual*, factors that determine whether an inpatient admission is medically necessary include:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;
- the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- the availability of diagnostic procedures at the time when and at the location where the patient presents.

The *Benefit Policy Manual* also states that "[a]dmissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital."

For 40 of the 131 selected inpatient claims, Heartland incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. Our independent medical reviewer determined that inpatient admission was not medically necessary for these beneficiaries. For example, in one case, the medical reviewer stated, "[t]he services planned at the time of admission ... were of the intensity that could have been safely provided at the observation level."

These errors occurred because Heartland did not have effective controls to ensure that it billed Medicare correctly. As a result of these errors, Heartland received overpayments of \$260,787.²

² Heartland may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor prior to the issuance of our report.

Manufacturer Credits for Replaced Medical Devices 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 a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device (42 CFR § 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, the hospital must code its Medicare claims with a combination of condition code 49 or 50, along with value code “FD” (chapter 3, § 100.8).

For 2 of the 131 selected inpatient claims, Heartland received a reportable medical device credit from a manufacturer but did not adjust its claims with the proper condition and value codes to reduce payments as required. Heartland stated that these overpayments occurred due to inadequate controls. As a result of these errors, Heartland received overpayments of \$9,250.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Heartland incorrectly billed Medicare for 24 of 63 selected outpatient claims, which resulted in net overpayments of \$11,960.

Incorrectly Billed as Outpatient

Federal regulations state: “The prospective payment system provides a payment amount for inpatient operating costs, including.... Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary’s admission to the hospital and during the 3 calendar days [72 hours] immediately preceding the date of the beneficiary’s admission to the hospital...” (42 CFR § 412.2(c)(5)). The Manual states that Medicare Part A covers certain items and nonphysician services furnished to inpatients; consequently, the IPPS rate covers these services (chapter 3, § 10.4).

For 9 of the 63 selected outpatient claims, Heartland incorrectly billed Medicare Part B for outpatient services provided within 72 hours before or during inpatient stays. These services should have been included on Heartland’s inpatient (Part A) claims to Medicare. Heartland stated that these overpayments occurred due to inadequate controls. As a result of these errors, Heartland received overpayments of \$5,061.

Manufacturer Credit for a Replaced Medical Device Not Reported

Federal regulations require a reduction in the OPSS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45). For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the

replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.³

For 1 of the 63 selected outpatient claims, Heartland received a manufacturer credit for a replaced device but did not report the “FB” modifier and reduced charges on its claim. Heartland stated that this overpayment occurred due to inadequate controls. As a result of this error, Heartland received an overpayment of \$4,347.

Incorrectly Billed Healthcare Common Procedure Coding System Codes or Number of Units

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). In addition, the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed” (chapter 4, § 20.4).

For 14 of the 63 selected outpatient claims, Heartland submitted claims to Medicare with unsupported HCPCS codes (10 claims), incorrect HCPCS codes (3 claims), or with an incorrect number of units (1 claim). Heartland stated that these errors occurred due to human error. As a result of these errors, Heartland received net overpayments of \$2,552.

RECOMMENDATIONS

We recommend that Heartland:

- refund to the Medicare contractor \$281,997, consisting of \$270,037 in overpayments for 42 incorrectly billed inpatient claims and \$11,960 in net overpayments for 24 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, Heartland concurred in part with our first recommendation. Heartland also described actions that it had taken to address our second recommendation and stated that it would continue to use the results of this audit as guidelines for further process improvement and strengthening of its controls.

Heartland disagreed with our findings on 40 inpatient claims, consisting of \$260,787 in questioned costs, in which we found that Heartland should have billed the claims as outpatient or outpatient with observation services. Heartland stated that we (that is, our medical review

³ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPI (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

contractor) "... based their review on the time the [physician's] order was placed in the computer." Heartland noted that there was a lag in time for information from a physician to appear in a patient's chart.

Heartland also stated that our medical review contractor did not consider individual factors related to the ability to safely care for these patients in an outpatient setting and that we "... did not give sufficient weight to the possibility of adverse events and scarcity of resources in a rural setting." In this regard, Heartland stated that "[i]t was the professional judgment of three physicians ... that care for these patients could not safely be provided in any less restrictive environment, and that inpatient care was medically necessary and appropriate, and was anticipated to be necessary for greater than 24 hours." In addition, Heartland noted that "[c]ontrols have been improved since 2010 to include dedicated [emergency department] managers who are present in the facility rather than on-call for weekends."

For the remaining 26 claims, Heartland concurred with our findings and said that it had either refunded or would refund a total of \$21,210.

Heartland's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Heartland's comments, we maintain that our findings and recommendations are valid.

Our independent medical review contractor did not base its determinations solely upon the information that was available when the physician's order was placed in the computer. Instead, our contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether Heartland billed the inpatient claims according to Medicare requirements.

With respect to Heartland's comments that our medical review contractor did not consider factors related to the setting where the services were performed, our contractor advised us that the scarcity of resources in a rural setting did not impact its medical determination regarding the reasonableness of inpatient status versus the status as outpatient or outpatient with observation services. To this point, we note that although observation services are performed in an outpatient setting, these services are conducted in the hospital, thereby using the same resources.

