



FEB 27 2002

Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

CIN: A-01-01-00527

Dr. Joseph Amaral
President
Rhode Island Hospital
593 Eddy Street
Providence, Rhode Island 02903

Dear Dr. Amaral:

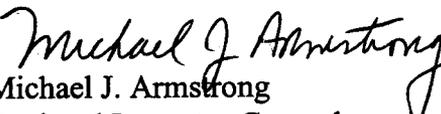
Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled *"Review of Medicare Outlier Payments at Rhode Island Hospital for Fiscal Year 1999."* A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

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

In accordance with principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-01-01-00527 in all correspondence relating to this report.

Sincerely,


Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures -- as stated

Direct Reply to HHS Action Official:

Roger Perez
Acting Regional Administrator
Centers for Medicare & Medicaid Services -- Region I
Room 2325
J.F.K. Federal Building
Boston, Massachusetts 02203

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE OUTLIER
PAYMENTS AT RHODE ISLAND
HOSPITAL FOR FISCAL YEAR 1999**



JANET REHNQUIST
Inspector General

FEBRUARY 2002
A-01-01-00527

Office of Inspector General

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

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

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The OIG's Office of Audit Services (OAS) provides all 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 in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

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The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

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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 in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

Background

Under Medicare's prospective payment system (PPS), fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to program beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). An additional payment is made for atypical cases that generate extremely high costs when compared to most discharges in the same DRG; these atypical cases are referred to as outliers. In fiscal year (FY) 1999, Rhode Island Hospital (RIH) received, in addition to its DRG payments, \$5.5 million for 400 outlier claims.

Objective

The objective of our review was to determine whether hospital outlier payments were reimbursed in accordance with Medicare laws and regulations. Our review focused on outlier payments made to RIH during FY 1999.

Results of Review

We analyzed RIH's FY 1999 outlier claims to identify high risk claims, such as those where charges for a single revenue center code represented a significant percentage of total claim charges. Based on our analysis, we judgmentally selected 15 FY 1999 outlier claims for review. We reviewed these claims in conjunction with medical review staff from Qualidigm, the peer review organization (PRO).

Our review found that due to control problems related to the billing process, RIH billed \$315,472 in charges involving services that were not ordered by a physician, were not properly documented, or resulted from a clerical billing error. Based on the Medicare reimbursement methodology for outliers, we determined that these billed services resulted in overpayments to RIH of \$105,686.

Recommendations

Given the importance of proper medical record documentation for both patient treatment and accurate reimbursement, we recommend RIH:

- Review documentation requirements with hospital staff to ensure that all services provided are appropriately documented in the medical record in accordance with standards of practice and Medicare laws and regulations, emphasizing the need to document physician orders.
- Improve its controls over the billing process to ensure that only services that are ordered by a physician and are supported by appropriate documentation are billed;

- Return to the appropriate FI, the \$11,373 associated with payments for services identified as not properly documented or not ordered by a physician.

Regarding the \$94,313 clerical payment error, the RIH issued an adjustment to reimburse Medicare for the overpayment after the error was identified; however, we recommend RIH strengthen its controls related to the detection and prevention of improper charges for “open” service codes.

The draft report was issued to RIH for comment on January 16, 2002. In response to the draft report, RIH generally concurred with our findings and identified steps they have taken, and plan to take, to address our recommendations.

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INTRODUCTION

BACKGROUND

The Medicare program, established by the Title XVIII of the Social Security Act provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Centers for Medicare & Medicaid Services (CMS). Under Medicare's prospective payment system (PPS), fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis-related group (DRG).

Section 1886(d)(5)(A) of the Social Security Act requires the Medicare program to pay an additional amount beyond the basic DRG payment for outlier cases. Outliers are those cases that have extraordinarily high costs when compared to most discharges classified in the same DRG.

