

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
BERGAN MERCY MEDICAL CENTER
FOR 2013 AND 2014**

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



Brian P. Ritchie
Assistant Inspector General
for Audit Services

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Office of Inspector General

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

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EXECUTIVE SUMMARY

Bergan Mercy Medical Center did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately \$70,000 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) 2014, Medicare paid hospitals \$159 billion, which represents 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 Bergan Mercy Medical Center (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification. 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.

The Hospital is a 315-bed hospital located in Omaha, Nebraska. Medicare paid the Hospital approximately \$130 million for 200,145 outpatient and 9,405 inpatient claims for services provided to beneficiaries during CYs 2013 and 2014 based on CMS's National Claims History data.

Our audit covered \$3,306,594 in Medicare payments to the Hospital for 224 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 5 outpatient and 219 inpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 219 of the 224 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining five claims, resulting in overpayments of \$69,800 for CYs 2013 and 2014. Specifically, three outpatient claims had billing errors, resulting in overpayments of \$63,102, and two inpatient claims had billing errors, resulting in overpayments of \$6,698. 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.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$69,800, consisting of \$63,102 in overpayments for three incorrectly billed outpatient claims and \$6,698 in overpayments for two incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital concurred with all of our findings and described corrective actions that it had taken or planned to take to implement our recommendations.

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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) 2014, Medicare paid hospitals \$159 billion, which represents 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

Our objective was to determine whether Bergan Mercy Medical Center (the Hospital) complied with Medicare requirements for billing outpatient and inpatient 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 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 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

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

(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 Claims at Risk for Incorrect Billing

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

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

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)).

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). In addition, the Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Bergan Mercy Medical Center

The Hospital is a 315-bed hospital located in Omaha, Nebraska. Medicare paid the Hospital approximately \$130 million for 200,145 outpatient and 9,405 inpatient claims for services provided to beneficiaries during CYs 2013 and 2014 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$3,306,594 in Medicare payments to the Hospital for 224 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 5 outpatient and 219 inpatient claims. We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and did not use 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 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 219 of the 224 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining five claims, resulting in overpayments of \$69,800 for CYs 2013 and 2014. Specifically, three outpatient claims had billing errors, resulting in overpayments of \$63,102, and two inpatient claims had billing errors, resulting in overpayments of \$6,698. 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. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for three of five selected outpatient claims that we reviewed. These errors resulted in overpayments of \$63,102.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of 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.²

For two out of five selected claims, the Hospital received full credits for replaced medical devices but did not report the “FB” modifier and reduced charges on its claims. The Hospital said that it was in the implementation phase of a medical device credit process improvement initiative and that staff did not yet have a good understanding of how credits and modifiers were to be reported on the claims. As a result of these errors, the Hospital received overpayments of \$49,481.

Unsupported Number of Service Units

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

For one out of five selected claims, the Hospital billed Medicare for an unsupported number of service units. The Hospital said this overpayment was due to human error. As a result of this error, the Hospital received an overpayment of \$13,621.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 2 of 219 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$6,698.

Unsupported Codes

Medicare payment 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)).

For 2 out of 219 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain diagnosis codes were not supported in the medical records. The Hospital said that coding personnel made errors in coding the medical records. As a result of these errors, the Hospital received overpayments of \$6,698.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$69,800, consisting of \$63,102 in overpayments for three incorrectly billed outpatient claims and \$6,698 in overpayments for two incorrectly billed inpatient claims, and

² CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPTS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital concurred with all of our findings and described corrective actions that it had taken or planned to take to implement our recommendations.

The Hospital's comments appear in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$3,306,594 in Medicare payments to the Hospital for 224 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 5 outpatient and 219 inpatient claims.

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and did not use medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the outpatient and inpatient 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 audit work from August 2015 to June 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient and inpatient paid claim data from CMS's National Claims History file for CYs 2013 and 2014;
- obtained information on known credits for replacement medical devices for CYs 2013 and 2014;
- 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 224 claims (5 outpatient and 219 inpatient) 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 the Hospital to support the selected claims;

- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Hospital officials on June 30, 2016.