Based on the contractor's conclusions, we determined, and continue to believe, that the 40 inpatient claims should have been billed as outpatient or outpatient with observation services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$2,886,744 in Medicare payments to Heartland for 194 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 131 inpatient and 63 outpatient claims with dates of service in CYs 2010 and 2011 (audit period).

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 46 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of Heartland'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 CMS's 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 Heartland for Medicare reimbursement.

We conducted our fieldwork at Heartland in August 2012 and April 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Heartland'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 medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 194 claims (131 inpatient and 63 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by Heartland to support the selected claims;

- requested that Heartland conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed Heartland's procedures for submitting Medicare claims;
- submitted Heartland's medical records for 46 claims to an independent medical review contractor to determine whether the claims met medical necessity requirements;
- discussed the incorrectly billed claims with Heartland officials to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Heartland officials on August 26, 2013.

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: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Under / Over-payments	Value of Net Over-payments
Inpatient				
Short Stays	44	\$306,502	40	\$260,787
Manufacturer Credits for Replaced Medical Devices	3	85,579	2	9,250
Claims Billed With High Severity Level Diagnosis-Related Group Codes	39	1,543,537	0	0
Claims Paid in Excess of Charges	35	721,626	0	0
Same-Day Discharges and Readmissions	8	80,962	0	0
Transfers	2	28,591	0	0
Inpatient Totals	131	\$2,766,797	42	\$270,037
Outpatient				
Claims Billed Before and During Inpatient Stays	18	\$35,008	9	\$5,061
Manufacturer Credits for Replaced Medical Devices	1	6,537	1	4,347
Claims Billed With Modifiers	32	35,137	14	2,552
Claims Paid in Excess of Charges	5	22,781	0	0
Claims Billed for Doxorubicin Hydrochloride	5	14,412	0	0
Claims Billed for Surgeries With Units Greater Than One	1	4,839	0	0
Claims Billed for Lupron Injections	1	1,233	0	0
Outpatient Totals	63	\$119,947	24	\$11,960
Inpatient and Outpatient Totals	194	\$2,886,744	66	\$281,997

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 Heartland. 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 C: AUDITEE COMMENTS



November 12, 2013

Mr. Patrick Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 E. 12th St., Rm 0429
Kansas City, MO 64106

RE: Report Number: A-07-12-01120

Dear Mr. Cogley:

Heartland Regional Medical Center (“HRMC” or “Hospital”) appreciates the opportunity to review and respond to the U.S. Department of Health and Human Services, Office of Inspector General’s (“OIG”) draft report entitled *Medicare Compliance Review of Heartland Regional Medical Center for Calendar Years 2010 and 2011*. HRMC is committed to complying with all regulations and standards governing federal health care programs, improving internal controls and proactively auditing and monitoring our processes and procedures to minimize the risk of errors.

Overall, process improvements and education initiatives had already taken place in HRMC’s Care Management, coding and billing departments before the OIG auditors arrived to review the nearly three-year old claims. In addition, the aged billing and coding system has been replaced which included a process redesign with the installation of the new system which further improved and strengthened controls.

HRMC’s responses to the OIG’s specific findings and recommendations are listed on the following pages. Unless otherwise stated, HRMC has accepted the OIG’s findings and the overpayment amounts for the incorrectly billed claims have been (or are in the process of being) refunded through our Medicare Administrative Contractor (WPS).

OIG FINDING #1:

Incorrectly Billed as Inpatient

For 40 of 131 selected inpatient claims, HRMC incorrectly billed Medicare Part A beneficiary stays that should have been billed as outpatient or outpatient with observation services. The OIG independent medical reviewer determined that inpatient admission was not medically necessary for these beneficiaries. These errors occurred because HRMC did not have effective controls to ensure that it billed Medicare correctly. As a result of these errors, the Hospital received overpayments totaling \$260,787.

HRMC RESPONSE #1:

HRMC respectfully disagrees with OIG finding #1 that the services could have been appropriately furnished as outpatient services safely for these patients, taking into account individual circumstances. The scope of the audit was limited to patients who arrived at the hospital on Friday and departed on Monday. In these cases it was the professional medical opinion of the Emergency Department Provider and the Attending Provider that these patients required an inpatient level of care and were expected to need that care for greater than 24 hours, who then ordered admission.

Interqual is used as a screening tool by hospital Care Managers to review admission determinations in order to assure appropriate documentation for admission is entered into the medical record. As a screening tool, however, it cannot quantify the medical decision making and risks to the patient. Because the process at the time required the Care Manager to request that the physician cancel the admission order until secondary review was completed, they did so; these patients' admissions were then forwarded for a second level review and the admission order was cancelled pending completion of that review.

Upon receipt of the confirmation from the secondary Provider reviewer that the admission was medically necessary, the admission was reinstated. Because the attending physician is not affected by the patient's inpatient or outpatient status they allowed the changes to status. This process is currently under review with an Enterprise Process Improvement Initiative which already includes weekend on-site coverage by care managers rather than on-call coverage. However, this does not negate the fact that three physicians agreed that the patients needed inpatient care.

