



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-09-11-02060

Mr. Michael Moody
Chief Financial Officer
John Muir Health
1440 Treat Boulevard
Walnut Creek, CA 94597

Dear Mr. Moody:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of John Muir Medical Center, Walnut Creek, for Calendar Years 2008 Through 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 call Annie Weber, Senior Auditor, or Shon Dormoy, Audit Manager, at (415) 437-8360. Please refer to report number A-09-11-02060 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
JOHN MUIR MEDICAL CENTER,
WALNUT CREEK,
FOR CALENDAR YEARS
2008 THROUGH 2010**



Daniel R. Levinson
Inspector General

February 2012
A-09-11-02060

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.

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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.

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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.

John Muir Medical Center, Walnut Creek (the Hospital), is an acute-care hospital located in Walnut Creek, California. Medicare paid the Hospital approximately \$408 million for 20,020 inpatient and 915,121 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 through 2010 based on CMS's National Claims History data.

Our audit covered \$8,884,218 in Medicare payments to the Hospital for 197 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2008 through 2010 and consisted of 148 inpatient and 49 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 162 of the 197 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 \$308,111 for CYs 2008 through 2010. Specifically, 29 inpatient claims had billing errors, resulting in overpayments totaling \$254,942, and 6 outpatient claims had billing errors, resulting in overpayments totaling \$53,169. 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 \$308,111, consisting of \$254,942 in overpayments for the incorrectly billed inpatient claims and \$53,169 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

The Hospital concurred with our findings and recommendations and provided information on actions taken to address the 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.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.

John Muir Medical Center, Walnut Creek

John Muir Medical Center, Walnut Creek (the Hospital), is an acute-care hospital located in Walnut Creek, California. Medicare paid the Hospital approximately \$408 million for 20,020 inpatient and 915,121 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 through 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 \$8,884,218 in Medicare payments to the Hospital for 197 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2008 through 2010 and consisted of 148 inpatient and 49 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 in March and April 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 through 2010;

- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2008 through 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 197 claims (148 inpatient and 49 outpatient claims) for detailed review;
- reviewed available data from CMS's Common Working File 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 162 of the 197 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 \$308,111 for CYs 2008 through 2010. Specifically, 29 inpatient claims had billing errors, resulting in overpayments totaling \$254,942, and 6 outpatient claims had billing errors, resulting in overpayments totaling \$53,169. 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 29 of 148 selected inpatient claims, which resulted in overpayments totaling \$254,942.

Incorrect Charges Resulting in Incorrect Outlier Payments

The Manual, chapter 3, section 10, states that a hospital may bill only for services provided. In addition, 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, of the Manual states that hospitals receive an add-on payment for the costs of furnishing blood clotting factors to certain Medicare beneficiaries, such as hemophiliacs, and that the providers must use revenue code 0636 so that the clotting factor charges are not included in the cost outlier computations.

For 11 of 148 selected inpatient claims, the Hospital submitted claims to Medicare with incorrect charges that resulted in incorrect outlier payments:

- For six claims, the Hospital billed Medicare for incorrect charges, specifically related to room and board. For example, for one claim, the Hospital billed for a patient’s stay as 10 days in intensive care and 30 days in definitive care when it should have billed the patient’s stay as 7 days in intensive care and 33 days in definitive care. The Hospital stated that these errors occurred because the Hospital did not correctly adjust room charges when delays occurred in transferring patients to the rooms that the physicians ordered.
- For four claims, the Hospital billed Medicare with an incorrect revenue code. Specifically, when billing for blood clotting factor drugs, the Hospital used revenue code 0250 instead of revenue code 0636, which caused the clotting factor charges to be included in the cost outlier computations, resulting in incorrect outlier payments. The Hospital stated that these errors occurred because the Hospital did not correctly identify the blood clotting factor drugs as hemophilia drugs.
- For one claim, the Hospital billed Medicare for an incorrect number of units of an administered drug. The Hospital stated that the incorrect billing occurred because of human error.

As a result of the 11 errors, the Hospital received overpayments totaling \$187,938.

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.”

