

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CHI ST. VINCENT INFIRMARY: AUDIT OF
OUTPATIENT OUTLIER PAYMENTS**

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Office of Inspector General

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Report in Brief

Date: February 2020
Report No. A-06-16-01002

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 CHI St. Vincent Infirmiry (St. Vincent) based on outpatient outlier payments increasing from \$216,484 in 2013 to \$1.4 million in 2014.

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

How OIG Did This Audit

Our audit covered 593 outpatient outlier payments totaling \$1,694,991 paid to St. Vincent for services rendered July 1, 2014, through June 30, 2016. We selected a stratified random sample of 120 outlier payments totaling \$622,742 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 120 outlier payments to St. Vincent for them to review. We requested that St. Vincent 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.

CHI St. Vincent Infirmiry: Audit of Outpatient Outlier Payments

What OIG Found

St. Vincent properly billed 17 of the 120 sampled claims which had outliers totaling \$41,606. However, St. Vincent did not properly bill the remaining 103 sampled claims which resulted in improper outlier payments during our audit period. These 103 claims, which had outliers totaling \$581,136, contained 173 billing errors. The billing errors primarily occurred because St. Vincent did not have adequate controls to prevent errors related to overcharged time, charge errors, and coding errors.

What OIG Recommends and St. Vincent Comments

We recommend that St. Vincent amend the claims with errors to identify and return any improper outlier payments. We also recommended that St. Vincent improve procedures and provide education to ensure claims billed to Medicare are accurate.

In written comments to our draft report, St. Vincent did not explicitly agree or disagree with our recommendations; however, St. Vincent stated that it has already refunded the amounts specified in OIG's first three recommendations. In addition, St. Vincent agreed with our first three findings regarding overcharged time, charge errors, and coding errors, and described corrective actions that it had taken or planned to take for each finding. St. Vincent did not agree or disagree with our fourth finding regarding its procedures not ensuring compliance with Federal requirements. Instead, St. Vincent stated that, based on OIG's findings, it has updated policies and procedures, revised systems, extended training to staff and implemented enhanced monitoring to promote billing compliance.

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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 payments found that billing errors led to increased outlier payments.² Therefore, we are performing multiple audits of hospital outpatient outlier payments.³

We selected CHI St. Vincent Infirmary (St. Vincent) based on outpatient outlier payments increasing from \$216,484 in 2013 to \$1.4 million in 2014.

OBJECTIVE

The objective of this audit was to determine whether outpatient outlier payments received by St. Vincent 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.

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

² OIG *Review of Outlier Payments Made to Eastern Maine Medical Center Under the Outpatient Prospective Payment System for the Period August 1, 2000 Through June 30, 2001*, Jan. 2003, (A-01-02-00507); OIG *Review of Medicare Outpatient Prospective Payment System Outlier Payments made to Rush-Presbyterian-St. Luke's Medical Center*, July 2003, (A-05-03-00033)

³ Additional audits are ongoing.

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, 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. OPPS 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.

The *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 (Pub. No. 15-1, Part 1, § 2202.4). 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.

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 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)).

⁴ 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 CMS *Medicare Claims Processing Manual* (the Manual) requires claims to be completed 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).

OIG believes that this audit report constitutes credible information of potential overpayments. Providers who receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments.⁵

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.⁶

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 implemented NCCI edits within their claim processing systems for dates of service on or after January 1, 1996.⁷

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.

⁵ The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

⁶ CMS, *Provider Reimbursement Manual*, Pub. No. 15-1, Part 1, § 2203 and § 2202.4.

⁷ 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.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 593 outpatient outlier payments totaling \$1.7 million to St. Vincent for services rendered July 1, 2014, through June 30, 2016 (audit period).⁸ We selected a stratified random sample of 120 outlier payments totaling \$622,742 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 120 outlier payments to St. Vincent for them to review. We requested that St. Vincent 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 and Appendix B contains our statistical sampling methodology.

FINDINGS

St. Vincent properly billed the claims for 17 of the 120 sampled outlier payments totaling \$41,606. However, St. Vincent did not properly bill the claims related to the remaining 103 outlier payments which resulted in improper outlier payments during our audit period. These 103 claims, which had outliers totaling \$581,136, contained 173 billing errors. The billing errors primarily occurred because St. Vincent did not have adequate controls to prevent errors related to overcharged time, charge errors, and coding errors.

