



February 23, 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 John Muir Medical Center, Walnut Creek, for Calendar Years 2008 Through 2010 (A-09-11-02060) and Medicare Compliance Review of University of California, San Diego, Medical Center for Calendar Years 2008 and 2009 (A-09-11-02055)

Attached, for your information, are advance copies of our final reports for two of our hospital compliance reviews. We will issue these reports to John Muir Medical Center, Walnut Creek, and University of California, San Diego, Medical Center 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, or your staff may contact Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through email at Lori.Ahlstrand@oig.hhs.gov.

Attachment

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

February 28, 2012

Report Number: A-09-11-02055

Ms. Lori R. Donaldson
Chief Financial Officer
University of California, San Diego, Medical Center
200 West Arbor Drive, M/C: 8987
San Diego, CA 92103-8987

Dear Ms. Donaldson:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of University of California, San Diego, Medical Center for Calendar Years 2008 and 2009*. 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 call Iman Zbinden, Senior Auditor, at (619) 557-6131, extension 109, or Alice Norwood, Audit Manager, at (415) 437-8360. Please refer to report number A-09-11-02055 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
Regional Inspector General
for Audit Services

Enclosure

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 12th Street, Room 235
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF UNIVERSITY OF
CALIFORNIA, SAN DIEGO,
MEDICAL CENTER FOR
CALENDAR YEARS
2008 AND 2009**



Daniel R. Levinson
Inspector General

February 2012
A-09-11-02055

Office of Inspector General

<http://oig.hhs.gov>

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:

Office of Audit Services

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.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
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 hospital inpatient 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 payments to hospitals using computer matching, data mining, and analysis of claims. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

University of California, San Diego, Medical Center (the Hospital) is an acute-care hospital located in San Diego, California. Medicare paid the Hospital approximately \$277 million for 12,947 inpatient and 177,075 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 and 2009 based on CMS's National Claims History data.

Our audit covered \$10,790,735 in Medicare payments to the Hospital for 210 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2008 and 2009 and consisted of 169 inpatient and 41 outpatient claims.

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 111 of the 210 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 99 claims, resulting in overpayments totaling \$350,897 for CYs 2008 and 2009. Specifically, 72 inpatient claims had billing errors, resulting in overpayments totaling \$238,021, and 27 outpatient claims had billing errors, resulting in overpayments totaling \$112,876. These overpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$350,897, consisting of \$238,021 in overpayments for the incorrectly billed inpatient claims and \$112,876 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital stated that it generally agreed with our findings. Regarding our first recommendation, the Hospital stated that it had corrected all 99 claims with billing errors and submitted the adjusted claims to the Medicare contractor. The Hospital disagreed with our recommended refund because the overpayment amounts based on the revised adjudicated claims were less than the overpayment amounts we calculated based on the original adjudicated claims. In addition, for 14 claims, the Hospital disagreed with our classification of the errors.

The Hospital provided information on actions that it had taken to address our second recommendation and provided its own recommendations for improvement.

The Hospital's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments and the adjusted claims information, we determined that some of the claims originally adjusted by the Medicare contractor were further adjusted after the issuance of our draft report. Where appropriate, we made changes in our final report to reflect the subsequent adjustments. We maintain that our error classifications for the 14 claims are valid.