For 11 of 148 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient services. The Hospital subsequently reviewed each of the claims and determined that the patients did not meet the severity of illness or level of care required to be admitted as inpatients. The Hospital stated that these errors occurred because of inadequate internal controls over case review during staffing shortages or peak census periods. As a result of these errors, the Hospital received overpayments totaling \$32,440.

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 5 of 148 selected inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to other facilities. For each claim, 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. The Hospital stated that these errors occurred because of conflicting information contained in the medical records and because of human error. As a result of these errors, the Hospital received overpayments totaling \$25,836.

Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations (42 CFR § 412.89(a)) require a reduction in the IPPS 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 the 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 that to correctly bill for a replacement device that was provided with a credit, hospitals must use the combination of condition code 49 or 50 (which identifies the replacement device) and value code FD (which identifies the amount of the credit or cost reduction received by the hospital for the replaced device).

For 1 of 148 selected inpatient 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 claim with the proper condition and value codes to reduce payment as required. The Hospital stated that this error occurred because of inadequate controls to identify and report credits from device manufacturers. As a result, the Hospital received an overpayment of \$4,900.

Incorrect Diagnosis-Related Group

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 1 of 148 selected inpatient claims, the Hospital billed Medicare with an incorrect DRG. Specifically, the Hospital used the DRG for usage of a mechanical ventilator for more than 96 hours rather than using the DRG for usage of a mechanical ventilator for less than 96 hours. The Hospital stated that this error occurred because of a miscalculation of days. As a result, the Hospital received an overpayment of \$3,828.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 6 of 49 selected outpatient claims, which resulted in overpayments totaling \$53,169.

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 3 of 49 selected outpatient claims, the Hospital received full manufacturer credits for replaced devices but did not report the -FB modifier or reduced charges on its claims. The Hospital stated that these errors occurred because of inadequate controls to identify and report credits from device manufacturers and because of human error. As a result of these errors, the Hospital received overpayments totaling \$53,091.

Incorrectly Billed as Outpatient

The Manual, chapter 3, section 10.4.A, states that Medicare Part A covers certain items and nonphysician services furnished to inpatients and consequently the inpatient prospective payment rate covers these services.

For 3 of 49 selected outpatient claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays. These services should have been included on the Hospital's inpatient (Part A) claims to Medicare. The Hospital stated that the incorrect billing occurred because of human error. As a result of these errors, the Hospital received overpayments totaling \$78.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$308,111, consisting of \$254,942 in overpayments for the incorrectly billed inpatient claims and \$53,169 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

The Hospital concurred with our findings and recommendations and provided information on actions taken to address the recommendations. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: HOSPITAL COMMENTS



John Muir Health
 Walnut Creek, CA 94598
 Phone: 925.938.9000

Report Number: A-09-11-02060

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

Dr. Ms Ahlstrand:

This letter is in response to the draft *Medicare Compliance Review of John Muir Medical Center, Walnut Creek, for Calendar Years 2008 Through 2010*. John Muir Health concurs with all findings and recommendation noted in this document. John Muir Health made appropriate repayments (\$308, 111) associated with this audit as of August 26, 2011. The following describes the corrective actions and internal controls John Muir Health has taken for each of the following specific findings. In addition to the specific corrective actions internal controls described below, John Muir Health has: (1) reported these findings and recommendations to Senior Management, the Board of Directors and the Compliance Committee; (2) included all of these findings in its compliance risk assessment; and (3) as appropriate, will perform subsequent internal and external audits to ensure the measures have been, and continue to be, effective.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Incorrect Charges Resulting in Incorrect Outlier Payments

In an effort to avoid incorrect charging practices that may lead to inappropriate outlier payments, John Muir Health has adopted the following corrective actions and internal controls:

1. Provided feedback and additional training to the departments responsible for the errors. This process was completed May, 2011.
2. Met with Patient Financial Service Managers to discuss Hemophilia Drug Carve-Out qualifiers and billing considerations to ensure that DSG edits properly stop claims for review. This process was completed March, 2011.
3. Validate the accuracy of room charges via the Room & Board charge reconciliation report. This is an ongoing process.