We could not determine the appropriate portion of each outlier payment without St. Vincent's correcting the billing error(s) by amending the claim. During our fieldwork, St. Vincent had not properly amended all of the claims which had errors. Therefore, we were unable to determine the correct amount for many of our sampled outlier payments. As a result, we could not estimate the dollar value of the inappropriate outlier payments in our sampling frame.

St. Vincent has amended 80 claims based on our audit findings.⁹ Of the 80 claims, 70 were amended correctly and lowered the outlier payments by \$362,999. However, 10 of the claims

⁸ The audit period encompassed the most current data available at the time we initiated our audit.

⁹ The rebilling of the claim does not mean that all errors were corrected. Some of the rebilled claims still have billing errors that should be corrected.

still contain billing errors but were partially corrected and lowered the outlier payments by \$1,266.¹⁰

We could not determine the error amount related to the 23 remaining claims in our sample that were not amended. These 23 claims had outlier payments totaling \$78,566. However, 11 of the 23 claims not amended were for claims with only undercharges. Outpatient outliers for the 11 claims totaled \$39,620. Because the undercharges would increase the outlier payment, St. Vincent decided not to amend these claims. The remaining 12 claims had outliers totaling \$38,946. The table below presents a summary of the correct claims, amended claims, and claims not amended.

As of the publication of this report, some of the erroneous claims in our sample (i.e., some of the 10 incorrectly amended claims and some of the 23 remaining claims that were not amended) are outside the 4-year period for reopening for good cause (the 4-year claims reopening period).¹¹ Notwithstanding, St. Vincent can request that a Medicare contractor reopen the initial determinations for those claims for the purpose of reporting and returning overpayments under the 60-day rule.¹²

Table: Summary of the 120 Outlier Claims

	Number of Claims	Original Outlier	Amended Outlier*	Difference
Correct Claims	17	\$41,606		
Amended Claims				
Correctly Amended	70	\$463,002	\$100,003	\$362,999
Incorrectly Amended	10	39,568	38,302	1,266
Total	80	\$502,570	\$138,305	\$364,265
Claims Not Amended				
Contain Undercharges	11	\$39,620	Not amended	Unknown
Contain Overcharges	12	38,946	Not amended	Unknown
Total	23	\$78,566	Not amended	Unknown
Total	120	\$622,742	\$138,305	Unknown

* For claims not amended, we were unable to determine the correct outlier payment.

¹⁰ St. Vincent continued to amend claims from our sample items since the issuance of the draft report. The numbers in the final report do not include these subsequent amendments.

¹¹ 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).

¹² 42 CFR § 405.980(c)(4).

We also could not determine the error amount for the 473 claims with outpatient outlier payments totaling \$1.1 million that we did not review.¹³ However, based on our findings, St. Vincent has already corrected 22 of the 473 claims, lowering outlier payments by \$65,701.

MEDICARE REQUIREMENTS

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)). Claims must be completed accurately so that Medicare contractors may process them correctly and promptly (the Manual, Chapter 1 § 80.3.2.2).

So that its charges may be allowable for use in apportioning costs under the program, 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 (PRM, part 1, § 2203).

Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services (the Manual, Chapter 4, § 290.1). Also, the hospital is required to report a charge of zero or a token charge (e.g. \$1.00) for an implanted device that was furnished at no cost to the hospital (The Manual, Chapter 4, § 61.3.5).

Payment may be made under Part B for physician services and for the non-physician medical and other health services when furnished by a participating hospital to an inpatient of the hospital, but only if payment for the services cannot be made under Part A.¹⁴

Packaged services are included in APCs and are not paid separately. When providing conscious sedation, recovery is included and not reported separately.¹⁵

The NCCI Policy Manual for Medicare Services states that modifier 59 and other NCCI-associated modifiers should not be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.¹⁶

¹³ The actual amount was \$1,072,249.

¹⁴ Medicare Benefit Policy Manual, Pub. No. 100-02, Chapter 6, § 10.