TABLE OF CONTENTS

| | <u>Page</u> |
|---|-------------|
| INTRODUCTION | 1 |
| BACKGROUND | 1 |
| Hospital Inpatient Prospective Payment System | 1 |
| Hospital Outpatient Prospective Payment System..... | 1 |
| Hospital Payments at Risk for Incorrect Billing..... | 2 |
| Medicare Requirements for Hospital Claims and Payments | 2 |
| University of California, San Diego, Medical Center..... | 3 |
| OBJECTIVE, SCOPE, AND METHODOLOGY | 3 |
| Objective..... | 3 |
| Scope..... | 3 |
| Methodology..... | 3 |
| FINDINGS AND RECOMMENDATIONS | 4 |
| BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS | 5 |
| Incorrect Discharge Status | 5 |
| Incorrectly Billed as Inpatient..... | 5 |
| Incorrect Revenue Code and/or Number of Units | 6 |
| Incorrect Diagnosis-Related Groups..... | 6 |
| Incorrectly Billed as Separate Inpatient Stay..... | 7 |
| BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS | 7 |
| Incorrect Healthcare Common Procedure Coding System Codes or Number of Units | 7 |
| Manufacturer Credit for Replaced Medical Device Not Reported | 8 |
| RECOMMENDATIONS | 8 |
| HOSPITAL COMMENTS | 8 |
| OFFICE OF INSPECTOR GENERAL RESPONSE | 9 |
| APPENDIX | |
| HOSPITAL COMMENTS | |

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.¹

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient 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. For beneficiary stays incurring extraordinarily high costs, section 1886(d)(5)(A) of the Act provides for additional payments (called outlier payments) to Medicare-participating hospitals.

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. 106-113.² 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.³ All services and items within an APC group are comparable clinically and require comparable resources.

¹ 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.

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

³ 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 payments to hospitals using computer matching, data mining, and analysis of claims. Examples of the types of claims at risk for noncompliance included the following:

- inpatient claims for short stays,
- inpatient transfer claims,
- inpatient claims with high severity level DRG codes,
- inpatient claims for blood clotting factor drugs,
- outpatient claims billed prior to and during inpatient stays,
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day),
- inpatient and outpatient claims paid in excess of charges, and
- inpatient and outpatient claims involving manufacturer credits for replaced medical devices.

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 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.” 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.

University of California, San Diego, Medical Center

University of California, San Diego, Medical Center (the Hospital) is an acute-care hospital located in San Diego, California. Medicare paid the Hospital approximately \$277 million for 12,947 inpatient and 177,075 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 and 2009 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 \$10,790,735 in Medicare payments to the Hospital for 210 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2008 and 2009 and consisted of 169 inpatient and 41 outpatient claims.

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 but 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 claims selected for 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 inpatient and outpatient claims 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 March to October 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 CYs 2008 and 2009;

- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2008 and 2009;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 210 claims (169 inpatient and 41 outpatient claims) for detailed review;
- reviewed available data from CMS's Common Working File (CWF) for the selected claims to determine whether the claims had been canceled or adjusted;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- 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 objectives. 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 111 of the 210 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 99 claims, resulting in overpayments totaling \$350,897 for CYs 2008 and 2009. Specifically, 72 inpatient claims had billing errors, resulting in overpayments totaling \$238,021, and 27 outpatient claims had billing errors, resulting in overpayments totaling \$112,876. These overpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 72 of 169 selected inpatient claims, which resulted in overpayments totaling \$238,021.

Incorrect Discharge Status

Federal regulations (42 CFR § 412.4(b)) state that a discharge of a hospital inpatient is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge. A discharge of a hospital inpatient is also considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to a home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 26 of 169 selected inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to other facilities. For a majority of these claims, the Hospital should have coded the discharge status as a transfer to another facility instead of as a discharge to a home; thus, the Hospital should have received the per diem payment instead of the full DRG payment. For 1 of the 26 claims, the entire Medicare payment was in error because Medicare was subsequently determined to be the secondary payer. The Hospital stated that these errors primarily occurred because the coding staff did not identify the disposition status information in the discharge plans and physician orders. For 2 of the 26 errors, the Hospital stated that the patients decided to seek alternative health care services at other facilities without the Hospital's knowledge. As a result of these errors, the Hospital received overpayments totaling \$103,630.

Incorrectly Billed as Inpatient

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." Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if "... with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment ..."

For 25 of 169 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for these claims as inpatient:

- For 23 claims, the Hospital incorrectly billed for beneficiary stays that should have been billed as outpatient services. The Hospital subsequently reviewed each of the claims and

determined that the patient did not meet the severity of illness or level of care required to be admitted as an inpatient.