Incorrectly Billed as Inpatient

To ensure proper identification of patient status determination for Medicare admissions, John Muir Health has instituted a seven (7) day a week internal utilization review process and has added a second level physician utilization review process through an outside vendor. This process was initiated in the third quarter of 2011.

Incorrect Discharge Status

To ensure appropriate discharge status on claims for Medicare beneficiaries, John Muir Health has adopted the following corrective actions and internal controls:

1. Validated the accuracy of the discharge dispositions and mappings listed in our health information system. This process was completed on 12/12/11.

2. Provided feedback and additional training to the coding specialists responsible for the errors. This process was completed on 5/25/11.
3. Shared the audit findings with all coding specialists and communicated the need for accuracy in assigning the discharge disposition. This process was completed on 7/28/11.
4. Met with Case Management staff and communicated the need for non-conflicting data in the medical record as it relates to the patient's discharge disposition; added additional fields in Midas to better reflect the patient's discharge status. This process was completed on 5/10/11.
5. Continue to perform ongoing monitoring of the discharge disposition and share results with staff. This is an ongoing process.

Manufacturer Credit for Replaced Medical Device Not Reported

To ensure John Muir Health appropriately bills for devices that are replaced without cost, or for devices in which it receives full or partial credit for the cost of the replaced device (equal to or greater than 50% of the cost of replacement), John Muir Health has adopted the following corrective actions and internal controls:

1. Provided feedback and additional training to the departments responsible for the error for the case where the warranty replacement was known at the time of service. This process was completed May, 2011.
2. Created a multi-disciplinary team from Charge Description Master (CDM Group), Patient Accounting, Accounts Payable & Cardiovascular Services who are tasked with developing a Policy & Procedure to outline the steps and processes for accurate charge entry and billing of medical devices in which warranty credits or replacements have or may occur. The initial draft of this policy was completed in November, 2011. The final draft of this policy is estimated to be completed at the end of January, 2012.
3. Work with our large volume device vendors (i.e. St. Jude, Boston Scientific, etc.) to generate annual or bi-annual reports of warranty credits issued to facilitate internal monitoring related to this issue. This is an ongoing process.

Incorrect Diagnosis-Related Group

To ensure the appropriate DRG for usage of a mechanical ventilator, John Muir Health has adopted the following corrective actions and internal controls:

1. Discussed findings with the coding specialist responsible for the error and provided additional education, including the need for accuracy in calculating the length of time patients are on a ventilator. This process was completed on 6/29/11.
2. Communicated with all coding specialists the need for accuracy in calculating the length of time patients are on the ventilator. This process was completed on 7/28/11.
3. Continue to perform ongoing monitoring of the DRG assignment process with emphasis on DRG 207 versus DRG 208. This is an ongoing process.
4. Share results of ongoing monitoring with staff. This is an ongoing process.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Manufacturer Credit for Replaced Medical Device Not Reported

To ensure John Muir Health appropriately bills for devices that are replaced without cost, or for devices in which it receives full or partial credit for the cost of the replaced device (equal to or greater than 50% of the cost of replacement), John Muir Health has adopted the following corrective actions and internal controls:

- a. Provided feedback and additional training to the departments responsible for the error for the case where the warranty replacement was known at the time of service. This process was completed May, 2011.
- b. Created a multi-disciplinary team from Charge Description Master (CDM Group), Patient Accounting, Accounts Payable & Cardiovascular Services who are tasked with developing a Policy & Procedure to outline the steps and processes for accurate charge entry and billing of medical devices in which warranty credits or replacements have or may occur. The initial draft of this policy was completed in November, 2011. The final draft of this policy is estimated to be completed at the end of January, 2012.
- c. Work with our large volume device vendors (i.e. St. Jude, Boston Scientific, etc.) to generate annual or bi-annual reports of warranty credits issued to facilitate internal monitoring related to this issue. This is an ongoing process.

Incorrectly Billed as Outpatient

The error associated with this finding was due to one particular biller that was overriding an edit in the lab system. John Muir Health provided additional feedback and training to this biller in March of 2011.

Please let me know if you have any questions or comments related to the responses provided above. We look forward to the final draft.

Sincerely,



Michael Moody
Chief Financial Officer
John Muir Health