¹⁵ Current Procedural Terminology 2013, page 558, copyright 2012 American Medical Association. CPT codes that include Conscious Sedation are listed in Appendix G of the CPT manual.

¹⁶ NCCI Policy Manual for Medicare Services, January 1, 2014, Chapter 1, (E)(1)(d).

ST. VINCENT OVERCHARGED 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.¹⁷ Additionally, the Manual states that observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.¹⁸

Of the 120 claims reviewed, 47 errors of overcharged time were identified for 32 claims.

- Seven claims include an overcharge for operating room. For one claim, operating room was charged for 98 hours instead of 2.5 hours, increasing charges by \$338,688.
- Eight claims include an overcharge for anesthesia. For one claim, anesthesia was charged for 25 hours instead of 2 hours, increasing charges by \$8,316.
- Eighteen claims included overcharge time for recovery room. For one claim, recovery room was charged for 7 hours instead of 1 hour, increasing charges by \$5,049.
- Fourteen claims included overcharge time for observation. For one claim, observation was charged for 24 hours with no physician's order, increasing charges by \$940.

St. Vincent officials stated that in some instances the staff is required to enter the system and edit charges. These edits caused the operating room and anesthesia ending date to be incorrectly modified. When charges are edited, the procedure end date should be reviewed to verify that the original end date is in the system.

ST. VINCENT HAD CHARGE ERRORS

So that its charges may be allowable for use in apportioning costs under the program, 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.¹⁹ According to St. Vincent's policies, for codes entered into the billing system based on APC payment, the markup should be set at 30 percent above APC if the APC payment is greater than \$5,000.

¹⁷ The Act § 1833(e).

¹⁸ The Manual, Chapter 4, § 290.1.

¹⁹ CMS, PRM, Part 1, § 2203.

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.²⁰ Also, when a hospital implants a device for which it incurs no cost, the hospital is required to report a charge of zero or a token charge (e.g. \$1.00).²¹

Of the 120 claims reviewed, 24 errors of overcharged hard coded charges were identified for 24 claims.

- Twelve claims contained billing codes that did not follow St. Vincent's pricing policies. We identified five billing codes that were not entered into the billing system according to pricing policies. For example, the markup for one code based on policy would have been \$9,223.50, but the actual markup was \$19,157.15. St. Vincent officials stated that this discrepancy was caused by human error, resulting in the incorrect markup percentage being applied.
- Six claims contained an incorrect code and charge. For example, a code and charge of \$28,502 was incorrect on one claim. St. Vincent determined that a supply item was improperly linked in the billing system and was pulling in an incorrect code and charge line. St. Vincent identified the issue and additional claims during our audit period that were impacted. St. Vincent corrected the issue and amended 26 additional claims affected outside of our sample items.²² Twenty-two of those claims were included in our sample frame.
- Five claims contained one billing code that had inconsistent charges when more than one unit was billed. For example, when one unit was billed, the charge was \$262. When three units were billed, the charge was \$51,572. For this code, St. Vincent has a contract with the vendor in which they pay a flat rate no matter how many supply items were utilized during the procedure. St. Vincent determined that for each procedure they should have billed a flat supply charge under the contract multiplied by the applicable markup percentage.
- One claim had full charges for a billing code when the hospital had received a full credit for the medical device. St. Vincent did bill the claim to show the amount of the credit, however they did not change the device charge to \$0.00 or a token charge (e.g. \$1.00). St. Vincent stated that not reducing the charges for the device credit was caused by human error.

²⁰ The Act § 1833(e).

²¹ CMS, Manual, Pub. 100-04, Chapter 4, § 61.3.5.

²² The 26 additional claims were amended as of July 2018.

ST. VINCENT 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.²³ Furthermore, claims must be completed accurately so that Medicare contractors may process them correctly and promptly.²⁴

According to the CPT description, conscious sedation includes recovery and should not be billed separately.²⁵ Additionally, modifier 59 and other NCCI-associated modifiers should not be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met.²⁶ Also, generally, if a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, the hospital may be paid for certain Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient.²⁷

Of the 120 claims reviewed, 102 coding errors were identified for 87 claims.