- For two claims, the Hospital incorrectly billed for an inpatient stay that lacked a physician order to admit the patient to inpatient care.

The Hospital stated that the errors occurred because of inadequate internal controls. Specifically, because of the short nature of patient stays, case management review did not always occur. In addition, the Hospital stated that clerical errors resulted in the incorrect assignment of patient statuses because physician orders with information on admission statuses were overlooked or updated. As a result of these errors, the Hospital received overpayments totaling \$159,320.⁴

Incorrect Revenue Code and/or Number of Units

Chapter 1, section 80.3.2.2, of the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 3, section 20.7.3.A, states that hospitals receive an add-on payment for the costs of furnishing blood clotting factors to certain Medicare beneficiaries and that the provider must use revenue code 0636 so that the clotting factor charges are not included in the cost outlier computations.

For 12 of 169 selected inpatient claims, the Hospital submitted claims to Medicare with blood clotting factor drugs billed with an incorrect revenue code. Specifically, the Hospital used revenue code 0250 instead of using revenue code 0636, which caused the clotting factor charges to be included in the cost outlier computations, resulting in incorrect outlier payments. In addition, for a majority of these claims, the Hospital billed the incorrect number of clotting factor units. The Hospital stated that these errors occurred because the clotting factors were mapped to the incorrect revenue center in the billing system. As a result of these errors, the Hospital was overpaid for 3 of the 12 claims, totaling \$40,848, and was underpaid for the remaining 9 claims, totaling \$169,898. The combination of the overpayments and underpayments was a net underpayment of \$129,050.

Incorrect Diagnosis-Related Groups

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.” Chapter 1, section 80.3.2.2, of the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For 7 of 169 selected inpatient claims, the Hospital submitted claims to Medicare with incorrect DRGs. For example, for one claim, the Hospital used the DRG for vascular procedures with major complication/comorbidity rather than using the DRG for vascular procedures without

⁴ At the time of our audit, for one claim, CMS’s Recovery Audit Contractor (RAC) also determined the claim to be in error, and the overpayment was recovered. As a result, we did not include this claim in our calculation of overpayments.

complication/comorbidity or major complication/comorbidity. The Hospital stated that the seven errors occurred because coding staff unintentionally selected diagnosis codes that were not supported by the medical records, resulting in incorrect DRGs. As a result of these errors, the Hospital received overpayments totaling \$67,105.

Incorrectly Billed as Separate Inpatient Stay

The Manual, chapter 3, section 40.2.5, states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 2 of 169 selected inpatient claims, the Hospital incorrectly billed Medicare for related discharges and readmissions within the same day. The Hospital stated that these errors occurred because the coding staff did not identify the previous related admissions. As a result of these errors, the Hospital received overpayments totaling \$37,016.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 27 of 41 selected outpatient claims, which resulted in overpayments totaling \$112,876.

Incorrect Healthcare Common Procedure Coding System Codes or Number of Units

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. The Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately." 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 23 of 41 selected outpatient claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes or an incorrect number of units:

- For 16 claims, the Hospital billed Medicare using incorrect HCPCS codes. For example, for one claim, rather than billing the HCPCS code for a complex repair of retinal detachment, the Hospital billed individual HCPCS codes for release of eye fluid, removal of inner eye fluid, replacement of eye fluid, laser treatment of retina, and treatment of retinal lesion.

- For seven claims, the Hospital billed Medicare for an incorrect number of units. For example, for one claim, rather than billing one unit for the insertion or repositioning of electrode leads and the insertion of a pulse generator, the Hospital billed two units.

The Hospital stated that these errors occurred because of clerical mistakes. As a result of these errors, the Hospital received overpayments totaling \$53,233.

Manufacturer Credit for Replaced Medical Device Not Reported

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.

