

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

Office of Audit Services
Region IX

**SAINT LOUISE HOSPITAL AND HEALTH
CENTER'S SKILLED NURSING FACILITY
BILLINGS AND COSTS FOR ANCILLARY
MEDICAL SUPPLIES FOR THE PERIOD
JULY 1, 1992 THROUGH JUNE 30, 1994**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represents the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS operating divisions.



JUNE GIBBS BROWN
Inspector General

MAY 1997
A-09-96-00078



Region IX
Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

MAY 07 1997

CIN: A-09-96-00078

Ms. Jacqueline Anderson
General Manager
Medicare Program
Blue Cross of California
21555 Oxnard Street
Woodland Hills, California 91367

Dear Ms. Anderson:

This report provides you with the results of an Office of Inspector General (OIG) audit of Saint Louise Hospital and Health Center's (Saint Louise) skilled nursing facility (SNF) billings to Medicare for ancillary medical supplies and its associated costs as claimed on the Medicare cost reports for fiscal years ended (FYE) June 30, 1993 and June 30, 1994.

During this 2-year period, the Saint Louise SNF billed Medicare about \$1 million for ancillary medical supplies (i.e., medical supplies not included in the patient's daily routine care) and claimed costs of about \$1 million for these supplies.

The objective of our review was to determine if unallowable charges had been billed to Medicare and unallowable costs had been claimed on the cost reports.

According to Medicare reimbursement rules, supplies and services that can be considered ancillary are limited to only those supplies and services that are directly identifiable to an individual patient, furnished at the direction of a physician because of special medical needs, and are either not reusable, represent a cost for each preparation, or are complex medical equipment.

We found that the Saint Louise SNF billed Medicare for ancillary medical supplies that were not in compliance with Medicare's rules and misclassified significant costs on the Medicare cost reports. About one-half of the ancillary billings and costs in our two judgmental samples were for routine medical supplies.

However, the improper billings and cost classifications did not have a material financial effect for our 2-year review period because the SNF had an exemption from the Medicare limit on its routine costs during this time period. Thus, it would receive full cost reimbursement even if the billings and costs were treated as routine.

The errors we noted occurred because Saint Louise's master list that classified each medical supply item as routine or ancillary had incorrect classifications for Medicare. The list treated Medicare patients the same as private patients. According to Saint Louise staff, they continued the same billing and cost classification practices after the exemption expired on June 30, 1994. Therefore, Saint Louise SNF may have been overpaid by Medicare for its FYE June 30, 1995 and June 30, 1996.

We recommend that for the 2-year period ended June 30, 1996, Blue Cross of California ensure that Saint Louise SNF:

- o Identifies and adjusts its claims to reverse all routine items billed as ancillary medical supplies.
- o Identifies and reclassifies any routine costs previously claimed as ancillary on its cost reports, and
- o Does not bill or claim future routine medical supplies as ancillary.

O'Connor Hospital, the entity responsible for Medicare billing and cost report preparation for Saint Louise, and Blue Cross of California, the fiscal intermediary (FI), concurred with our findings and recommendations. In its response to our draft report, O'Connor Hospital indicated that it has taken corrective action since our visit and agreed to identify and reclassify appropriate items on its current master list. The hospital agreed to work with the FI to obtain its concurrence prior to filing amended cost reports. The FI plans to provide educational training on and additional audits of the issues raised in our report. The hospital's and the FI's comments are attached as appendices.

INTRODUCTION

Background

As part of the Department of Health and Human Services' efforts to combat fraud, waste, and abuse, the OIG, in partnership with

the Health Care Financing Administration (HCFA) and the Administration on Aging, undertook an initiative called Operation Restore Trust. This project was designed to specifically target Medicare and Medicaid abuse and misuse in nursing home care, home health care, and durable medical equipment, three of the fastest growing areas in Medicare.

The OIG's audit of the Saint Louise SNF was one of several conducted in a national review of ancillary medical supplies. States included in this review were California, Florida, Illinois, New York, and Texas. We selected the Saint Louise SNF for this review because its medical supply costs were significantly higher than other SNFs of similar size in California.

Saint Louise, located in Morgan Hill, California, is one of two hospitals located in the San Jose area which are owned by the Daughters of Charity National Health System and Catholic Health Care West. The other is O'Connor Hospital. Staff at O'Connor Hospital billed Medicare, prepared the cost reports, and provided other financial and accounting services to the Saint Louise SNF. Both hospitals included a SNF, but the SNF at O'Connor Hospital was licensed for only a portion of our audit period (April 1, 1994 to June 30, 1994) and, therefore, we did not include it in our review.