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 Over-payments	Value of Over-payments
Outpatient				
Manufacturer Credits for Replaced Medical Devices	2	\$60,648	2	\$49,481
Claims With Payments Greater Than \$25,000	1	27,243	1	13,621
Claims Billed With Modifiers	2	29,223	0	0
Outpatient Totals	5	\$117,114	3	\$63,102
Inpatient				
Diagnosis-Related-Group Verification	105	\$1,353,601	2	\$6,698
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	112	1,794,632	0	0
Manufacturer Credits for Replaced Medical Devices	1	30,114	0	0
Claims Paid in Excess of Charges	1	11,133	0	0
Inpatient Totals	219	\$3,189,480	2	\$6,698
Outpatient and Inpatient Totals	224	\$3,306,594	5	\$69,800

Notice: The table above illustrates the results of our review by risk area. In it, we have organized outpatient and inpatient 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 C: AUDITEE COMMENTS



Bergan Mercy
7500 Mercy Road
Omaha, NE 68124

CHIhealth.com

September 13, 2016

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, Missouri 64106

Re: Audit Report, A-07-15-05084, *Medicare Compliance Review of Bergan Mercy Medical Center for 2013 and 2014.*

Dear Mr. Cogley,

CHI Health Bergan Mercy ("Bergan Mercy") is in receipt of the August 22, 2016 Department of Health and Human Services, Office of the Inspector General (OIG), draft report entitled *Medicare Compliance Review of Bergan Mercy Medical Center for 2013 and 2014.*

We appreciate the opportunity to review and comment on the draft report. Catholic Health Initiatives has a robust compliance program in place at each of its hospitals and other health care facilities and is committed to compliance with all applicable laws and regulations.

The draft report indicates Bergan Mercy complied with Medicare billing requirements for 219 of 224 claims that the OIG judgmentally selected as potentially at risk for billing errors. The OIG recommends Bergan Mercy refund to the Medicare contractor \$69,800, consisting of \$63,102 in overpayments for three incorrectly billed outpatient claims and \$6,698 in overpayments for two incorrectly billed inpatient claims, and strengthen controls to ensure full compliance with the Medicare requirements.

Bergan Mercy concurs with the findings of the report and the recommendation to refund WPS Medicare in the amount of \$69,800, and has already refunded those amounts.

Bergan Mercy Responses:

Manufacturer Credits for Replaced Medical Devices Not Reported

OIG Finding: For two out of five selected claims, the Hospital received full credits for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims. As a result of these errors, the Hospital received overpayments of \$49,481.

Bergan Mercy concurs with this finding.

Bergan Mercy
Creighton University Medical Center
Good Samaritan
Immanuel
Lakeside

Mercy Council Bluffs
Midlands
Nebraska Heart
St. Elizabeth
St. Francis

Missouri Valley
Mercy Corning
Plainview
Schuyler
St. Mary's

Lasting Hope Recovery Center
Richard Young Behavioral Health
CHI Health Alegent Creighton Clinic

Bergan Mercy has implemented a "Processing of Medical Device Credits" policy containing Medicare billing requirements for medical device credits received, department roles and responsibilities, directions on how to calculate and code the credit, and supporting forms to implement the policy. Department staff have received education on the policy. The Corporate Responsibility department continues to conduct monitoring of medical device credit compliance with the policy.

Unsupported Number of Service Units

OIG Finding: For one of five selected claims, the Hospital billed Medicare for an unsupported number of service units. As a result of this error, the Hospital received an overpayment of \$13,621.

Bergan Mercy concurs with this finding.

Bergan Mercy implemented a system where supervisors compare all charges, procedures and supplies to revenue usage reports in the department where the error occurred. Claims are corrected if errors are identified.

Unsupported Codes

OIG Finding: For 2 out of 219 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain diagnosis codes were not supported in the medical records. As a result of these errors, the Hospital received overpayments of \$6,698.

Bergan Mercy concurs with this finding.

Bergan Mercy coding staff received coding education on correct assignment of principal and secondary diagnosis selection. Coding audits are routinely conducted and ongoing education provided.

Bergan Mercy would like to thank the OIG audit staff who conducted this Medicare compliance review. We are committed to maintaining a strong compliance program to meet Medicare billing requirements.

Sincerely,

/Marie Knedler/

Marie Knedler, MS, MBA, FACHE
President