

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF UNIVERSITY OF
MISSISSIPPI MEDICAL CENTER FOR
2013 AND 2014**

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Office of Inspector General

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EXECUTIVE SUMMARY

University of Mississippi Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated net overpayments of at least \$356,000 over nearly 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar years 2013 and 2014, Medicare paid hospitals \$156 billion and \$159 billion, respectively, which represented 45 and 46 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether University of Mississippi Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient 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, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Under section 1128J(d) of the Social Security Act and 42 CFR part 401 subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

The Hospital is a 722-bed diagnostic and treatment referral center located in Jackson, Mississippi. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$218 million for 10,276 inpatient and 120,610 outpatient claims with dates of payment from January 1, 2013, through August 31, 2014.

Our audit covered \$28,707,564 in Medicare payments to the Hospital for 6,112 claims that were potentially at risk for billing errors. We selected a stratified random sample of 217 claims with payments of \$3,121,606 for review. These 217 claims had payment dates in the period January 1, 2013, through August 31, 2014 (audit period), and consisted of 107 inpatient and 110 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 137 of the 217 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 80 claims, resulting in net overpayments of \$67,942 for the audit period. Specifically, 12 inpatient claims had billing errors, resulting in net overpayments of \$41,135, and 68 outpatient claims had billing errors, resulting in net overpayments of \$26,807. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received net overpayments of at least \$356,766 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$356,766 (of which \$67,942 was net overpayments identified in our sample) in estimated overpayments for incorrectly billed services;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed with all of our findings except our determinations on two outpatient claims. The Hospital did not address our recommendations; however, it commented that it had taken steps to correct the problems that caused the identified billing errors and had strengthened controls to ensure full compliance with Medicare requirements.

OUR RESPONSE

We stand by the independent medical review contractor's determinations and the auditors' professional judgments that the Hospital did not fully comply with Medicare billing requirements for the disputed claims. Therefore, we maintain that all of our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar years 2013 and 2014, Medicare paid hospitals \$156 billion and \$159 billion, respectively, which represented 45 and 46 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

The objective of this review was to determine whether University of Mississippi Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

CMS contracts with Medicare Administrative Contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). 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, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, CMS 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.¹ All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- inpatient manufacturer credits for replaced medical devices,
- inpatient claims paid in excess of charges,
- inpatient claims billed with high-severity-level DRG codes,
- outpatient manufacturer credits for replaced medical devices,
- outpatient claims paid greater than \$25,000, and
- outpatient claims billed with modifier -59.

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.” We reviewed these risk areas as part of this review.

Medicare Requirements for Hospital Claims and Payments

Under the Social Security Act (the Act), 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” (§ 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

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

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

¹ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Under section 1128J(d) of the Social Security Act and 42 CFR part 401 subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

University of Mississippi Medical Center

The Hospital is a 722-bed diagnostic and treatment referral center located in Jackson, Mississippi. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$218 million for 10,276 inpatient and 120,610 outpatient claims with dates of payment from January 1, 2013, through August 31, 2014.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$28,707,564 in Medicare payments to the Hospital for 6,112 claims that were potentially at risk for billing errors. We selected a stratified random sample of 217 claims with payments of \$3,121,606 for review. These 217 claims had payment dates in the period January 1, 2013, through August 31, 2014 (audit period), and consisted of 107 inpatient and 110 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals and evaluated compliance with selected billing requirements. We submitted 16 claims to an independent medical review contractor to determine whether the services met coding requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims that the Hospital submitted for Medicare reimbursement.

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 objectives.

See Appendix A for the details of our scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 137 of the 217 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 80 claims, resulting in net overpayments of \$67,942 for the audit period. Specifically, 12 inpatient claims had billing errors, resulting in net overpayments of \$41,135 and 68 outpatient claims had billing errors, resulting in net overpayments of \$26,807. These errors occurred primarily because the Hospital did not have

adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

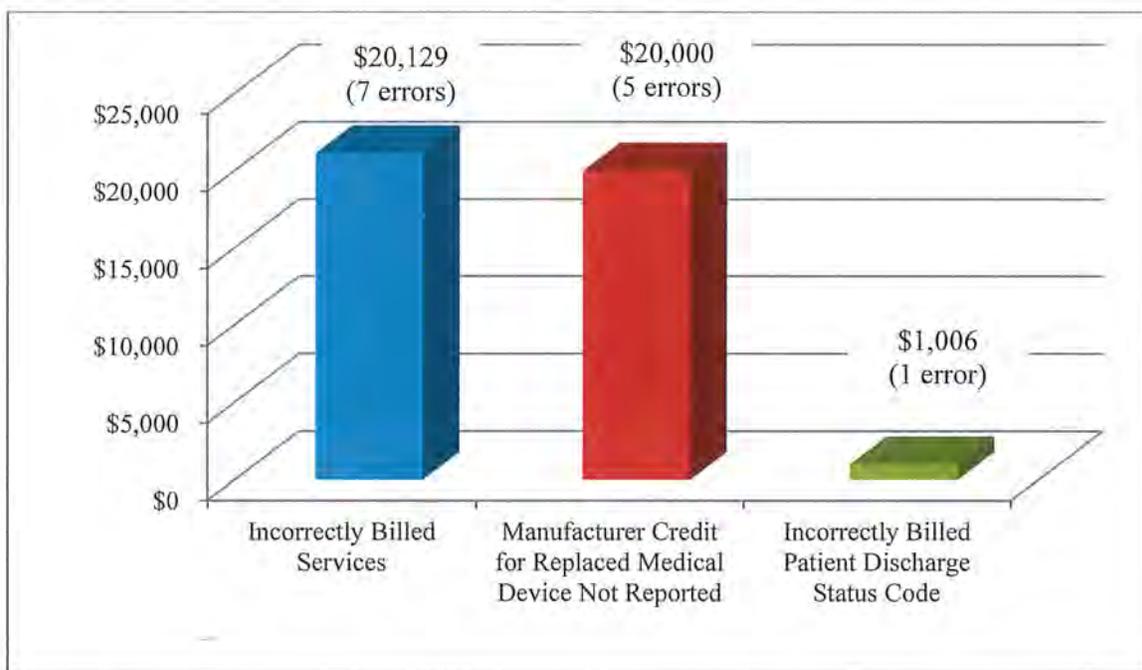
On the basis of our sample results, we estimated that the Hospital received net overpayments of at least \$356,766 for the audit period.

See Appendix B for our sample design and methodology, Appendix C for our sample results and estimates, and Appendix D for the results of our review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 12² of 107 sampled inpatient claims, which resulted in net overpayments of \$41,135 as shown in Figure 1 below.

Figure 1: Inpatient Billing Errors



Incorrectly Billed Services

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(a)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 7 of the 107 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary services. The Hospital billed six claims with an incorrect DRG and one claim with incorrect charges. Hospital officials attributed these incorrectly billed services to human error.

² Of the 12 inpatient claims, 1 claim had more than 1 type of error for a total of 13 errors.

As a result of these errors, the Hospital received net overpayments of \$20,129.

Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations require reductions in the IPPS payments 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 device cost (42 CFR § 412.89(a)). The Manual states that to correctly bill for a replacement device that was provided with a credit, hospitals must code Medicare claims with a 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 a hospital for the replaced device) (chapter 3, § 100.8).

Federal regulations state: “All payments to providers of services must be based on the reasonable cost of services ...” (42 CFR § 413.9). The CMS *Provider Reimbursement Manual* (PRM), Pub. No. 15-1, reinforces these requirements in additional detail.³

For 5 of the 107 sampled claims, the Hospital received a reportable medical device credit from manufacturers but did not adjust its inpatient claim with the proper condition and value code to reduce payment as required. Hospital officials stated that these errors occurred because the Hospital was not aware it had received the medical device credits.

As a result of these errors, the Hospital received overpayments of \$20,000.

Incorrectly Billed Patient Discharge Status Code

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(a)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 1 of the 107 sampled claims, the Hospital billed Medicare with an incorrect discharge status code. The Hospital billed this claim as discharge to home (status code “01”). However, the patient was discharged to a Skilled Nursing Facility (status code “03”). Therefore, this claim was incorrectly billed as a routine discharge instead of Discharged/Transferred to a Skilled Nursing Facility with Medicare Certification in Application of Skilled Care.⁴

³ The PRM states: “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service.... If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program” (part I, § 2102.1). Section 2103 further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103.C.4 provides the following example: “Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment supplied.”