- Twenty-eight claims contained charges for recovery room with conscious sedation. Because recovery room is included when billing conscious sedation, it should not be billed separately. For one claim, recovery room was charged when conscious sedation was charged, increasing charges by \$3,485.60
- Four claims contained charges for three billing codes that were not separately reportable because the code is part of the procedure. Modifiers were used to bypass the NCCI edits. For one claim, a code was charged when it was included as part of the procedure, increasing charges by \$574.
- Ten claims contained charges for seven billing codes not supported by documentation. For one claim, two units for a device were charged when only one unit was utilized, increasing charges by \$61,432.
- One claim contained charges for a denied inpatient claim. After the denied inpatient claim was paid as an outpatient claim, the inpatient claim was resubmitted and paid. The outpatient payment and outlier totaled \$2,630.59

²³ The Act § 1833(e).

²⁴ CMS, Manual, Pub. No. 100-04, Chapter 1, § 80.3.2.2.

²⁵ Current Procedural Terminology 2013, page 558, copyright 2012 American Medical Association.

²⁶ NCCI Policy Manual for Medicare Services, January 1, 2014, Chapter 1, (E)(1)(d).

²⁷ Medicare Benefit Policy Manual, Pub. No. 100-02, Chapter 6, § 10.1.

- Thirty-six claims did not contain charges for services documented. For one claim, anesthesia was performed but not charged, resulting in an undercharge of \$1,745.10
- Twenty-three claims contained errors for inaccurate coding. When the claims were reviewed by St. Vincent, it was determined that other coding better described the service provided. For many of these claims, the coding change will increase the overall APC payment.

St. Vincent stated that all of the coding errors were caused by human error.

ST. VINCENT’S PROCEDURES DID NOT 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.²⁸ Furthermore, claims must be completed accurately so that Medicare contractors may process them correctly and promptly.²⁹

St. Vincent did not have adequate controls to ensure claims billed to Medicare are accurate. We identified billing errors on 103 of the 120 claims in our sample (86 percent). We noted 173 billing errors with some claims having more than one error. The inaccurate claims caused underpayments and overpayments including unnecessary outlier payments.

RECOMMENDATIONS

We recommend that CHI St. Vincent Infirmary:

- return the \$362,999 in improper outlier payments for the 70 claims that have been amended correctly;³⁰

²⁸ The Act § 1833(e).

²⁹ CMS, Manual, Pub. No. 100-04, Chapter 1, § 80.3.2.2.

³⁰ OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to HHS action officials. Action officials at CMS, acting through a MAC or other contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Part A/B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a decision by the Office of Medicare Hearings and Appeals. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

- amend the 33 claims (10 incorrectly amended and 23 not amended) to identify and return any improper outlier payments that are within the 4-year claims reopening period;³¹
- for any of the 33 claims that are outside of the 4-year claims reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation;
- exercise reasonable diligence to identify and return any additional similar overpayments (including overpayments received during our audit period for the remaining \$1,072,249 in outlier payments that we did not review and overpayments outside of our audit period), in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- improve procedures and provide education to ensure claims billed to Medicare are accurate.

ST. VINCENT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments to our draft report, St. Vincent did not explicitly agree or disagree with our recommendations; however, St. Vincent stated that it has already refunded the amounts specified in OIG's first three recommendations. In addition, St. Vincent agreed with our first three findings regarding overcharged time, charge errors, and coding errors, and described corrective actions that it had taken or planned to take for each finding. St. Vincent did not agree or disagree with our fourth finding regarding its procedures not ensuring compliance with Federal requirements. Instead, St. Vincent stated that, based on OIG's findings, it has updated policies and procedures, revised systems, extended training to staff and implemented enhanced monitoring to promote billing compliance.

St. Vincent stated that it has substantial concerns with OIG's audit process. St. Vincent stated that the audit scope was discussed at the entrance conference but was not set out in writing. St. Vincent also expressed concern about OIG continuing to ask additional questions and request additional documentation after St. Vincent's initial self-audit, and it stated that OIG priorities appeared to shift. Finally, St. Vincent stated that it hoped OIG would consider its own audit policies and processes to ensure that providers have a clear, written understanding of the purpose and full scope of any audit because providers must have some ability to plan for audits in time and resources.

