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Medicare Compliance Review Turns Up No Errors at Memphis Hospital

The HHS Office of Inspector General on May 22 issued three new Medicare compliance reviews, and for the first time since implementing this audit method, it found no errors at one of the hospital targets.

Regional Medical Center at Memphis came up clean in this particular audit, during which OIG identified 60 inpatient claims from 2009 and 2010 that were potentially at risk for billing errors. OIG looked at only two issues: inpatient claims with payments greater than $150,000 and inpatient claims with high severity level MS-DRG codes. But all was well, and the results published by OIG were the shortest of any Medicare compliance review in the history of these comprehensive audits, during which auditors set up shop at hospitals, examine multiple kinds of errors at the same time and evaluate internal controls *(RMC 1/9/12, p. 1; 2/27/12, p.1).*

"It appears they had a more limited review than other hospitals," says Boston attorney Larry Vernaglia, with Foley & Lardner LLP. "This is a data mining exercise and maybe this organization was not an outlier on the other topics."

He also notes the hospital's Medicare volume is significantly lower than other hospitals. A 650-bed hospital, Regional Medical Center of Memphis had $57 million in Medicare revenue for 2009 and 2010. By comparison, Medicare paid $225 million in 2009 and 2010 to 481-bed Piedmont Hospital in Atlanta, the subject of another new Medicare compliance review.

The findings also may reflect the variances in Medicare compliance review audits, which are conducted by auditors from different OIG regional offices around the country, Vernaglia says. Because there is some variability, "the internal [hospital] team really needs to be on its game when approaching this audit," he says. "They need complete mastery of the files selected for review."

For the Medicare compliance review of Piedmont Hospital, OIG audited 62 inpatient claims submitted in 2009 and 2010 and found two errors. The overpayment amount was $129,000.

Auditors looked at 22 inpatient claims greater than $150,000 at Piedmont and found one error, for which the hospital billed Medicare with the wrong DRG code. Things got complicated when the hospital tried to fix its mistake. "The Medicare contractor rejected the adjusted claim as a duplicate because of a technical misunderstanding by the hospital's billing department, which coded the adjusted bill as an original bill. As a result of this error, the hospital received an overpayment totaling $126,367," OIG says. Tracy Field, executive vice president for compliance, tells *RMC* this was "a fluke. We already identified it was a mistake. It crossed in the mail."

OIG also audited 20 claims for high-severity DRGs at Piedmont and found one error. In this case, a coder assigned the wrong DRG, based on test results and not the physician notes in the medical records, OIG says. The overpayment here was $3,286.

Field recommends that hospitals have a staffer accompany OIG auditors during Medicare compliance reviews. "We didn't just put them in a room and say 'have at it,'" she says. "We made sure people were readily available and physically in the room with them." That enables hospitals to answer questions, give more information or clear up misunderstandings while auditors are reviewing the medical records. For example, electronic health records (EHRs) look much different on screen than when they are printed out, Field says. "Just because the electronic signature appears at the end of the chart doesn't mean they were entered after the fact," she says. "Understanding the [EHR] timeline takes time."

Piedmont was "open and candid" with OIG auditors. She preferred to get their questions answered and resolve problems upfront. "It takes a lot of time and is challenging in this environment with RACs coming through. It's taxing on the resources." But she says it probably saves a lot of time in the long run.

In the third compliance review announced May 22, OIG audited 145 inpatient and outpatient claims submitted in 2009 and 2010 by South Miami Hospital. *The results:* 60 errors and a $468,323 overpayment amount. "Additionally, we set aside $21,292 of the hospital's liability insurance claim as it awaits adjudication by a

Medicare Secondary Payer Recovery Contractor," OIG says.

On the inpatient side, OIG contends South Miami Hospital used the wrong DRG codes; billed inpatient stays that should have been billed as outpatient; and submitted incorrect charges on inpatient claims greater than $150,000, which triggered incorrect outlier payments.

On the outpatient side, the hospital submitted the wrong HCPCS codes on claims for payments over $25,000; made unit of service errors when billing for an anti-cancer drug (J9171); failed to get a manufacturer credit for a replaced device; and used modifier 59 incorrectly, OIG said.

In its written response to OIG, South Miami Hospital's chief compliance officer, Karen Brady, noted that 79% of the overpayments identified stemmed from one error, which occurred when converting doses of the anti-cancer drug into billable units, a common compliance snafu *(RMC 4/2/12, p. 1)*. To fix the problem, the hospital took immediate corrective action, including:

◆ Fixing the conversion factor in the charge master.

◆ Reviewing any claims outside the OIG sample that may have been incorrectly paid.

◆ Reviewing all drug conversion factors loaded in the charge master, "including the conversion factors loaded for every drug reported with any HCPCS code."

◆ Implementing a two-step process to validate conversion factor calculation and entry.

South Miami Hospital also will repay the overpayment. However, the hospital took issue with the amount of the overpayment and requested an adjustment, partly because it had already identified errors. For example, "prior to the OIG's review, the hospital had self-initiated refunds for these self-identified claims; an estimated $180,000 of the total estimated overpayment."

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