⁴ Under Medicare’s transfer policy, DRG payments are reduced when a patient is transferred to a Skilled Nursing Facility (Patient Status Code 03).

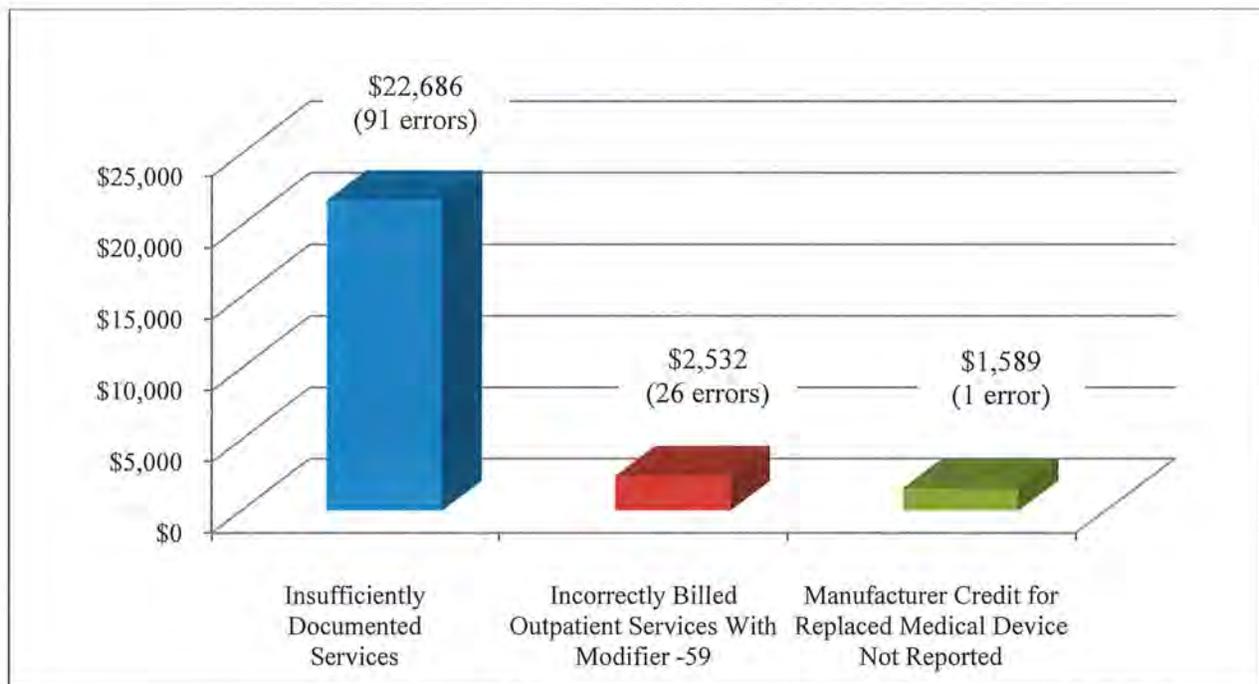
Hospital officials attributed the incorrectly billed discharge code to human error.

As a result of this error, the Hospital received an overpayment of \$1,006.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 68⁵ of 110 sampled outpatient claims, which resulted in net overpayments of \$26,807 as shown in Figure 2 below.

Figure 2: Outpatient Billing Errors



Insufficiently Documented Services

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

For 51⁶ of the 110 sampled claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record. Hospital officials attributed the incorrectly billed services to human error.

As a result of these errors, the Hospital received net overpayments of \$22,686.

⁵ Of the 68 outpatient claims, 29 claims had more than 1 type of error for a total of 118 errors.

⁶ These 51 outpatient claims involved a total of 91 errors for services that were not supported in the medical record.

Incorrectly Billed Outpatient Services With Modifier -59

The Manual states: “The ‘-59’ modifier is used to indicate a distinct procedural service.... This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)” (chapter 23, § 20.9.1.1). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 23⁷ of the 110 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes, appended with modifier -59, which either were already included in the payments for other services billed on the same claim or did not require modifier -59. Hospital officials attributed the incorrect use of modifier -59 to human error.