Medicare generally reimburses SNFs on a reasonable cost basis as determined under principles established in the law and regulations. In order to determine their reasonable costs, providers are required to submit cost reports annually, with the reporting period based on the provider's fiscal accounting year. The SNFs are paid on an interim basis (based upon their billings to Medicare), and the cost report is used to arrive at a final settlement amount. Costs are classified on the cost report as either routine or ancillary.

Routine services are generally those services included by the provider in a daily service--sometimes referred to as the "room and board" charge. Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of certain equipment and facilities for which a separate charge is not customarily made.

According to Medicare rules, ". . . the following types of items and services. . . are always considered routine in an SNF for purposes of Medicare cost apportionment, even if customarily considered ancillary by an SNF:

"0 All general nursing services, including administration of oxygen and related medications. . .handfeeding, incontinency care, tray service, enemas, etc.

"0 Items which are furnished routinely and relatively, uniformly to all patients, e.g., patient gowns, paper tissues, water pitchers, basins, bed pans, deodorants, mouthwashes.

"0 Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities, e.g., alcohol, applicators, cotton balls, bandaids, antacid, aspirin, (and other nonlegend drugs ordinarily kept on hand), suppositories, tongue depressors.

"0 Items which are utilized by individual patients but which are reusable and expected to be available in an institution providing an SNF level of care, e.g., ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, other durable medical equipment (DME) which does not meet the criteria for ancillary services in SNFs under §2203.2, and the requirements for recognition of ancillary charges under §2203....

"0 Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician...." (Provider Reimbursement Manual, section 2203.1)

Ancillary services are those services directly identifiable to individual patients, such as laboratory, radiology, drugs, medical supplies, and therapies. Section 2203.2 of the Provider Reimbursement Manual, effective during our audit period,¹ specified that certain items and services could be considered ancillary if they met each of the following three requirements:

"0 direct identifiable services to individual patients, and

¹ This section was revised effective March 1995. The phrase "furnished at the direction of a physician because of specific medical needs" (see above) was replaced by "not generally furnished to most patients." In addition, "Support Surfaces" was added as another option for the third requirement.

"o furnished at the direction of a physician because of specific medical needs, and

"o one of the following:

- Not reusable - e.g., artificial limbs and organs, braces, intravenous fluids or solutions, oxygen (including medications), disposable catheters;

- Represent a cost for each preparation, e.g., catheters and related equipment, colostomy bags, drainage equipment, trays and tubing; or

- Complex medical equipment - e.g., ventilators, intermittent positive pressure breathing (IPPB) machines, nebulizers, suction pumps, continuous positive airway pressure (CPAP) devices, and bead beds such as air fluidized beds.

Medicare pays its portion of a provider's reasonable costs based upon an apportionment between program beneficiaries and other patients so that Medicare's share of the costs is based on services received by Medicare beneficiaries. For routine costs, Medicare's share is determined on the basis of a ratio of Medicare patient days to total patient days. For ancillary costs, Medicare's share is determined on the basis of the ratio of total covered beneficiary charges for ancillary services to total patient charges for such services.

Classifying costs as ancillary rather than as routine can result in higher Medicare reimbursement to SNFs because of two factors. First, SNFs generally have higher Medicare utilization for ancillary services than for routine services. That is, Medicare eligible patients generally receive more ancillary services than other patients but comprise a smaller portion of the total number of patients. Thus, Medicare's share of ancillary costs is usually greater than its share of routine costs. Second, Federal law (specifically, section 1888 of the Social Security Act) limits Medicare reimbursement for SNFs' routine costs to 112 percent of the mean operating costs of other similar SNFs. Thus, Medicare does not share in routine costs exceeding the Federal limit, unless the provider applies for and receives an exception or exemption from HCFA.

During the period under review (July 1, 1992 through June 30, 1994), Saint Louis SNF was granted an exemption by HCFA from its routine cost limit. This exemption expired on June 30, 1994.

The HCFA administers the Medicare program and designates certain fiscal intermediaries to perform various functions, such as processing Medicare claims, performing audits, and providing consultation to assist SNFs as providers. Blue Cross of California served as the FI for Saint Louis from July 1, 1992 through June 30, 1996.