OIG clearly stated the objective and scope during the entrance conference and welcomed any follow-up questions. The objective did not change during our audit. Audit planning is a

³¹ Because 11 of the 33 claims contained only undercharges that would increase the outlier payment, St. Vincent decided not to amend these claims.

continuous process throughout the audit because we are obligated to obtain sufficient evidence to satisfy the objective. St. Vincent's initial self-audit of the claims identified billing errors, however, there were still many claims with no explanation as to why thousands in outliers were being paid. The follow-up questions related to the errors St. Vincent identified but also the claims they stated were billed correctly. Our follow-up questions identified additional billing errors for those claims.

St. Vincent's comments appear in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 593 outpatient outlier payments, totaling \$1,694,992 paid to St. Vincent for services rendered during our audit period (July 1, 2014, through June 30, 2016). The claims data was obtained from the CMS National Claims History file on the OIG Data Warehouse. We excluded claims with outlier payments of less than \$1,000, claims longer than 1 day, and 2 claims previously under review by the Recovery Audit Contractor. We selected a stratified random sample of 120 outlier payments to review.

We did not perform an overall assessment of St. Vincent'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 120 outpatient outlier payments from the sampling frame,
- sent the claims related to our 120 selected outlier payments to St. Vincent,
- requested St. Vincent review the documentation supporting these claims to verify that an outlier should have been paid,
- reviewed codes and charges on the claims related to our 120 selected outlier payments to look for inconsistencies,
- reviewed documentation obtained from St. Vincent to determine if billing errors contributed to outlier payments, and
- discussed the results of our audit with St. Vincent.

Appendix B contains our statistical sampling methodology.

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

TARGET POPULATION

The population consisted of outpatient outlier payments made to St. Vincent for dates of service between July 1, 2014, through June 30, 2016.

SAMPLING FRAME

The sampling frame consisted of 593 outpatient outlier payments totaling \$1,694,991.82 for services rendered during our audit period, July 1, 2014, through June 30, 2016.

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 four 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	Dollar Value of the Sample
1	≥ \$1,003.59 and ≤ \$2,050.65	333	34	\$478,168.34	\$48,389.82
2	≥ \$2,058.56 and ≤ \$4,110.68	153	33	442,454.85	89,408.90
3	≥ \$4,110.92 and ≤ \$8,097.31	87	33	473,427.89	184,002.99
4	≥ \$8,103.46 and ≤ \$42,598.83	20	20	300,940.74	300,940.74
Total		593	120	\$1,694,991.82	\$622,742.45

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 generating the random numbers for each stratum, we selected the corresponding sample units.

ESTIMATION METHODOLOGY

We could not determine the appropriate portion of each outlier payment without St. Vincent's correcting the billing error(s) by amending the claim. During our fieldwork, St. Vincent had not properly amended all of the claims which had errors. Therefore, we were unable to determine the correct amount for many of our sampled outlier payments. As a result, we could not estimate the dollar value of the inappropriate outlier payments in our sampling frame.

APPENDIX C: ST. VINCENT COMMENTS



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November 15, 2019

VIA FEDERAL EXPRESS and E-MAIL

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-06-16-01002

Dear Ms. Wheeler:

CHI St. Vincent Infirmary (“SVI”) appreciates the opportunity to comment on the validity of the facts and reasonableness of the recommendations outlined in the Office of Inspector General, Office of Audit Services (“OIG”) draft report dated September, 2019. SVI understands and takes seriously its obligations to bill Medicare appropriately for hospital outlier services rendered to program beneficiaries, and acknowledges the important role the OIG plays in enforcing these obligations.

Having reviewed the OIG’s preliminary findings and recommendations, SVI offers its comments below. As a general matter, and as discussed previously, SVI has substantial concerns with the audit process, and believes the published report should reflect these concerns.

I. Introduction

SVI is an acute care hospital serving the Little Rock, Arkansas and surrounding areas. It is a non-profit, faith-based hospital with 615 beds. SVI is ranked as a “best regional hospital” in Arkansas by U. S. News and World Report and is the first hospital to earn Magnet© recognition from the American Nurses Credentialing Center. SVI serves patients who seek advanced care in specialties for heart care, neurosciences (brain and spine), and orthopedics. The system includes a network of 300 primary care and specialty physicians, a home health agency, a joint venture inpatient rehabilitation facility, and affiliations with more than 1,000 physicians.

