



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



May 1, 2012

**TO:** Peter Budetti  
Deputy Administrator and Director  
Center for Program Integrity  
Centers for Medicare & Medicaid Services

Deborah Taylor  
Director and Chief Financial Officer  
Office of Financial Management  
Centers for Medicare & Medicaid Services

**FROM:** /Brian P. Ritchie/  
Assistant Inspector General for the  
Centers for Medicare & Medicaid Audits

**SUBJECT:** Medicare Compliance Review of Barnes Jewish Hospital for Calendar Years 2009 and 2010 (A-07-11-05014) and Medicare Compliance Review of Indiana University Health for the Period October 2008 Through September 2010 (A-05-11-00069)

Attached, for your information are advance copies of two of our final reports for hospital compliance reviews. We will issue these reports to Barnes Jewish Hospital and Indiana University Health within 5 business days.

These reports are part of a series of the Office of Inspector General's hospital compliance initiative, designed to review multiple issues concurrently at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at [Brian.Ritchie@oig.hhs.gov](mailto:Brian.Ritchie@oig.hhs.gov), or your staff may contact the respective Regional Inspectors General for Audit Services:

Barnes Jewish Hospital

Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII  
(816) 426-3591, email – [Patrick.Cogley@oig.hhs.gov](mailto:Patrick.Cogley@oig.hhs.gov)

Indiana University Health

Sheri L. Fulcher, Regional Inspector General for Audit Services, Region V  
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Attachment

cc: Daniel Converse  
Office of Strategic Operations and Regulatory Affairs  
Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION V  
233 NORTH MICHIGAN, SUITE 1360  
CHICAGO, IL 60601

May 7, 2012

Report Number: A-05-11-00069

Mr. Daniel F. Evans, Jr.  
President and Chief Executive Officer  
Indiana University Health  
340 W. 10th St. 6<sup>th</sup> Floor  
Indianapolis, IN 46206

Dear Mr. Evans:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Indiana University Health for the Period October 2008 Through September 2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Lynn Barker, Audit Manager, at (317) 226-7833, extension 21, or through email at [Lynn.Barker@oig.hhs.gov](mailto:Lynn.Barker@oig.hhs.gov). Please refer to report number A-05-11-00069 in all correspondence.

Sincerely,

/Sheri L. Fulcher/  
Regional Inspector General  
for Audit Services

Enclosure

cc:

Marijane Armbruster, Executive Director Revenue Cycle,  
Indiana University Health

Kimberly Carter, Revenue Cycle System Manager,  
Indiana University Health

**Direct Reply to HHS Action Official:**

Ms. Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 East 12<sup>th</sup> Street, Room 235  
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF  
INDIANA UNIVERSITY HEALTH  
FOR THE PERIOD OCTOBER 2008  
THROUGH SEPTEMBER 2010**



Daniel R. Levinson  
Inspector General

May 2012  
A-05-11-00069

# *Office of Inspector General*

<http://oig.hhs.gov>

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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# *Notices*

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

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays 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, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Indiana University Health (the Hospital) is a 1,570-bed acute care hospital located in Indianapolis, Indiana. Medicare paid the Hospital approximately \$590 million for 36,060 inpatient and 354,177 outpatient claims for services provided to beneficiaries from October 2008 through September 2010 based on CMS's National Claims History data.

Our audit covered \$11.6 million in Medicare payments to the Hospital for 122 inpatient and 76 outpatient claims that we judgmentally selected as potentially at risk for billing errors. These 198 claims had dates of service from October 2008 through September 2010.

### **OBJECTIVE**

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

## **SUMMARY OF FINDINGS**

The Hospital complied with Medicare billing requirements for 163 of the 198 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 35 claims resulting in overpayments totaling \$279,993 from October 2008 through September 2010. Specifically, 15 inpatient claims had billing errors, resulting in overpayments totaling \$109,198, and 20 outpatient claims had billing errors, resulting in overpayments totaling \$170,795. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$279,993, consisting of \$109,198 in overpayments for 15 incorrectly billed inpatient claims and \$170,795 in overpayments for 20 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **INDIANA UNIVERSITY HEALTH'S COMMENTS**

In written comments on our draft report, the Hospital concurred with our findings and recommendations. The Hospital's comments are included in their entirety as the Appendix.