The OIG auditor based their review on the time the order was placed in the computer. Because of the age of these claims, the computerized physician order entry (CPOE) had not been implemented. There was a lag in time between the physicians communicating, relaying the information to a nurse, and then the information actually appearing on the chart. Further, the reviewers did not consider individual factors related to the ability to safely care for these patients in an outpatient setting, including the unavailability of appropriate outpatient resources and sub-acute care in this rural setting.

It was the professional judgment of three physicians (ED Provider, Attending Provider, and Second Level Provider Reviewer) that care for these patients could not safely be provided in any less restrictive environment, and that inpatient care was medically necessary and appropriate, and

was anticipated to be necessary for greater than 24 hours. The OIG auditor did not give sufficient weight to the possibility of adverse events and scarcity of resources in a rural setting. Had they reviewed the care management and social services notes they would have seen that they could not arrange new home oxygen and skilled or nursing home admissions on the weekends as these types of providers do not staff for 24/7 admissions in this setting.

Controls have been improved since 2010 to include dedicated ED Care Managers who are present in the facility rather than on-call for weekends.

OIG FINDING #2:

Inpatient Manufacturer Credit for Replaced Medical Device Not Reported

For 2 of the 131 selected inpatient claims, HRMC received a reportable medical device credit from a manufacturer but did not adjust its claims with the proper condition and value codes to reduce payments as required. HRMC stated that these overpayments occurred due to inadequate controls. As a result of these errors, the Hospital received overpayments totaling \$9,250.

HRMC RESPONSE #2:

HRMC concurs with OIG finding #2 and determined there was a break in the very complex manual process. At the time of these transactions, HRMC relied on the manufacturers to relay the amount of credit, as HRMC did not know the dollar amount which was covered under warranty/recall. HRMC has revised this process and now has a coder contact our billing department directly to rebill.

The overpayment amount has been refunded and HRMC will continue to monitor and strengthen its controls in order to assure compliance with Medicare billing requirements.

OIG FINDING #3:

Incorrectly Billed as Outpatient

For 9 of the 63 selected outpatient claims, HRMC incorrectly billed Medicare Part B for outpatient services provided within 72 hours before or during inpatient stays. These services should have been included on the Hospital's inpatient (Part A) claims to Medicare. As a result of these errors, the Hospital received overpayments totaling \$5,061.

HRMC RESPONSE #3:

HRMC concurs with OIG finding #3 and determined there was a break in the manual process of the old billing system. A completely new billing system has been installed and implemented as of 05/20/13.

The billing department is in the process of ensuring the overpayment amount is refunded. HRMC will continue to monitor and strengthen its controls in order to assure compliance with Medicare billing requirements.

OIG FINDING #4:

Outpatient Manufacturer Credits for Replaced Medical Device Not Reported

For 1 of the 63 selected outpatient claims, HRMC received a manufacturer credit for a replaced device but did not report the "FB" modifier and reduced charges on its claims. HRMC stated that this overpayment occurred due to inadequate controls. As a result of this error, HRMC received an overpayment totaling \$4,347.

HRMC RESPONSE #4:

HRMC concurs with OIG finding #4 and determined there was a break in the very complex manual process. At the time of this transaction, HRMC relied on the manufacturers to relay the amount of credit as HRMC did not know the dollar amount which was covered under warranty/recall. Heartland has revised this process and now has a coder that contacts our billing department directly to rebill.

The overpayment amount has been refunded and HRMC will continue to monitor and strengthen its controls in order to assure compliance with Medicare billing requirements.

OIG FINDING #5:

Incorrectly Billed Healthcare Common Procedure Coding System Codes or Number of Units

For 14 of the 63 selected outpatient claims, HRMC submitted claims to Medicare with unsupported HCPCS codes (10 claims), incorrect HCPCS codes (3 claims), or with an incorrect number of units (1 claim). HRMC stated that these errors occurred due to human error. As a result of these errors, HRMC received net overpayments of \$2,552.

HRMC RESPONSE #5:

HRMC concurs with OIG finding #5. It was identified that when HRMC took over St. Joe Oncology in mid-2010, the coding was not being performed by a credentialed coder. As process errors were detected, claims were corrected and re-submitted. HRMC's standard process before the acquisition and currently is to only employ credentialed coders in the Oncology Department. Since the acquisition, there was a process change where the provider coders and the facility coders are making sure the CPT codes match before sending out the claims and all staff has been re-educated.

The billing department is in the process of ensuring the overpayment amount is refunded. HRMC will continue to monitor and strengthen its controls in order to assure compliance with Medicare billing requirements.

HRMC appreciates the opportunity to learn from the findings of this review. Despite the objection, above, HRMC recognizes its responsibilities and reconfirms its obligation to interpret and bill services appropriately and will continue to use the results of this audit as guidelines for further process improvement and strengthening of our controls.

If you require any additional information, or if I can provide any further assistance, please do not hesitate to contact me.

Sincerely,



Lynn Thuente
Corporate Compliance Officer
Heartland Regional Medical Center