As a result of these errors, the Hospital received overpayments of \$2,532.

Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations 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 a replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45(a)). As described in footnote 3 of this report, the PRM reinforces these requirements in additional detail.

For 1 of the 110 selected outpatient claims, the Hospital received a full credit for a replaced device but did not report the -FD modifier and reduce charges on its claim. Hospital officials stated that this error occurred because the Hospital was not aware it had received the medical device credit.

As a result of this error, the Hospital received an overpayment of \$1,589.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received net overpayments of at least \$356,766 for the audit period.

⁷ These 23 outpatient claims involved a total of 26 errors for HCPCS codes, appended with modifier -59, which were already included in the payments for other services billed on the same claim or did not require modifier -59.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$356,766 (of which \$67,942 was net overpayments identified in our sample) in estimated overpayments for incorrectly billed services;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed with all of our findings except our determinations on two outpatient claims. The Hospital did not address our recommendations; however, it commented that it had taken steps to correct the problems that caused the identified billing errors and had strengthened controls to ensure full compliance with Medicare requirements.

OFFICE OF INSPECTOR GENERAL RESPONSE

We stand by the independent medical review contractor's determinations and the auditors' professional judgments that the Hospital did not fully comply with Medicare billing requirements for the disputed claims. Therefore, we maintain that all of our findings and recommendations are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$28,707,564 in Medicare payments to the Hospital for 6,112 claims that were potentially at risk for billing errors. We selected a stratified random sample of 217 claims with payments totaling \$3,121,606 for review. These 217 claims had payment dates in the period January 1, 2013, through August 31, 2014, and consisted of 107 inpatient and 110 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals and evaluated compliance with selected billing requirements. We submitted 16 claims to an independent medical review contractor to determine whether the services met coding requirements.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork from July 2015 through September 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's National Claims History file for the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 217 claims (107 inpatient and 110 outpatient) totaling \$3,121,606 for detailed review (Appendix B and C);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for submitting Medicare claims;
- used an independent medical review contractor to determine whether 16 claims met coding requirements;
- 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;
- used the results of the sample review to calculate the estimated Medicare overpayments to the Hospital (Appendix C); 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 objectives.

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

TARGET POPULATION

The target population contained inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during the audit period.

SAMPLING FRAME

Inpatient Claims

According to CMS's National Claims History data, Medicare paid the Hospital approximately \$170 million for 10,276 inpatient claims from January 1, 2013, through August 31, 2014, for services provided to beneficiaries. Our Advanced Audit Techniques Staff (AATS) provided us with a database of claims totaling \$110 million for 6,019 claims in 13 high-risk areas.

From these 13 risk areas, we selected 3 areas consisting of 2,778 claims totaling \$51,158,291 for further refinement. The high-risk areas were:

- inpatient manufacturer credits for replaced medical devices,
- inpatient claims billed with high-severity-level DRG codes, and
- inpatient claims paid greater than charges.

We performed data filtering and analysis of the claims within each of the three high-risk areas. The specific filtering and analysis steps performed varied, depending on the risk area, but included such procedures as removing:

- claims with certain patient discharge status codes;
- \$0 paid claims;
- claims duplicated within individual risk areas by assigning each inpatient claim that appeared in multiple risk areas to just one category on the basis of the following hierarchy:
 - inpatient manufacturer credits for replaced medical devices,
 - inpatient claims billed with high-severity-level DRG codes, and
 - inpatient claims paid greater than charges; and
- claims under review by the Recovery Audit Contractor as of April 16, 2015.

This data filtering resulted in a sampling frame of 1,193 unique Medicare claims totaling \$15,037,602.

Outpatient Claims

According to CMS's National Claims History data, Medicare paid the Hospital approximately \$48 million for 120,610 outpatient claims from January 1, 2013, through August 31, 2014, for services provided to beneficiaries. Our AATS provided us with a database of claims totaling \$24 million for 32,640 claims in 22 high-risk areas.

From these 22 risk areas, we selected 3 areas consisting of 25,130 claims totaling \$21,318,381 for further refinement. The high-risk areas were:

- outpatient manufacturer credits for replaced devices,
- outpatient claims with payments greater than \$25,000, and
- outpatient claims billed with modifier -59.

