



DEC 31 2001

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CIN: A-01-01-00524

John Randolph
Compliance Officer
University of Massachusetts Memorial Medical Center
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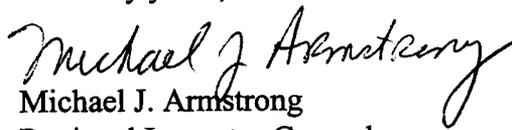
Dear Mr. Randolph:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services final report entitled, "Review of Outpatient Clinic Services Provided By the University of Massachusetts Memorial Medical Center for Fiscal Year Ended September 30, 1999." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determinations as to actions to be taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made available to the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.) To facilitate identification, please refer to Common Identification Number A-01-01-00524 in all correspondence relating to this report.

Sincerely yours,


Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Mr. George Jacobs, II
Regional Administrator
Centers for Medicare and Medicaid Services – Region I
U.S. Department of Health and Human Services
Room 2425, JFK Federal Building
Boston, Massachusetts 02203

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT CLINIC
SERVICES PROVIDED BY THE
UNIVERSITY OF MASSACHUSETTS
MEMORIAL MEDICAL CENTER
FOR FISCAL YEAR 1999**



JANET REHNQUIST
Inspector General

DECEMBER 2001
A-01-01-00524

Office of Inspector General

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

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EXECUTIVE SUMMARY

Background

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient clinic services. Medicare regulations define *clinic services* as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The University of Massachusetts Memorial Medical Center (Hospital) has entered into a contract with the UMass Memorial Medical Group, Inc. (Physician Group) to provide direct medical services at Hospital owned or controlled clinic locations for Hospital outpatients. These direct services involve diagnostic and therapeutic services that are commonly furnished in a physician's office and include various specialty fields of medicine, as well as, general practice. For many patients, the clinic physician is their primary care physician.

The Hospital bills the Fiscal Intermediary (FI) for the technical component of the encounter, while the Physician Group bills the Carrier for the professional component. The Hospital also separately codes and bills any additional services that are provided at the time of the visit.

Objective

The objective of our review was to determine whether clinic services rendered on an outpatient basis are billed for and reimbursed in accordance with Medicare regulations. Our review covered the fiscal year (FY) October 1, 1998 to September 30, 1999.

Summary of Findings

For the FY ending September 30, 1999, the Hospital submitted to Medicare for reimbursement about \$2.4 million in charges for clinic services included under revenue center code (RCC) 510. The Medicare Hospital Manual specifically states that the provider should not bill for a clinic visit if the sole reason for the visit was to undergo a scheduled laboratory, radiology, or diagnostic test or surgical or medical procedure. These additional services provided at the time of the visit are billed and reimbursed separately. Medicare regulations also require the medical records contain sufficient documentation to justify the clinic services provided.

To determine whether controls were in place to ensure compliance with Medicare regulations, we reviewed the medical and billing records for a sample of 100 claims totaling \$4,393 in clinic service charges. Our analysis showed that \$570 of the clinic service charges did not meet Medicare criteria for reimbursement as follows:

- \$482 in additional charges for clinic visits which are not covered by Medicare because the purpose of the visit was solely to receive a scheduled laboratory test, injection, or diagnostic test. These tests were billed and reimbursed separately.

- \$88 for clinic visits which were determined to be not medically necessary or adequately supported in the patient's medical records.

Based on a statistical sample, we estimated that the Hospital billed at least \$181,118¹ for Medicare clinic visit charges that did not meet the Medicare reimbursement criteria. We found that the Hospital did not follow proper procedures in ensuring that clinic visits submitted for reimbursement were allowed and documented in accordance with Medicare regulations.

Recommendations

We recommend that the Hospital strengthen its procedures to ensure that charges for outpatient clinic services are covered and properly documented in accordance with Medicare regulations. We will provide the results of our review to the FI, Associated Hospital Services, so that it can apply the appropriate adjustment of \$181,118 to the Hospital's FY 1999 Medicare cost report.

The Hospital, in its response dated November 30, 2001 (see APPENDIX B), agreed with our findings and recommendations with the exception of 3 outpatient clinic service charges; 2 in which we questioned the medical necessity of the services and 1 which we questioned as an overcharge for an injection. Hospital officials believe that these charges should be allowed.