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# INTRODUCTION

## BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.<sup>1</sup>

### **Hospital Inpatient Prospective Payment System**

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays 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, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>2</sup> The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.<sup>3</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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<sup>1</sup> Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

<sup>2</sup> In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

<sup>3</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

## **Hospital Payments at Risk for Incorrect Billing**

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. The types of payments to hospitals reviewed by this and related audits included payments for claims billed for:

- inpatient claims for short stays,
- inpatient claims for same-day discharges and readmissions,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims with payments greater than \$150,000,
- inpatient hospital-acquired conditions and present on admission indicator reporting,
- inpatient transfers,
- outpatient claims with payments greater than \$25,000,
- outpatient surgeries billed with units greater than one,
- inpatient and outpatient claims involving manufacturer credits for replaced medical devices, and
- inpatient and outpatient 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.”

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

## **Medicare Requirements for Hospital Claims and Payments**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and 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.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment.

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

## **Indiana University Health**

Indiana University Health (the Hospital) is a 1,570-bed acute care hospital located in Indianapolis, Indiana. Medicare paid the Hospital approximately \$590 million for 36,060 inpatient and 354,177 outpatient claims for services provided to beneficiaries from October 2008 through September 2010 based on CMS's National Claims History data.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### **Scope**

Our audit covered \$11,623,239 in Medicare payments to the Hospital for 122 inpatient and 76 outpatient claims that we judgmentally selected as potentially at risk for billing errors. These 198 claims had dates of service from October 2008 through September 2010.

We focused our review on the risk areas that we had identified during and as a result of prior 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 inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review enabled 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.

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 fieldwork at the Hospital from May through November 2011.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for October 2008 through September 2010;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for calendar years 2008, 2009, and 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 198 claims (122 inpatient and 76 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled 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 sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- 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.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATIONS**

The Hospital complied with Medicare billing requirements for 163 of the 198 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 35 claims, resulting in overpayments totaling \$279,993 from October 2008 through September 2010. Specifically, 15 inpatient claims had billing errors, resulting in overpayments totaling \$109,198, and 20 outpatient claims had billing errors, resulting in overpayments totaling \$170,795. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 15 of the 122 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$109,198.

### **Inpatient Manufacturer Credits for Replaced Medical Devices**

Federal regulations (42 CFR § 412.89) require reductions in the inpatient prospective payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

The Manual, chapter 3, section 100.8, states: To correctly bill for a replacement device that was provided with a credit ... hospitals must use the combination of condition code 49 or 50, along with value code "FD." The condition code 49 or 50 will identify a replacement device while value code FD will communicate to Medicare the amount of the credit, or cost reduction, received by the hospital for the replaced device.

For 8 of the 18 sampled claims, the Hospital received a reportable medical device credit for a replaced medical device from a manufacturer. However, the Hospital did not adjust its inpatient claims with the proper value and condition codes to reduce payment as required. The Hospital stated that these errors occurred because there were incomplete controls to identify, obtain, and properly report credits from the manufacturers to ensure it submitted claims correctly. As a result, the Hospital received overpayments of \$59,649.

### **Inpatient Claims Billed With High Severity Level Diagnosis Related Group Codes**

Section 1862(a)(1)(A) of the Act states that 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." Additionally, the Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 4 of the 20 sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that these errors occurred due to human error and because these claims were not selected in their coding quality reviews. As a result, the Hospital received overpayments totaling \$42,183.

### **Inpatient Claims Paid in Excess of \$150,000**

Section 1862(a)(1)(A) of the Act states that 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."

For 3 of the 20 sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that these errors occurred due to human error and the existing quality control system that did not pick-up on the errors. As a result, the Hospital received overpayments totaling \$7,366.

## **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 20 of 76 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$170,795.

### **Outpatient Manufacturer Credits for Replaced Medical Devices**

Federal regulations (42 CFR § 419.45) 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.