Hot Springs

Infirmary

Morrilton

North

Medical Group

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SVI has evolved over time to meet the ever increasing challenges of the contemporary healthcare landscape, its mission in service to those who are sick – especially those who are poor and vulnerable – remains ever strong. Driven by its deep commitment to reduce suffering and promote human flourishing, SVI continues to focus its resources on the health needs of the communities it serves including offering inpatient behavioral health services and providing low-cost community clinics in underserved areas. SVI offered more than \$30 million in charity care in 2019. The mission of SVI is to deliver high quality, accessible care for all Arkansans.

II. The OIG Audit Process

SVI received an undated and unsigned letter from OIG on or about February 20, 2017, requesting that SVI conduct a self-audit of outpatient outlier claims for certain services furnished between July 1, 2014 and June 30, 2016 (“Audit Request”). Following this Audit Request and an entrance conference on February 21, 2017, in which the audit scope was discussed but not set out in writing, OIG identified 120 claims for review by SVI on June 20, 2017. SVI conducted a full review of those 120 claims and provided the results to OIG on September 29, 2017. SVI determined that the 120 claims contained a variety of errors that impacted and overstated the outlier payments in the aggregate. The claims also showed a variety of underpayments. SVI then corrected and re-billed claims and/or made refunds for claims that contained overpayment errors. SVI continued to review all claims that could have been impacted by the errors determined in the self-audit conducted pursuant to the Audit Request.

SVI completed the work from the Audit Request on September 29, 2017. Since that time, OIG has continued to ask additional questions and request additional documentation and information through email, tabs in spreadsheets and during phone discussions. The process was extremely arduous for a small staff, particularly as requests for documentation continued and priorities appeared to shift. Despite this, SVI has prioritized compliance with OIG’s many requests, though SVI has certainly been challenged by the volume and changing-nature of the requests.

As providers and the various HHS agencies (CMS, OIG) continue to work together to improve care to beneficiaries and safeguard the Medicare trust, it is important for providers and HHS agencies alike to acknowledge areas for improvement and take proper steps in that direction. SVI takes seriously its mission to provide quality health care to all patients it serves and to do so in an efficient and accurate manner, taking into account the many rules of the Medicare system. This response acknowledges SVI’s role in that process and responsibility for any errors, while engaging in continuous improvement opportunities. SVI hopes that OIG will similarly consider its own audit policies and processes to ensure that providers have a clear, written understanding of the purpose and full scope of any audit. Providers must have some ability to plan for these audits in time and resources.

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III. OIG Substantive Findings

OIG had findings in four areas in which SVI claims contained errors that impacted outlier payments. Each of these areas is discussed below, along with SVI's response.

A. OIG Alleges That SVI Overcharged Time (32 of 120 Claims)

OIG determined that 32 of the 120 claims reviewed included errors in the amount of time billed for operating room, anesthesia, recovery room and observation services. These errors generally resulted from an overstatement in the number of hours recorded for these services. Because each hour of these services has an associated charge, the overstated hours increased the total charges, impacting outlier payments.

SVI agrees with this finding and has implemented changes to address the time input errors. These errors were a combination of system and human error. The system contained a flaw that would overwrite the end date of a procedure as the edit date if a record was entered in order to edit charges on a later date. After an edit was complete, the staff was then required to change the end date of the procedure back to the actual end date. Thus, not all time-based claims contained this error—many claims were never edited so no new “end” date was created, and for other claims the staff accurately changed the end date back on edited claims. The errors have been corrected and these claims have been corrected. SVI performed a root cause analysis (RCA) and educated staff to ensure that the end dates of procedures match in the system, to enter charges timely to reduce the need for edits, and to conduct ongoing monitoring of the charge error reports. SVI continues to audit potential outlier errors related to time reporting and has expanded the review to outlier items outside of the initial sample.

B. OIG Alleges that SVI Had Charge Errors (24 of 120 Claims)

OIG concluded that 24 claims contained charge errors caused by charges that were not consistent with SVI pricing policies.