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 4 of 41 selected outpatient claims, the Hospital received manufacturer credits for replaced devices but did not report the modifier -FB or reduced charges on its claims. The Hospital stated that these errors occurred because the coding staff was not aware of modifiers for device credits. As a result of these errors, the Hospital received overpayments totaling \$59,643.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$350,897, consisting of \$238,021 in overpayments for the incorrectly billed inpatient claims and \$112,876 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital stated that it generally agreed with our findings. Regarding our first recommendation, the Hospital stated that it had corrected all 99 claims with billing errors and submitted the adjusted claims to the Medicare contractor. The Hospital disagreed with our recommended refund because the overpayment amounts based on the revised adjudicated claims were less than the overpayment amounts we calculated based on the original adjudicated claims.

For 14 claims, the Hospital disagreed with our classification of the errors:

- For one claim related to incorrect discharge status, the Hospital stated that the overpayment amount was due to an error in the Medicare CWF and that Medicare was retrospectively indicated as the secondary payer.
- For one claim identified as incorrectly billed as inpatient, the Hospital stated that the claim was previously addressed during a Medicare RAC audit and recommended that the claim be excluded from our report.
- For 12 claims related to an incorrect revenue code and/or number of units, the Hospital disagreed that the incorrect number of units of blood clotting factor was billed and contributed to incorrect payments to the Hospital.

The Hospital provided information on actions that it had taken to address our second recommendation and provided its own recommendations for improvement.

The Hospital's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments and adjusted claims information included in the CWF, we determined that some of the claims originally adjusted by the Medicare contractor were further adjusted after the issuance of our draft report. Where appropriate, we made changes in our final report to reflect the subsequent adjustments.

We maintain that our error classifications for the 14 claims are valid:

- We acknowledge that the overpayment for one claim was due to Medicare being the secondary payer. However, for reporting purposes, we classified the error as an incorrect discharge status because the claim also had this deficiency.
- After completion of our review, the Hospital informed us that one claim was previously addressed by the RAC audit. Therefore, we did not show an overpayment amount for this error but included the claim in our report.
- Based on our review of supporting documentation for the 12 claims, errors in the billing of the number of administered units of blood clotting factors resulted in underpayments and overpayments on the adjusted claims. Therefore, we did not revise our finding.

APPENDIX

APPENDIX: HOSPITAL COMMENTS



January 21, 2012

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Ref: Report Number A-09-11-02055

Dear Ms. Ahlstrand:

Please accept the following comments from the University of California San Diego Medical Center in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG), draft report entitled "Medicare Compliance Review of University of California, San Diego, Medical Center for Calendar Years 2008 and 2009." We appreciate the opportunity to respond to the draft report.

The University of California San Diego Medical Center (Hospital) generally agrees with the OIG's findings. Claims identified with payment adjustments have been submitted to the Medicare Administrative Contractor (MAC) through the Fiscal Intermediary Standard System.

Responses to the OIG's recommendations follow:

*OIG Recommendation 1: Refund identified overpayments of \$627,555 to the Medicare Administrative Contractor (MAC).**

Response: The Hospital, in accordance with the OIG recommendation, corrected all 99 claims identified as having billing errors during the audit and submitted the adjusted claims to the MAC. To date, the MAC has adjudicated 90 of the 99 corrected claims, and 9 are pending final processing with the MAC.

OIG Recommendation 2: Strengthen controls to ensure full compliance with Medicare billing requirements.

Response: The Hospital has, since the dates covered by the OIG audit (2008 and 2009 dates of service), implemented a number of educational programs, leveraged new and existing technology, and redesigned processes to strengthen controls in areas covered by the audit that impact billing. The following is a partial list of these changes:

1. Training and Education:

- Providing regular coding and compliance education and conduct coding reviews for coding and billing personnel.
- Providing physician training regarding admission orders and admission status criteria utilizing the electronic medical record (EMR).

* **Office of Inspector General Note:** Because of adjustments made after issuance of the draft report, the overpayments for the 99 erroneous claims totaled \$350,897. The Hospital stated that it had submitted all of the adjustments to the Medicare contractor.