Objective, Scope and Methodology

Our objective was to determine if the \$1,014,326 billed to Medicare as charges to patients and the \$1,076,752 in costs claimed on the Medicare cost reports for the 2-year period ended June 30, 1994 were allowable as ancillary medical supplies.

The Saint Louis SNF billed Medicare \$415,780 for ancillary medical supplies for FYE June 30, 1993 and \$598,546 for FYE June 30, 1994 (a total of \$1,014,326 for both years). It claimed \$422,141 as costs for these supplies for FYE June 30, 1993 and \$654,611 for FYE June 30, 1994 (a total of \$1,076,752 for both years).

To accomplish this objective, we reviewed a judgmental sample of 288 line items totaling \$10,689 that were billed to Medicare as ancillary medical supplies and discussed billing procedures with O'Connor Hospital's billing staff. Each line item was a separately identifiable product or service. To select our sample of the billings, we chose several Medicare patients and then reviewed all charges to Medicare for those patients.

We also reconciled the amount claimed on the Medicare cost reports for ancillary medical supplies to the accounting records and examined a judgmental sample of 167 ancillary medical supply line items totaling \$13,980 that were treated as ancillary costs. For our sample of costs, we selected invoices of those vendors that appeared to us to account for the most costs in each account. Because both of our samples were judgmental, we cannot project the results of our sample to the total billings or costs claimed.

In addition, we gained an understanding of Saint Louis's accounting system through discussions with reimbursement and accounting staff at O'Connor Hospital. Staff at O'Connor Hospital was assigned responsibility for Saint Louis's billing, accounting, and cost report preparation.

We relied on the FI's medical review staff to determine whether the sampled items were properly classified as ancillary using Medicare's guidelines.

Our review was made in accordance with generally accepted government auditing standards. The fieldwork was performed at the O'Connor Hospital in San Jose, California during July 1996.

FINDINGS AND RECOMMENDATIONS

We found that many routine medical supplies were billed to Medicare as ancillary supplies. Of the \$10,689 billed for medical supplies (288 line items) that we examined, \$5,740 or about 54 percent of the amount billed (147 line items) were actually routine medical supplies. The items included admission kits, incontinent pads, enteral feeding pumps and supplies, slippers, mattresses, sterile gloves, moisture cream, mouthwash, stockings (support), cleansing foam, wrist restraints, and adult briefs (diapers). They should not have been billed to Medicare as ancillary medical supplies.

We also found that the costs of many routine medical supplies were classified as ancillary costs on the Medicare cost reports. Of the \$13,980 for medical supply costs (167 line items) that we examined, \$7,682, or 55 percent of the amount claimed as costs (104 line items), was for routine supplies. These items included maternity kits, diapers, briefs, slippers, underpads, shaving cream, enteral feeding equipment, and admission kits.

According to Medicare's rules, such supplies do not qualify as ancillary. Because we selected the invoices in a nonrandom manner, however, the results we noted may not necessarily be representative of the total ancillary billings or costs included as ancillary on the cost reports.

Under Medicare's rules (see pages 3 and 4 of this report), items and services furnished routinely to all patients should always be considered routine. In order to be classified as ancillary, the item or service must be directly identifiable to an individual patient, furnished at the direction of a physician because of special medical needs, and be either not reusable, represent a cost for each preparation, or be complex medical equipment.

The billings and costs we identified were for supplies or services that did not meet the specific requirements for treatment as ancillary medical supplies.

The improper billings and cost classifications occurred because Saint Louise's master list that classified each medical supply item as routine or ancillary had incorrect classifications for Medicare. The list treated Medicare patients the same as private patients.

During our audit period, Saint Louise SNF operated under an exemption from Medicare's routine cost limit. Under this exemption, Saint Louise SNF was not subject to a limit on its routine costs. Therefore, the errors we noted did not result in a Medicare overpayment during this period. However, the exemption expired June 30, 1994, and according to Saint Louise staff, they continued the same billing and cost classification practices after the exemption expired. Accordingly, Saint Louise SNF may have been overpaid after June 30, 1994.

Recommendations

We recommend that for the 2-year period ended June 30, 1996, Blue Cross of California ensure that Saint Louise SNF:

- o Identifies and adjusts its claims to reverse all routine items billed as ancillary medical supplies.
- o Identifies and reclassifies any routine costs previously claimed as ancillary on its cost reports, and
- o Does not bill or claim future routine medical supplies as ancillary.