Rhode Island Hospital (RIH), located in Providence, Rhode Island is a private, not-for-profit, acute care hospital and a major teaching hospital of Brown Medical School. We found that outlier payments to RIH increased by approximately 72 percent from \$3.2 million in fiscal year (FY) 1996 to \$5.5 million in FY 1999. Part of this increase can be attributed to changes in the methodology used for calculating outlier payments at teaching and/or disproportionate share hospitals which became effective October 1, 1997, under provisions of the Balanced Budget Act of 1997. In FY 1999, RIH received, in addition to its DRG payments, \$5.5 million for 400 outlier claims.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine whether hospital outlier payments were reimbursed in accordance with Medicare laws and regulations. Our review included outlier payments made to RIH during FY 1999.

To accomplish our objective, we:

- Used CMS's National Claims History file to identify 400 outlier payments made to RIH during FY 1999.
- Analyzed RIH's FY 1999 outlier claims to identify high risk claims, such as those where charges for a single revenue code represented a significant percentage of total claim charges. Based on our analysis, we selected a judgmental sample of 15 outlier claims for review.

- Utilized medical review staff from Qualidigm, the peer review organization (PRO), to review the medical and billing records for 14 of the 15 sample claims. One of the original sample claims was excluded from PRO review because the correction of a significant billing error found prior to the PRO review caused this claim to no longer qualify for an outlier payment in addition to their normal DRG payment. The PRO determined whether the care was medically necessary and appropriate, whether services were correctly billed, furnished to the beneficiary, and ordered by a physician.
- Reviewed unusual or aberrant charges on the itemized bills associated with the 15 judgmentally selected claims.
- Discussed with hospital personnel, RIH's procedures for accumulating charges, creating inpatient bills and submitting Medicare claims.
- Reviewed the fiscal intermediary's calculation of, and supporting documentation for, the inpatient cost-to-charge ratio used to calculate RIH's FY 1999 outlier payments.

We limited consideration of the internal control structure to those controls concerning the accumulation of charges, creation of inpatient bills and submission of Medicare claims because the objective of our review did not require an understanding or assessment of the complete internal control structure at the hospital.

We conducted our audit during the period of January 2001 through December 2001 at the RIH in Providence, Rhode Island, the PRO in Middletown, Connecticut and the Boston regional office of the Office of Inspector General (OIG).

The draft report was issued to RIH for comment on January 16, 2002. Their written comments are included as an appendix to this report.

FINDINGS AND RECOMMENDATIONS

Our review found that due to control problems related to billing, RIH received \$105,686 in overpayments related to its FY 1999 outlier claims. These overpayments involved billed charges for services that were not ordered by a physician, were not properly documented, or resulted from a clerical billing error.

MEDICAL RECORD REVIEW

The PRO's review of 14 outlier claims found that \$31,243 in billed charges examined were in error due to documentation problems. As a result, under the Medicare reimbursement methodology for outliers, RIH received overpayments of \$11,373.

Documentation problems include services that:

- were not ordered by a physician; or
- were not properly documented in the medical record.

A properly documented medical record is essential to good clinical care. Medical record documentation is required to record pertinent facts, findings and observations about an individual's health history. The medical record documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his or her health care over time; and
- communication and continuity of care among physicians and other health care professionals involved in the patient's care.

Proper documentation, as well as adequate controls relative to billing functions, ensures that Medicare payments are made in accordance with laws and regulations.

Not Ordered by a Physician

The RIH submitted \$25,937 in charges where the medical records do not contain physician orders for the services billed.

42 CFR, Section 482.24(c)(2)(vi) requires that medical records document all practitioner's orders.

The PRO's review found instances where RIH billed for services that were not ordered by a physician.

The following were identified by the PRO as the most common reasons for their determination that billed services were not ordered:

- A significant number of charges for which there were no physician orders involved portable x-ray services provided to intensive care unit patients. When performing its review of FY 1999 outlier claims at RIH, the PRO relied on a November 1999 policy questionnaire prepared by the hospital. According to this policy, if a portable x-ray service is provided to an intensive care unit patient, the physician's order must specify the exam is to be portable. The PRO found that portable chest x-rays for intensive care unit patients were billed without specific physician orders that the exams be portable.
- In a smaller number of instances, the hospital maintains that physician orders for billed services are supported by entries on documents such as flowsheets and progress notes. While Medicare regulations do not specify where physician orders should be located in the medical record, the PRO's standard of practice is that orders must be documented on the physician's order sheet. The rationale for this standard is that orders not recorded on the order sheet may be overlooked by hospital staff or not acted upon timely. Given the importance of medical record documentation to patient care, the requirement to record orders on the physician's order sheet provides assurance of consistency and continuity.