We performed data filtering and analysis of the claims within each of the three high-risk areas. The specific filtering and analysis steps performed varied depending on the risk area, but included such procedures as removing:

- claims with certain patient discharge status codes and revenue codes;
- \$0 paid claims;
- claims duplicated within individual risk areas by assigning each outpatient claim that appeared in multiple risk areas to just one category on the basis of the following hierarchy:
 - outpatient manufacturer credits for replaced medical devices,
 - outpatient claims with payments greater than \$25,000, and
 - outpatient claims billed with modifier -59; and
- claims under review by the Recovery Audit Contractor as of April 16, 2015.

This data filtering resulted in a sample frame of 4,919 unique Medicare claims totaling \$13,669,962.

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into six strata on the basis of risk area and split two risk areas on the basis of dollar value. The split risk areas were: Inpatient Claims Paid Greater Than Charges (low and high), and Outpatient Claims Billed With Modifier -59 (low and high).

SAMPLE SIZE

We selected 217 claims for review as shown in Table 1.

Table 1: Stratum, Risk Area, Frame, and Sample Detail

Stratum	Risk Area	Frame Size	Value of Frame	Sample Size
1	Inpatient Manufacturer Credits for Replaced Medical Devices	7	\$250,126	7
2	Inpatient Claims Billed With High-Severity-Level DRG Codes	492	6,439,655	40
3	Low-Dollar Inpatient Claims Paid Greater Than Charges	524	4,733,189	30
4	High-Dollar Inpatient Claims Paid Greater Than Charges	170	3,614,632	30
5	Outpatient Manufacturer Credits for Replaced Medical Devices	10	206,983	10
6	Outpatient Claims Paid Greater Than \$25,000	116	3,344,975	30
7	Low-Dollar Outpatient Claims Billed With Modifier -59	4,025	3,716,825	30
8	High-Dollar Outpatient Claims Billed With Modifier -59	768	6,401,179	40
	Total	6,112	\$28,707,564	217

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General/Office of Audit Services (OIG/OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata two through four and six through eight. After generating the random numbers for these strata, we selected the corresponding frame items. We selected all claims in strata one and five.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments paid to the Hospital during the audit period. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Incorrect Payments in Sample
1*	7	\$250,126	7	\$250,126	5	\$28,762
2	492	6,439,655	40	511,943	1	-6,469
3	524	4,733,189	30	277,055	3	3,901
4	170	3,614,632	30	648,539	3	14,941
5*	10	206,983	10	206,983	8	3,783
6	116	3,344,975	30	880,553	6	364
7	4,025	3,716,825	30	26,639	23	1,536
8	768	6,401,179	40	319,768	31	21,124
Total	6,112	\$28,707,564	217	\$3,121,606	80	\$67,942

*We reviewed all claims in this stratum.

ESTIMATES

**Table 3: Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval**

Point Estimate	\$718,896
Lower Limit	\$356,766
Upper Limit	\$1,081,027

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Sampled Claims	Value of Sampled Claims	Number of Incorrectly Billed Claims	Value of Incorrect Payments
Inpatient				
Inpatient Manufacturer Credits for Replaced Medical Devices	7	\$250,126	5	\$28,762
Inpatient Claims Billed With High-Severity-Level DRG Codes	40	511,943	1	-6,469
Low-Dollar Inpatient Claims Paid Greater Than Charges	30	277,055	3	3,901
High-Dollar Inpatient Claims Paid Greater Than Charges	30	648,539	3	14,941
Inpatient Totals	107	\$1,687,663	12	\$41,135
Outpatient				
Outpatient Manufacturer Credits for Replaced Medical Devices	10	\$206,983	8	\$3,783
Outpatient Claims Paid Greater Than \$25,000	30	880,553	6	364
Low-Dollar Outpatient Claims Billed With Modifier -59	30	26,639	23	1,536
High-Dollar Outpatient Claims Billed With Modifier -59	40	319,768	31	21,124
Outpatient Totals	110	\$1,433,943	68	\$26,807
Inpatient and Outpatient Totals	217	\$3,121,606	80	\$67,942

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX E: UNIVERSITY OF MISSISSIPPI MEDICAL
CENTER COMMENTS



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December 7, 2016

Lori S. Pilcher
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth, SW Suite 3T41
Atlanta, GA 30303

RE: Report Number A-04-15-00105

Dear Ms. Pilcher:

On behalf of the University of Mississippi Medical Center (UMMC), thank you for the opportunity to respond to the draft report entitled "Medicare Compliance Review of University of Mississippi Medical Center for 2013 and 2014".