SVI agrees with this finding and has corrected these claims. SVI has instituted additional processes to promote accurate chargemaster review and charge input. On a quarterly basis, a minimum of 10 chargemaster maintenance requests are validated for quality control purposes. The maintenance requests are randomly selected by a Revenue Integrity manager. The review validates every aspect of a charge request to ensure policy is followed. The results of those reviews are reported monthly. In the event a metric is failed, a root cause is identified.

SVI has also instituted new policies with respect to billing medical devices that are subject to certain manufacturer credits. SVI also reviewed all cases for which a device credit was received and corrected and rebilled all claims that did not contain the token charge.

C. OIG Alleges that SVI Had Coding Errors (87 of 120 Claims)

OIG concluded that 87 claims contained coding errors related to the inclusion of separate billing for included service charges (these are bundled), charges for codes not supported by the

documentation (and lack of charges for documented services,) charges for a denied inpatient claim previously billed as an outpatient claim, and errors in code selection and accuracy (both overcoding and undercoding.)

SVI agrees with the coding error findings and has corrected these claims. SVI has also updated its coding compliance policies and has trained staff on the updated policies. Coders are subject to audits for coding accuracy by a manager who is not responsible for supervision of their work. A minimum of 95.5% coding accuracy, as measured by these audits is required. In addition, investigation as to the causes of the coding discrepancies, remediation of potential claims coded in error, and education on trends identified, if any, is undertaken.

D. OIG Alleges that SVI's Procedures Did Not Ensure Compliance with Federal Requirements

SVI takes seriously its obligations to bill Medicare appropriately and asserts that its former procedures and processes were structured to ensure compliance with federal requirements; however, based on the findings above, SVI has updated policies and procedures, revised systems, extended training to its staff and implemented enhanced monitoring in order to promote billing compliance generally and for outliers specifically.

IV. Response to OIG Recommendations

- ***Recommendation #1: Return the \$362,999 in improper outlier payments for the 70 claims that have been amended correctly.***

SVI has already refunded these amounts through corrected claims. OIG has confirmed to SVI that this recommendation has been completed.

- ***Recommendation #2: Amend the 33 claims (10 incorrectly amended and 23 not amended) to identify and return any improper outlier payments that are within the 4-year reopening period.***

SVI has already refunded these amounts for the 10 incorrectly amended claims and the 12 claims previously not amended which contain overcharges through corrected claims. OIG has confirmed to SVI that this recommendation has been completed.

- ***Recommendation #3: For any of the 33 claims that are outside of the 4-year claims reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation.***

SVI has already refunded these amounts through corrected claims. OIG has confirmed to SVI that this recommendation has been completed.

- ***Recommendation #4: Exercise reasonable diligence to identify and return any additional similar overpayments (including overpayments received during our audit period for the remaining \$1,012,249 in outlier payments that we did not review and overpayments outside of the audit period), in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation.***

SVI is in the process of reviewing all outlier claims for the period of the self-audit. Of these claims, when overpayments have been found, SVI has refunded these amounts through corrected claims.

As OIG has stated in the Draft Audit Report, SVI had already corrected 22 of these claims. Others are in process through the claims processing system while additional claims require manual adjustment. SVI continues to correct and re-process those claims that require adjustment in accordance with these audit results.

- ***Recommendation #4: Improve procedures and provide education to ensure claims billed to Medicare are accurate.***

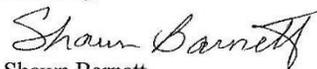
SVI takes seriously its obligations to bill Medicare appropriately and asserts that its former procedures and processes were structured to ensure compliance with federal requirements; however, based on the findings above, SVI has updated policies and procedures, revised systems, extended training to its staff and implemented enhanced monitoring in order to promote billing compliance generally and for outliers specifically.

V. Closing

SVI respects OIG's oversight authority and the need to ensure Medicare services are properly furnished and billed. SVI takes its responsibility of compliance seriously and takes ownership of its errors. SVI continues to pursue policies and procedures to improve its billing practices. SVI also hopes that OIG will consider its own audit practices to ensure that the scope is well defined to offer some timing and resource predictability to providers whose scarce human and capital resources are generally fully deployed towards patient care.

Thank you for the opportunity to provide this response.

Sincerely,



Shawn Barnett
President, CHI St. Vincent