With respect to the 2 clinic services originally determined to be not medically necessary, the Hospital provided additional justification to support the charges. We reviewed the additional information provided and have discussed these services with the FI's medical reviewers and agree they meet Medicare criteria for reimbursement. Regarding the other service in question, we believe that the injection was an allowable service. However, based on evidence in the medical record we believe that the injection was miscoded resulting in a \$43 overcharge. In our opinion, we believe that this is a payment error and should remain in our projected estimate of overcharges.

Based on the Hospital's response, we revised our previously reported statistical projection of estimated clinic overcharges from \$229,019 to \$181,118.

¹ This amount has been adjusted subsequent to the issuance of our draft report dated November 1, 2001.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
BACKGROUND	1
OBJECTIVE, SCOPE AND METHODOLOGY	2
FINDINGS AND RECOMMENDATIONS	3
<i>Noncovered Services</i>	3
<i>Services Not Sufficiently Documented</i>	4
CONCLUSION	4
RECOMMENDATIONS	5
HOSPITAL'S RESPONSE	5
OIG'S COMMENTS	5
APPENDICIES	
APPENDIX A – STATISTICAL SAMPLE INFORMATION	
APPENDIX B – HOSPITAL'S RESPONSE	

INTRODUCTION

BACKGROUND

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient clinic services. Medicare Intermediary Manual states that an outpatient is a person who has not been admitted by the hospital as an inpatient, but is registered on the hospital's records as an outpatient and receives services from the hospital. Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.

A clinic visit is defined in the Medicare Hospital Manual as direct personal contact between a registered hospital outpatient and a physician (or other person who is authorized by State licensure law and where applicable, by hospital staff bylaws to order or provide services for the patient) for purposes of diagnosis or treatment of the patient. The clinic visit typically includes a history taking, examination, and a medical decision making to resolve a patient's presenting problem. A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter.

The Hospital entered into a contract with the Physician Group to provide direct medical services at Hospital owned or controlled clinic locations for Hospital outpatients. These direct services involve diagnostic and therapeutic services that are commonly furnished in a physician's office or at the entry point into the health care system. The direct services contracted for are in various specialty fields of medicine, as well as, general practice. For many patients, the clinic physician is their primary care physician.

Regarding Medicare billing, the Physician Group bills the Carrier for the professional component of the encounter, while the Hospital bills the FI for the technical component of the encounter. The Hospital should also code separately any additional services involving laboratory, radiology, diagnostic tests, or other procedures that are provided at the time of the visit. However, the Medicare Hospital Manual specifically states, the provider should not bill for a clinic visit "if the sole reason for the visit was to undergo a laboratory, radiology, or diagnostic test, a surgical or medical procedure...." Medicare also requires that charges reflect reasonable costs and that services provided be supported by medical records. These records must contain sufficient documentation to justify the clinic service provided.

Clinic charges identified in this audit encompassed a wide spectrum of services from cardiology to urology. Claims are submitted for services rendered and are reimbursed on an interim basis based on submitted charges. At year-end, the Hospital submits a cost report to the Medicare FI for final reimbursement.

The Hospital is a 761 bed acute care facility located in Worcester, Massachusetts. The Hospital has 104 clinics associated with one of its three campuses. During the period

October 1, 1998 through September 30, 1999, the Hospital submitted for Medicare reimbursement \$2,421,529 in charges for clinic services. Such charges were incurred through the Hospital's regular outpatient clinic departments.

OBJECTIVE, SCOPE AND METHODOLOGY

Our review was made in accordance with generally accepted government auditing standards. The objective of our review was to determine whether clinic services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare regulations. Our review included services provided during the period October 1, 1998 through September 30, 1999.

We limited consideration of the internal control structure to those controls concerning claims submission because the objective of our review did not require an understanding or assessment of the complete internal control structure at the Hospital.