O'Connor Hospital's Comments

O'Connor Hospital concurred with our findings and recommendations. The hospital agreed to identify and reclassify items which were not allowable as ancillary. It has taken corrective action since our visit and has agreed to work with the FI to obtain its concurrence prior to filing amended cost reports.

FI's Comments

The FI also concurred with our findings and recommendations. It plans to provide educational training on and additional audits of the issues raised in our report.

Page 9 - Ms. Jacqueline Anderson

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination. To facilitate identification, please refer to the common identification number A-09-96-00078 in all correspondence relating to this report.

-- -- -- -- --

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent that the information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

Sincerely yours,



Lawrence Frelot
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Elizabeth Abbott
Regional Administrator
Health Care Financing Administration
75 Hawthorne Street
San Francisco, California 94105

APPENDICES

O'Connor Hospital

Member, Catholic Healthcare West

2105 Forest Avenue
San Jose, California 95128-1471**CERTIFIED MAIL**

P 369 070 320

March 28, 1997

Mr. Lawrence Frelot
Department of Health & Human Services
Office of Inspector General
50 United Nations Plaza
San Francisco, CA 94 102

Re: CM: A-09-96-00078

Dear Mr. Frelot:

Thank you for the above report and the opportunity to response.

St. Louise Hospital was first certified under the Medicare program on October 1989, the date the hospital first opened, as a 60 bed general acute care hospital. St. Louise Hospital's SNF was established on July 1990. Nineteen of the hospital's acute bed were reclassified as SNF beds by the California Department of Health Services.

Medicare inpatient acute services **were** reimbursed under the prospective payment system since the inception of the hospital (October, 1989). Medicare inpatient SNF services were reimbursed under the reasonable cost principles beginning July 1990. Routine SNF cost was apportioned to the Medicare program using the ratio of Medicare SNF days to total SNF days. SNF ancillary costs were apportioned based on the ratio of Medicare charges to **total** charges (this denominator includes both acute and SNF inpatient charges, and outpatient charges)

The hospital maintains uniform charges across all payer categories and across **all** provider setting. The charges are maintained in a file called the Charge Master. Each revenue producing departments have their **own** set of charges with its own set of **identifying** codes. The charges were established based on what was commonly charged-for **in** the community.

The charges in dispute were primarily issued out of the hospital's central supply department. This department serviced only the acute care patients prior to the establishment of the SNF. **After** the SNF opened, the same charge master that was in

place for **the** acute patients was used for the SNF patients. The central supply department's set of charges were applied uniformly to all patients.

~~The hospital concur with the findings and recommendation in the above~~ -
-. The hospital, however, finds the rules and regulations confusing and in constant flux. For instance, in the acute setting, Provider Reimbursement Manual, Part I, Section 2203 states:

“Where there is no common or established classification of an item or service as **routine** or ancillary among providers of the same class in the same State; a provider's customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program.”

And, secondly, ~~Provider Reimbursement Manual, Part I, Section 2203.1~~ states:

“**Exception:** To facilitate accurate and equitable cost apportionment within a single hospital-SNF complex where both components have customarily followed a uniform charging practice, the same classification of items and services as routine or ancillary may continue to be used by a participating hospital-based SNF as is used by the related hospital for Medicare reimbursement purposes.”

Thirdly, the **hospital** applied for an adjustment to the SNF routine cost **limit** in FY 95. It has been my experience that Blue Cross, our fiscal intermediary, has treated non-chargeable medical supplies costs charged to the routine SNF cost center as **central supply** costs for the purpose of determining the **allowable** cost requested under the RCL exception. They also reclassified non-prescription pharmaceuticals back to the pharmacy cost center.

Fourthly, the list of medical supplies **that** should be considered as routine was deleted from the **PRM** in 1972. Since then, we have not seen a comprehensive list from our intermediary. I understand one will be **published** in a future Medicare Bulletin. And, the items considered routine or ancillary have changed over time. For example, the 1972 list in **PRM** section 2203.1 listed intermittent positive pressure breathing machines (**IPPB**) as routine but in the citation (**PRM** section 2203.2) quoted on page four of the **OIG** report listed the **IPPB** machines as ancillary.

Since we charge uniformly, the hospital does *not believe* there is an inequitable apportionment of costs to the program for FY 93 and FY 94. In the case of St. Louise Hospital, Medicare utilization of the central supply department (medical supplies charged to patients cost center on the cost report) is not higher than the SNF routine services. For example:

FYE June 30, 1993 Audited cost Report	SNF	Medical Supplies
Medicare Routine Days / Charges	5,018	\$422,141
Total Routine Days / Charges	10,727	\$1,401,054
Utilization Percentage	46.8%	30.1%

For FY 95 and FY 96, the misclassification of supply costs between routine and ancillary may have an impact due to the application of the SNF routine cost limit (RCL) to the extent any request for an adjustment to the RCL does not provide full relief.