Because RIH billed for services that were not ordered by a physician, the hospital received overpayments of \$9,441.

Services Billed Not Properly Documented

The RIH submitted \$5,306 in charges for products or services that were not properly documented in the medical record.



The PRO's review of medical records found instances where RIH charged for services where the medical records do not support services billed. For instance:

Services such as chest x-rays were billed; however, there are no signed radiology reports in the medical record to support these services.

Contrary to Medicare regulations, RIH billed for services that were not properly documented. As a result, RIH was overpaid \$1,932.

ITEMIZED BILL REVIEW

The OIG's review of the itemized bills associated with 15 outlier claims at RIH found one claim with an improperly billed sterile supply service. A clerical error that was not discovered by the hospital resulted in \$287,100 in billed charges for a sterile supply service when the correct charge would have been \$2,871. "Open" service codes are used at RIH to bill for "exceptional" supplies that fall outside the normal supplies that are included in the medical supplies per diem charge. In this case, a decimal error was made when the charge was entered into the billing system. As a result, under the Medicare reimbursement methodology for outliers, RIH received an overpayment of \$94,313. The RIH issued an adjustment to reimburse Medicare for the overpayment after the error was identified.

RECOMMENDATIONS

Given the importance of proper medical record documentation for both patient treatment and accurate reimbursement, we recommend RIH:

- Review documentation requirements with hospital staff to ensure that all services provided are appropriately documented in the medical record in accordance with standards of practice and Medicare laws and regulations, emphasizing the need to document physician orders.
- Improve its controls over the billing process to ensure that only services that are ordered by a physician and are supported by appropriate documentation are billed.
- Return to the appropriate FI, the \$11,373 associated with payments for services identified as not properly documented or not ordered by a physician.

Regarding the \$94,313 clerical payment error, we recommend RIH strengthen its controls related to the detection and prevention of improper charges for “open” service codes.

AUDITEE COMMENTS

In response to our draft report, RIH generally agreed with our findings and identified steps they have taken and plan to take, to address our recommendations. However, RIH questioned the PRO’s use of a policy questionnaire to determine the hospital’s standard of practice regarding portable radiology exams. Furthermore, the hospital expressed disappointment that our draft report “did not mention, nor take into consideration...services provided under a physician’s order, which were omitted from the original itemized bills.” The full text of the hospital’s comments are included as the APPENDIX to this report.

ADDITIONAL OIG COMMENTS

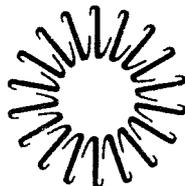
The PRO found a significant number of charges for portable x-ray services provided to intensive care unit patients where there were no physician orders. When performing its review of outlier claims, the PRO relied on a November 1999 policy questionnaire prepared by the hospital. In order for Qualidigm to accurately audit the standard practices of a facility, knowledge of their specific requirements is necessary. The questionnaire process is the facility’s opportunity to detail the accepted practices that support their coding and billing as accurate. At the beginning of this review, Qualidigm requested updated information concerning questionnaire responses, including the hospital’s requirement that portable radiology exams for intensive care unit patients must have physician orders. The hospital verified the questionnaire responses as correct. Accordingly, the review was conducted under the criteria presented by the hospital. When presented with the initial results of this review, RIH subsequently submitted a letter dated August 17, 2001 stating that it is the hospital’s standard of care to provide portable chest x-rays in the intensive care unit and that these services do not require a physician’s order specifying that the exam be portable.