To accomplish our objective, we:

- reviewed criteria related to outpatient clinic services,
- interviewed appropriate Hospital staff concerning internal controls over Medicare claims submission,
- performed a walk-through of a clinic to obtain an understanding of the billing process,
- used the Provider Statistical and Reimbursement Report provided by the FI to identify that 53,837 claims, valued at \$2,421,529 in outpatient clinic charges, were processed by the FI for FY 1999. These claims were extracted with RCC 510 and with dates of service during the period October 1, 1998 through September 30, 1999,
- employed a random sampling approach consisting of a simple random sample of 100 outpatient clinic visit claims,
- performed detailed audit testing on the billing and medical records for the 100 claims selected in the sample, and
- used a variable appraisal program to estimate the dollar impact of improper charges.

Our fieldwork was performed from April 2001 through July 2001 at the Hospital's Memorial and University Campuses in Worcester, Massachusetts.

FINDINGS AND RECOMMENDATIONS

For the FY ending September 30, 1999, the Hospital submitted for reimbursement \$2,421,529 in charges for clinic services included under RCC 510. We reviewed the billing and medical records for a random sample of 100 clinical claims with charges totaling \$4,393. Our analysis disclosed that 17 of these claims with charges totaling \$570 did not meet the Medicare criteria for reimbursement. Specifically, we found \$482 in noncovered services and \$88 in services not sufficiently documented. Based on a statistical sample, we estimate that the Hospital had overstated its Medicare clinic service charges by \$181,118¹ (during the FY ending September 30, 1999.) Findings from our review of the sample of 100 claims are described in detail below and in APPENDIX A.

Noncovered Services

We found that the Hospital did not follow proper procedures to preclude billing for a clinic visit when a patient came into the clinic building solely for the purpose of a laboratory test or other scheduled medical or diagnostic procedure. According to the Hospital Manual Chapter 442 section 7, the provider should not report a clinic visit “if the sole reason for the visit was to undergo a laboratory, radiology, or diagnostic test, a surgical or medical procedure...”

For the hospital to be able to charge for a clinic visit, the clinic patient needs to have had a face-to-face encounter with a physician, physician assistant, nurse practitioner, nurse-midwife, or visiting nurse, which includes a history taking, examination, and a medical decision making to resolve the patient’s disease, condition, illness, injury, complaint, or other reason for encounter.

To determine whether controls were in place to ensure compliance with Medicare regulations, we reviewed the medical and billing records for a sample of 100 claims totaling \$4,393 in clinic service charges. Our analysis identified \$482 in additional charges for clinic visits which are not covered by Medicare because the purpose of the visit was solely to receive a scheduled laboratory test, injection, or diagnostic test. These tests were billed and reimbursed separately. Specifically we found:

- 11 were anti-coagulation clinic (ACC) visits in which only laboratory services were performed. The ACC was established to routinely monitor and record blood thinness for patients taking the drug cumadin. Most ACC visits involve a blood draw, prothrombin time test on the blood, and recording the readings in a database. For the 11 ACC clinic visits in our sample, we found no history taking, examination, medical decision making or other physician involvement at the time of the laboratory service.
- 3 were clinic visits where the sole purpose for the visit was to receive a scheduled injection. The encounters solely consisted of the patient coming to the clinic and

¹ This amount has been adjusted subsequent to the issuance of our draft report dated November 1, 2001.

the nurse administering either a vitamin B-12 shot, an immuno-therapy injection, or an EPO injection .

- 2 were clinic visits where the sole purpose was a scheduled diagnostic test. The scheduled tests were problem focused eye exams. Contrary to the Hospital Manual, the Hospital billed the same encounter with the ophthalmologist as both an extended exam for ophthalmology services and a problem focused eye clinic visit.

As a result, we concluded that \$482 in clinic visits did not meet Medicare's criteria for reimbursement.

Services Not Sufficiently Documented

Our audit disclosed a weakness in the Hospital's system of internal controls regarding the medical record documentation supporting its clinic visit. Title 42 CFR, §482.24(c) states that, "...A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to... support the diagnosis, and describe the patient's progress and response to medications and services."

Our review of the billing and medical records for the 100 claims in our sample showed 2 claims containing \$88 in charges for outpatient clinic visits which were not adequately supported in the patient's medical record. The medical record to support one visit could not be found and another visit was overcharged as a miscoded injection.