#### *Prudent Buyer Principle*

Under 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services ....” CMS’s *Provider Reimbursement Manual (PRM)*, part 1, section 2102.1, states, “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.” Section 2103 of the PRM states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example:

Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.

#### *Billing Requirements for Medical Device Credits*

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual explain how a provider should report no-cost and reduced-cost devices under the OPPS. 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.

For 8 of the 27 sampled claims, the Hospital either received full credit for a replaced device but did not report the required “FB” modifier or reduced charges on its claims (7 errors) or the Hospital did not obtain a credit for a replaced device that was available under the terms of the manufacturer’s warranty (1 error). The Hospital stated that these errors occurred because there were incomplete controls to identify, obtain, and properly report credits from the manufacturers to ensure that it submitted claims correctly. As a result, the Hospital received overpayments of \$98,104.

### **Outpatient Claims Paid in Excess of Charges**

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. Additionally, the Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 5 of the 14 sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes and/or incorrect number of units of HCPCS codes. The Hospital stated that these errors occurred due to human error and the existing quality control system that did not pick-up on the errors. As a result, the Hospital received overpayments totaling \$46,814.

### **Outpatient Claims Paid in Excess of \$25,000**

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. Additionally, the Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 4 of the 10 sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes. The Hospital stated that these errors occurred due to human error and the existing quality control system that did not pick-up on the errors. As a result, the Hospital received overpayments totaling \$19,298.

### **Outpatient Surgeries Billed With Units Greater Than One**

The Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. In addition, chapter 4, section 20.4, of the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For 3 of the 25 sampled claims, the Hospital submitted claims to Medicare with incorrect numbers of surgical units of service performed and/or incorrect HCPCS codes. The Hospital stated that these errors occurred due to human error and the existing quality control system that did not pick-up on the errors. As a result, the Hospital received overpayments totaling \$6,579.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$279,993, consisting of \$109,198 in overpayments for 15 incorrectly billed inpatient claims and \$170,795 in overpayments for 20 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **INDIANA UNIVERSITY HEALTH'S COMMENTS**

In written comments on our draft report, the Hospital concurred with our findings and recommendations. The Hospital's comments are included in their entirety as the Appendix.

# **APPENDIX**

## APPENDIX: INDIANA UNIVERSITY HEALTH COMMENTS



Indiana University Health

March 19, 2012

Sheri L. Fulcher  
Regional Inspector General for Audit Services  
US DHHS, Office of Inspector General  
Office of Audit Services, Region V  
233 North Michigan Avenue  
Chicago, IL 60601

RE: Report Number A-05-11-00069

Dear Ms. Fulcher:

Indiana University Health (IUH) is in receipt of the draft report provided by the U.S. Department of Health and Human Services, Office of Inspector General (OIG), entitled *Medicare Compliance Review of Indiana University Health for the Period October 2008 through September 2010*. Please accept the following comments in response to the draft report.

As noted in the draft report, a total of 198 Medicare claims with dates of service from October 2008 through September 2010 were selected for review by the OIG. The 198 claims, totaling approximately \$11,623,239 in Medicare payments, were made up of 122 inpatient and 76 outpatient claims that were judgmentally selected as potentially at risk for billing errors based on prior OIG audits, investigations and inspections of payments to hospitals.

**Concurrence of Findings:**

The report indicates that IUH complied with Medicare billing requirements for 163 of the 198 inpatient and outpatient claim reviewed. However, billing errors were identified in 35 claims, resulting in overpayments totaling \$279,993 from October 2008 through September 2010. Specifically, 15 inpatient claims had billing errors, resulting in overpayments totaling \$109,198, and 20 outpatient claims had billing errors, resulting in overpayments totaling \$170,795. IUH is in general agreement with these findings and the identified overpayment amounts. Based on the age of the claims reviewed within the scope of the audit, claims identified with payment adjustments will be submitted to the Medicare Administrative Contractor (MAC) through the Voluntary Refund Process.