The RIH expressed disappointment that our draft report “did not mention, nor take into consideration...services provided under a physician’s order, which were omitted from the original itemized bills.” We acknowledge that RIH stated to us that they identified \$45,771 in services provided to the beneficiaries in our sample that were never billed to Medicare. We also acknowledge that the hospital spent considerable resources providing documentation to support their position. The RIH requested the PRO consider these unbilled services in determining the total of their finding. However, according to Section 4210.B of the Peer Review Manual, the PRO uses the appropriate medical records plus the itemized bill to determine that all services provided were medically necessary and appropriate and that the services *billed* were: (1) not duplicately or erroneously billed; (2) actually furnished; and (3) ordered by a physician. Since the PRO review of

cost outliers considers only services that were billed to Medicare and, consequently, impacted the Medicare payment to the hospital, these unbilled services were not offset against the PRO’s findings. However, we believe the results of RIH’s internal review can help the hospital identify and establish additional controls over the billing process.

APPENDIX

Rhode Island Hospital
A Lifespan Partner



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HHS/OIG/OAS
REGION I



BROWN UNIVERSITY
SCHOOL OF MEDICINE

February 14, 2002

Michael J. Armstrong
Regional Inspector General for Audit Services
Office of the Inspector General, Office of Audit Services
John F. Kennedy Federal Building, Room 2425
Boston, MA 02203
RE: CIN A-01-01-00527

Administration

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Joseph F. Amaral, MD, FACS
*President and
Chief Executive Officer*
Rhode Island Hospital

Professor of Surgery
Brown University
School of Medicine

Dear Mr. Armstrong:

After review and discussion with my staff, and subject to the comments that follow, I generally agree with your draft report addressed to me dated January 16, 2002.

I believe the following comments are relevant in evaluating and understanding the audit findings relating to Medicare Outlier payments for Fiscal Year 1999.

- The vast majority of your findings, \$287,100 of \$315,472, relate to one clerical mistake in which a decimal error increased a \$2,871 charge to \$287,100. Once this error was detected RIH promptly made a repayment.
- During Fiscal Year 1999, Rhode Island Hospital (RIH) reviewed specialized inpatient edit reports to assess the reasonableness of charges. However, the clerical error above occurred on an outpatient claim, for which there were no similar reports. The patient was subsequently admitted and the outpatient charges were transferred to the inpatient claim resulting in the Outlier payment. Since Fiscal Year 1999, RIH has created similar specialized edit reporting for all outpatient claims
- The majority of the \$25,937 the PRO disallowed as "not ordered by physicians" pertains to portable radiology charges incurred on Intensive Care Units. RIH provided the PRO with a letter, signed by the Medical Directors of our Intensive Care Units stating it has always been RIH's standard of care to provide chest x-rays in the intensive care unit. However, in reaching its conclusion, the PRO relied on a billing policy questionnaire completed by RIH in November of 1999 which indicates the physician's order must specify if the exam is to be done "portable". We would like to emphasize the fact that the standard of care cited above was in fact in place during Fiscal Year 1999. To do anything other than a portable radiology procedure on an intensive care patient, would present a quality of care issue.

Michael J. Armstrong
Regional Inspector General for Audit Services
February 14, 2002

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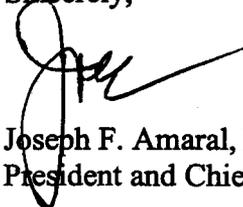
- Lastly, we are disappointed that your report did not mention, nor take into consideration, the \$45,771 relating to services provided under a physician's order, which were omitted from the original itemized bills. RIH staff spent considerable time comparing the medical records to the itemized bill and supplied the PRO with medical record documentation supporting these additional charges

In addition to establishing specialized edit reports to detect outpatient claim overcharges, RIH will implement the following steps to prevent similar problems in the future.

- Clinical Auditors will begin to review Medicare Outlier claims to help ensure the accuracy of the itemized bill.
- All Intensive Care Units will formalize Standard of Care Policies.
- The Hospital will return to the Rhode Island Fiscal Intermediary, the \$11,373 associated with payments for services identified in this review.

If you have any questions, please call Mr. Thomas Igoe, Lifespan Compliance Officer, at 401-444-4728 or me at 401-444-5131.

Sincerely,



Joseph F. Amaral, MD
President and Chief Executive Officer

C: David Lantto
Mamie Wakefield
Thomas Igoe
Marjorie Beal