As a result, we concluded that \$88 in outpatient clinic charges did not meet Medicare's criteria for reimbursement.

CONCLUSION

For the FY ending September 30, 1999, the Hospital submitted for Medicare reimbursement a total of 53,837 claims valued at \$2,421,529 in charges for outpatient clinic services under RCC 510. From this population, we randomly sampled 100 claims with RCC 510 charges totaling \$4,393. We found \$570 in clinic visit charges unallowable for Medicare reimbursement. Extrapolating the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident that the Hospital billed at least \$181,118 in error for FY 1999. We attained our estimate by using a variable sample appraisal program. Details of our sample appraisal can be found in APPENDIX A.

RECOMMENDATIONS

We recommend that the Hospital strengthen its procedures to ensure that only charges for covered outpatient clinic services are billed to Medicare. Further, the Hospital should follow proper procedures in ensuring clinic visits submitted for reimbursement are allowed and documented in accordance with Medicare regulations. We will provide the results of our review to the FI, Associated Hospital Services, so that it can apply the appropriate adjustment of \$181,118 to the Hospital's FY 1999 Medicare cost report.

HOSPITAL'S RESPONSE

The Hospital, in its response dated November 30, 2001 (see APPENDIX B), agreed with our findings and recommendations with the exception of 3 questioned claims. These included, 2 claims containing clinic visits for which we questioned the medical necessity of the services and 1 claim containing 2 RCC 510 charges, one of which represented an injection, which we questioned as being miscoded.

With respect to the 2 clinic visits we determined to be not medically necessary, the Hospital provided additional justification to support the charges. Hospital officials indicated that one visit was related to a patient in the Oncology Clinic and should be allowable based on additional criteria cited in 42 CFR Part 413, concerning education services involving cancer chemotherapy. Regarding the other visit, Hospital officials contend that the patient's history of a significant cardiac condition required close monitoring and, therefore, should be allowed.

With regard to the claim containing 2 RCC 510 clinic visit services, one of which was actually an injection, Hospital officials did not question our disallowance of the charge for the clinic visit, but stated that the other service charged at \$72 was coded correctly as an injection and should be allowed.

OIG's COMMENTS

Based on our review of the additional information provided and discussions with the FI's medical reviewers, we agree that the two clinic services originally questioned for medical necessity do in fact meet the Medicare criteria for reimbursement. Accordingly, we have revised our statistical projection of clinic charges billed in error to exclude these claims and reduced our projection of estimated overcharges to \$181,118.

Regarding the claim containing 2 RCC 510 clinic visit services, one of which was actually an injection, we disagree with the Hospital's position that the \$72 injection was coded correctly and should be allowed. The medical records showed that the injection was 1 of 10 prescribed immuno-therapy injections given the patient. The billing detail showed 8 of the 10 injections were coded "2132" immuno-therapy injections and charged \$29 per injection. However, for the other 2 injections the billing detail showed that they were miscoded as "2136" inter-muscular injections. As a result, the clinic service in question was charged at \$72. We agree that the Hospital is entitled to Medicare

reimbursement for the prescribed immuno-therapy injection billed on our sample claim, but it should have been charged at \$29 rather than the \$72 actually billed as a result of the miscoding. Consequently, we believe that the resulting difference, a \$43 overcharge, should be included in our projection of estimated overcharges.

APPENDICES

**REVIEW OF OUTPATIENT CLINIC SERVICES PROVIDED BY THE
UNIVERSITY OF MASSACHUSETTS MEMORIAL MEDICAL CENTER**

STATISTICAL SAMPLE INFORMATION

Our population consisted of outpatient clinic claims with dates of service from October 1, 1998 through September 30, 1999. Our sample consisted of a simple random sample of Medicare Part B outpatient claims containing clinic charges from the universe of all outpatient claims containing clinic charges.