The hospital believes that the reclassification of supplies from ancillary to the acute routine units have little or no impact on Medicare reimbursement since the acute reimbursement is DRG-based

The hospital proposes the following corrective action plan for prior cost reporting periods:

Allowable not as ancillary but as routine

1. Identify items which should have been routine that were recorded as medical supplies charged to patients; **summarize** the charges by total (all patients) and **medicare** for each year. We propose to **identify** the items by reviewing a sample of Medicare bills and correlating them back **to the** charge master applicable to the year in question.
2. Identify which part of the facility the items belong (i.e. acute or SNF). This will require a special report identifying the items by "patient type" (i.e. acute or SNF).
3. Identify the cost of these items through a sampling of invoices.
4. Reclassify **cost from** medical supplies charged to patients to the adult and pediatric, ICU, Nursery, and SNF cost centers.
5. Eliminate the **charges** for these items from total charges and **medicare** charges (acute and SNF) by filing amended cost reports for FY 93 through FY 96.

For noncovered items

1. Identify the items and the total and **medicare** charges for each year.
2. Remove total charges, **medicare** charges and cost from the medical supplies charged to patients cost center on the **medicare** cost report.

We propose to have the intermediary review our **workpapers** supporting our proposed adjustments and obtain their concurrence prior to the hospital filing amended cost reports for fiscal years 1993 to 1996 to incorporate the above changes. We understand the Intermediary has a list of supplies that should be considered routine in **draft** form. We

have asked for this have not received a copy. It **will** be helpful if the intermediary can provide this list prior to the start of our work. It will also be **helpful** if the intermediary would provide the hospital with the electronic audited cost reports **from** which the above adjustments will be posted.

Timetable

We estimate that identifying and costing the items in question **will** be the most time consuming **activity**. We estimate for the four years it will require six months to **marshall** the data processing resources to obtain the necessary information to make the corrections, and three months to reopen all the cost reports. We therefore estimate nine months from the time we receive the final **draft** of this report to the project completion date.


Corrective actions taken since the July 1996 audit:

Since the July 1996 exit conference, we have taken the following steps to correct the billing for the aforementioned items:

- A nurse auditor has reviewed the Medicare SNF accounts and deleted those charges that are not covered or should be considered routine.
- We have made changes to **our** charge master by making certain items nonchargeable. We still need to review our charge master against the intermediary's list of nonchargeable medical supply items.
- We have worked with our **MIS** department to reconfigure the billing system to bill the aforementioned items as non-covered.

Please **feel** free to call me at (408) 947-2726 should you have any question.

Sincerely,


Stanley Quan
Revenue Manager

Enclosures

cc: Les Wong, CFO
Diane Dennis, Controller
Nancy **Benn**, CHW Legal Dept.



Blue Cross
of California

An Independent Licensee of the
Blue Cross Association

Federal Medicare Intermediary

21555 Oxnard Street
Woodland Hills, California 91367

March 20, 1997

Douglas Leonard
OIG Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

RE: A-09-96-00078 - Saint Louise Hospital and Health Center

Dear Mr. Leonard:

This is in response to your letter dated February 5, 1997 to Jacqueline Anderson. We reviewed the draft audit report on Saint Louise Hospital and Health Center and the following are our comments:

1. We concur with your findings on the unallowable charges billed to Medicare and the unallowable charges claimed on the cost reports.
2. We plan to provide the provider with educational training regarding the issues raised in your letter and to make sure there are no improper billings in the future.
3. We plan to request from the provider a list of all charges made for the period of July 1, 1992 to June 30, 1996, so we may determine if cost report reopenings and/or adjustments are necessary. We will assess if reclassifying the costs to a Routine area will have a positive material effect to the Program.
4. Audit this reimbursement area in an upcoming audit after the training to ensure the provider is complying with your findings and recommendations.

We will start the implementation of the above items when we receive the your final audit report.

If you have any questions, please call Jeff McVicker at (818) 703-2833

Sincerely,

A handwritten signature in cursive script that reads "Janie Solomon".

Janie Solomon, Manager
Home Health & Hospice/ESRD