UMMC has a strong and abiding commitment to its regulatory obligations. UMMC's compliance efforts are designed to establish a culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law and health care program requirements, as well as UMMC's ethical and business policies. UMMC is committed to ensuring that appropriate operational procedures and controls are in place to minimize any potential billing risks.

After review of the audit findings, please note the following statements of concurrence with one of nonconcurrence.

1. Billing Errors Associated with Inpatient Claims.

- a. *OIG findings: Incorrectly Billed Services* - UMMC incorrectly billed 7 of the 107 sampled inpatient claims, resulting in an overpayment of \$20,129. Six errors were due to an incorrect DRG assignment and one error was due to incorrect charges.
 - These claims were reviewed with the coders so they could learn from their mistakes. These errors were attributable to human error.
 - An external coding validation audit will be scheduled within the next six months (due to State procurement rules).
 - Quarterly coding audits will be incorporated into the upcoming annual Hospital Compliance Monitoring plan.
- b. *OIG findings: Manufacturer Credit for Replaced Medical Device Not Reported* - UMMC incorrectly billed 5 of the 107 sampled inpatient claims, resulting in an overpayment of \$20,000. UMMC did not adjust its inpatient claim with the proper condition and value code to reduce payment as required.
 - A task force including representatives from Cardiology and Patient Financial Services was assembled to address the inpatient and outpatient issues.
 - A policy was developed to correct the issues identified during the audit.
 - Continued reviews are occurring to ensure the process is correct.

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umc.edu

c. *OIG findings: Incorrectly Billed Patient Discharge Status Code* – UMMC incorrectly billed 1 of the 107 sampled inpatient claims resulting in an overpayment of \$1,006.

- This was an inadvertent error. Continued training will be emphasized to our Coordinated Care team regarding the importance of documentation.
- The coding staff will be re-educated regarding the importance of appropriate discharge code selection.

2. Billing Errors Associated with Outpatient Claims.

a. *OIG findings: Insufficiently Documented Services* – UMMC incorrectly billed 51 of the 110 sampled outpatient claims, resulting in an overpayment of \$22,686. UMMC incorrectly billed for services that were not supported in the medical record.

- An external coding validation audit will be scheduled within the next six months (due to State procurement rules).
- Quarterly coding audits will be incorporated into the upcoming annual Hospital Compliance Monitoring plan.

b. *OIG findings: Incorrectly Billed Outpatient Services with Modifier -59* – UMMC incorrectly billed 23 of the 110 sampled outpatient claims, resulting in an overpayment of \$2,532. These services were already included in the payment for other services on the same claim or did not require modifier -59.

UMMC agrees with this finding except in two instances: Sample 19 and 24. We feel that the documentation justifying the services was provided for the IMRT cases. Further review was warranted.

In regards to the other findings:

- An external coding validation audit will be scheduled within the next six months (due to State procurement rules).
- Quarterly coding audits will be incorporated into the upcoming annual Hospital Compliance Monitoring plan.

c. *OIG findings: Manufacturing Credit for Replaced Medical Device Not Reported* - UMMC incorrectly billed 1 of the 110 sampled outpatient claims, resulting in an overpayment of \$1,589. UMMC did not report the -FD modifier and reduce charges on its claim.

- A task force with representatives from Cardiology and Patient Financial Services was assembled to address the inpatient and outpatient issues.
- A policy was developed to correct the issues identified during the audit.
- Continued reviews are occurring to ensure the process is correct.

Thank you again for the opportunity to address these findings. It was a pleasure working with the OIG staff and we appreciate their guidance throughout this process.

Regards,


Carol B. Denton, BS, RHIT, CCS, CPCO
Chief Integrity and Compliance Officer

CC: 

The Office of the Inspector General Note - The deleted text has been redacted because it is personally identifiable.