Lori A. Ahlstrand
January 21, 2012

2. Technology Enhancements:

- Creating standard admission order workflows for physicians built into the new EMR.
- Establishing standards for pharmacy billing across all care settings in the new pharmacy system.
- Developing targeted reports to monitor compliance related to admissions, utilization review, coding, and billing activities and work products.
- Expanding pre-billing validation of short-stay admissions at key points in the process, including post-discharge and prior to final coding, and post-coding and prior to claim submission.

3. Process Refinements:

- Performing enhanced monitoring of key processes related to admissions, concurrent utilization reviews, coding, and billing utilizing targeted reports.
- Conducting routine communication and dissemination of information within and across admissions, utilization review, coding, billing, and technology departments.
- Communicating with internal departments regarding additional information needed for billing of replacement of medical devices, e.g., full and/or partial credits received and product information – to ensure that respective claims accurately reflect the reduced charges and modifier per the requirements outlined in the Medicare Claims Processing Manual.
- Modifying billing processes to minimize manual activities and instituting routine monitoring of remaining manual billing tasks.

Other responses to the OIG audit and findings in the Draft Report:

While University of California San Diego Medical Center Hospital agrees with some of the OIG's findings in the draft report, the Hospital disagrees with the quantification of overpayments and the qualification of errors as described below.

1. Quantification of Overpayments: The Hospital agrees with the OIG on \$375,350 of \$627,555 in overpayments for claims that have been final processed by the MAC for the amounts indicated by the OIG. The Hospital cannot agree or disagree on \$151,624 related to claims that are pending final processing by the MAC. Lastly, the Hospital disagrees with the OIG on the remaining \$100,581 in overpayments indicated by the OIG based on the final adjudication by the MAC for which the remediated claim was paid more than what was reflected by the OIG. The variance between the amounts OIG indicated as being the remediated payment and the actual payment upon final adjudication of the corrected claim results in an underpayment amount of (\$73,602). Therefore, the OIG's overpayment amount of \$627,555 is overstated by \$174,183.
 - Overpayments for claims that have not been final processed by the MAC: 9 of 99 claims with errors have not been final processed by the MAC, yet overpayments of \$151,624 have been ascribed to these claims and thus contribute to the total overpayment amount of \$627,555 in the draft report.
 - Variances based on actual remediated claim payment amounts received as compared to OIG reimbursement projections: 24 of 99 claims that were final processed by the MAC yielded a payment amount greater than the OIG projected reimbursement amount. OIG indicates that these 24 claims were overpaid by \$100,581,

Lori A. Ahlstrand
January 21, 2012

when in fact these claims were underpaid by (\$73,602) based on final adjudication by the MAC consistent with the Hospital's expected payment amount.

- o 14 of 24 adjudicated claims were paid less than the original payment, but more than projected by OIG; thereby reducing the stated overpayment for these claims by (\$4,275). The OIG projected overpayment amount to be \$100,581. The actual overpayment for these 14 claims was \$96,306.
- o 10 of 24 claims were paid more than the original payment upon final adjudication of the corrected claims by the MAC, consistent with the Hospital's estimates. OIG reflected all 10 of these claims as contributing \$0 in overpayments, when in fact these claims were underpaid by (\$169,908), thereby reducing the total overpayment by this amount.