**Inpatient and Outpatient Manufacturer Credits for Replaced Medical Devices:**

For 8 of the 18 sampled inpatient claims and 7 of the 27 sampled outpatient claims, IUH received a reportable medical device credit for a replaced medical device from a manufacturer. However, the hospital did not adjust its inpatient and outpatient claims with the proper value and condition codes or report the required "FB" modifier or reduce charges on its claims to reduce payment as required. For 1 of the 27 sampled outpatient claims, IUH did not obtain a credit for a replaced device that was available under the terms of the manufacturer's warranty. Historically, IUH has relied on the notification of manufacturer device credits from the clinical staff responsible for applying for the

credits. However, as with other facilities around the country, ensuring that proper communication regarding manufacturer device credits flows back into Revenue Cycle from the clinical areas has been a challenge. As part of the internal control process, IUH will be contacting as many medical device vendors that we can identify to obtain lists of warranty credits issued to our facilities on a monthly basis. The lists will be confirmed with our clinical resource coordinators to ensure the credit has been received. Once the credit has been received and communicated to the billing department, the documentation will be used to file adjustment claims with the appropriate condition code or value code and adjusted charges, as applicable.

In addition to our internal controls, IUH believes that true compliance can be achieved in this area when requirements are placed on the medical device distributors and manufacturers to submit the information regarding medical device credits to facilities. This information will allow providers to facilitate accurate claim submission and will greatly reduce the high risks associated with overpayments in this area.

#### **Inpatient Claims Billed with High Severity Level Diagnosis Related Group Codes**

For 4 of the 20 sampled claims, IUH billed Medicare for incorrect DRG codes. As with any process that requires human assessment and intervention, errors can be made. IUH has a strong coding quality and compliance program in place to prevent as many coding errors as possible. The claims identified in this part of the review had not been under previous inspection through the course of the quality review program.

#### **Inpatient Claims Paid in Excess of \$150,000**

For 3 of the 20 sampled claims, the Hospital billed Medicare for incorrect DRG codes. As stated above, the claims identified in this part of the review had not been under previous inspection through the course of the quality review program.

#### **Outpatient Claims Paid in Excess of Charges**

For 5 of the 14 sampled claims, IUH submitted claims to Medicare with incorrect HCPCS codes and or incorrect number of units of HCPCS codes. These errors were either caused by incorrect CPT code assignment or incomplete billing corrections after an error was identified. Our billing correction process has since been streamlined to ensure corrections are completed timely when coding errors are identified. In addition, an internal coding quality audit will be initiated for review of accounts where neurostimulator leads are placed. Education will be provided to the applicable coding staff based on the outcomes of this audit.

#### **Outpatient Claims Paid in Excess of \$25,000**

For 4 of the 10 sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes. Based on our self-audit findings, an internal coding audit will be performed on accounts with lead revisions. Based on the subsequent findings, targeted education will be given to the coders to ensure proper code assignment.

#### **Outpatient Surgeries Billed with Units Greater Than One**

For 3 of the 25 sampled claims, the Hospital submitted claims to Medicare with incorrect numbers of surgical units of service performed and/or incorrect HCPC codes. These errors were largely caused by a pre-bill edit that was missing logic to identify all possible scenarios. The pre-bill edit has been corrected and when claims hit this edit, a credentialed, certified coder will review them to review the documentation and ensure the appropriateness of the multiple units and that accounts are corrected

prior to final bill. In addition the Charge Description Master will be reviewed to ensure that there is no duplication of soft- and hard-coded procedures. This will prevent inadvertent duplicate CPT code assignment to a bill.

Through this self-audit process, IUH has strengthened its internal controls to prevent future billing errors. In addition to the extensive coding quality checks that are currently in place, IUH will continue to perform targeted reviews on cases prone to coding errors which can lead to inappropriate payments. As stated above, IUH will refund any identified overpayments to the MAC.

IUH is committed to compliant, ethical, and accurate billing and coding. By way of its internal Compliance Program and Coding Quality Review Program, IUH will continue to work to identify areas of risk and non-compliance as well as implement stronger controls and promptly resolve identified deficiencies, especially as they relate to the areas audited by the OIG.

IUH appreciates the opportunity to provide comments related to this report. In addition, we would like to thank the audit staff assigned to our facility for their professionalism and their patience.

If you need additional information or have any further questions, please contact me at (317) 962-3191 or (317) 997-3018.

Respectfully,



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