	<u>Items</u>	<u>Dollars</u>
Population	53,837 Claims	\$2,421,529
Sample	100 Claims	\$ 4,393
Errors	17 Claims	\$ 570

**PROJECTION OF SAMPLE RESULTS¹
Precision at the 90 Percent Confidence Level**

Point Estimate: \$306,871
Lower Limit: \$181,118
Upper Limit: \$432,624

SUMMARY OF TOTAL ERRORS

Total \$181,118

¹ Based on sample appraisal methodology, we are 90 percent confident that the dollar value of errors is between \$181,118 and \$432,624. Accordingly, we are 95 percent confident that the dollar value of error is \$181,118 or more.



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November 30, 2001

Michael J. Armstrong
Regional Inspector General for Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203

John T. Randolph
Chief Compliance Officer

CIN: A-01-01-00524

Dear Mr. Armstrong:

The University of Massachusetts Memorial Medical Center is in receipt of your draft report entitled, "Review of Outpatient Clinic services Provided By the University of Massachusetts Memorial Medical Center for Fiscal Year Ended September 30, 1999".

After review of this report by the Corporate Compliance Office, there are three (3) identified issues, all from the paragraph heading "Services Not Sufficiently Documented," that we are in disagreement with. They are as follows:

- "One clinic visit was solely to receive patient education...". According to the Federal Register 42 CFR Part 413, et al. 'Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2002 Payment Rates; Proposed Rule' published Friday, August 24, 2001, Vol 66, No. 165, Page 44678: "...beneficiary education was appropriately billed as a clinic visit. The Panel stated that this would be true whether the education involved cancer chemotherapy, diabetes management, or congestive heart failure management." The patient in question presented and was admitted to services provided in the Oncology Clinic on 1/14/99 for a charge of \$101.00 for both initial assessment and education by a Registered Nurse. The services included and were documented as:
 - Admission to cancer services data sheet
 - Physical assessment
 - Functional health assessment
 - Interdisciplinary care management plan development including the patient education plan, discharge planning, safety, nutrition, psychosocial assessment, comfort alteration, and skin integrity

According to the above cited Federal Register which states that patient education *should have been billed as clinic visits prior to the proposed rule*, and the documentation presented in the medical record, UMass Memorial Medical Center believes the charge in question was appropriate. Associated Hospital Service

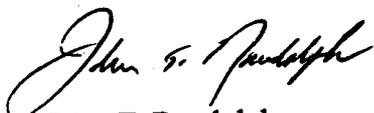
(Fiscal Intermediary for UMass Memorial Medical Center) also agrees with our findings.

- The second case in question is a patient that was seen in the Cardiovascular Clinic status post a Myocardial Infarction for a charge of \$42.00. The patient also had Coronary Artery Disease and hypertension. The draft report indicated "...the other exam was determined to be held without a medical condition or need identified." A physical assessment was performed by a Cardiologist. The patient was last seen in the clinic six (6) months prior to this encounter. The initial OIG finding reported to the Compliance Office was that it appeared the patient was seen for a routine annual exam. Based on the patient's significant cardiac history, there is indication that she required monitoring and close supervision by a Cardiac Specialist. The documentation in the chart clearly stated the diagnoses and the assessment findings. Even though the clinical findings were negative and the patient was to continue on her current medication regime, the reason for the visit should be deemed medically necessary and not be based on clinical findings/outcomes. The Fiscal Intermediary also informed UMass Memorial Medical Center that they found this visit to be medically necessary and not a routine physical exam.
- The last case stated "...another visit was overcharged as a miscoded injection." The injection for this patient was coded correctly as an injection. The patient was billed for both a visit and a \$72.00 injection charge separately. The clinic charge was already disallowed by the OIG in the section identified as "Noncovered Services." Therefore, we contend the injection charge was appropriate and should not be considered in the extrapolation.

With regard to your recommendation, the Compliance Office at UMass Memorial Medical Center routinely monitors coding, billing, charging, and documentation requirements for services rendered at the facility for Medicare, Medicaid, and other payer claims. Training on these subject matters is also conducted on an ongoing basis.

We request that the above modifications be made to your findings and report and, that they be reflected in extrapolated dollar amounts which you will request be adjusted in the UMass Memorial Medical Center Fiscal Year 1999 cost report.

Sincerely,



John T. Randolph
Chief Compliance Officer
UMass Memorial Health Care