2. **Qualification of Errors:** The Hospital disagrees with attribution and description of errors for instances described below in the OIG's draft report.
 - **1 claim as incorrect discharge status:** 1 claim OIG cited as having this error with an overpayment amount of \$38,860 was determined to be due to an error in the Medicare Common Working File (CWF). At the time of claim submission, the CWF reflected Medicare as the primary payor. However, subsequent to verification of the coordination of benefits against the CWF and claim submission to and payment by Medicare as primary, the CWF was revised by Medicare. Medicare was retrospectively indicated as the secondary payor. No alert was provided to the Hospital of this retrospective change. However, upon self-identifying this error during the course of the audit, the Hospital refunded Medicare and is pursuing the other payor for reimbursement citing delayed update of the CWF as the rationale.
 - **1 claim as incorrectly billed as inpatient:** 1 claim was previously addressed as part of a Medicare RAC audit, yet OIG reflected this claim as 1 of 99 total claims found to have errors in the draft report. While the OIG reflected \$0 overpayment impact, the Hospital recommends that this claim be excluded from the OIG audit sample and report.
 - **12 claims as incorrect revenue code and/or number of units:** The Hospital concurs with the OIG that 12 inpatient claims that included blood clotting factor were incorrectly billed due to this pharmacy item being reflected in the 0250 revenue code. The Hospital disagrees, however, with the OIG statement that the incorrect units of blood clotting factor were billed and contributed overpayments to the Hospital, citing the National Uniform Billing Committee guide billing requirements for items billed using revenue code 0250 as the rationale.

Provider recommendations for improvement:

Provider Recommendation 1 - Discharge Disposition Status Disparities

Suggestion applies to any scenario where a Medicare beneficiary discharges to another facility (location other than home), regardless of whether this information is known to the discharging facility or not at the time the patient is being discharged. For the specific situations where patients who are discharged to home, but who later seek additional health care at other health care facilities without notice to the hospital, it is not reasonable to expect the hospital will (a) be made aware of such instances and (b) inpatient claims would accurately reflect such unknown

Lori A. Ahlstrand
January 21, 2012

circumstances (occurring post-discharge). The MAC, upon receiving claims from both facilities, should be required to notify hospital providers to submit a claim adjustment or automatically trigger the adjustment via the existing HIPAA transaction-based communications.

Provider Recommendation 2 - Common Working File (CWF) Changes

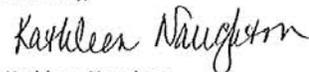
Similar to the recommendation for addressing variances in the discharge disposition status reflected on billed claims, the Hospital suggests alerting providers when a change to the CWF has a material impact to claims previously submitted to the MAC. The MAC's notice would also serve improve the accuracy of the CWF content by alerting providers. [Reference: Federal Register, Vol. 68, No. 148, page 45405, August 1, 2003, <http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi>]

Provider Recommendation 3 - Replacement of Medical Devices

The Hospital suggests that there be a requirement placed on the medical device distributors and manufacturers to submit quarterly information to a secure, central data repository for replacement devices that were issued as a "no cost" device or issued a partial or full credit for a faulty device. Example of data elements for the device repository: product serial number, model number, description, manufacturer, device type, applicable HCPCS codes, and the NPI number for the provider/provider entity who received the medical device. This information will allow the provider to facilitate accurate claim submission and will provide Medicare with the ability to verify the accuracy of provider claims based on registry information. If the content of a claim related to replacement devices does not align with the content in the database, the MAC can alert the provider of this disparity so that the claim can be addressed accordingly. In the instances where device credit information becomes available AFTER claim submission, the MAC could trigger a payment adjustment, as appropriate, to the provider. This would improve efficiency and accuracy for outpatient and inpatient device claims and could be utilized in lieu of modifiers.

The Hospital is committed to accurate billing. As stated in this response, the Hospital made all necessary corrections to errors identified through this audit by refunding the overpayments through the adjusted claim adjudication performed by the MAC. The Hospital in conjunction with the Compliance Program, has and will continue to actively strengthen controls to prevent billing errors, to monitor adherence to billing requirements, and to promptly remedy identified deficiencies, particularly for the audited areas.

Sincerely,



Kathleen Naughton
Chief Compliance & Privacy Officer

Cc: Lori R. Donaldson, Chief Financial Officer, University of California San Diego Medical Center
Betsy J. Grossman, Director, Revenue Cycle Administration, University of California San Diego Medical Center
Thomas V. McAfee, M.D., Interim Chief Executive Officer, University of California San Diego Health System