

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
UNIVERSITY OF KANSAS HOSPITAL
FOR CALENDAR YEARS
2009 AND 2010**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Patrick J. Cogley
Regional Inspector General

July 2013
A-07-11-01105

Office of Inspector General

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

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

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

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

Office of Investigations

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

Office of Counsel to the Inspector General

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

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://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 permanent kidney 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 inpatient hospital 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, intended to be 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 hospital claims at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for sampled claims for inpatient and outpatient services.

The University of Kansas Hospital (the Hospital) is a 606-bed short term hospital located in Kansas City, Kansas. Medicare paid the Hospital approximately \$308 million for 18,374 inpatient and 176,138 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$2,075,188 in Medicare payments to the Hospital for 79 claims that we judgmentally sampled as potentially at risk for billing errors. These claims consisted of 75 inpatient and 4 outpatient claims with dates of service in CYs 2009 and 2010.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on sampled claims.

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 38 of the 79 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 41 claims, resulting in net overpayments totaling \$254,411 for CYs 2009 and 2010. Specifically, 37 inpatient claims had billing errors, resulting in net overpayments totaling \$241,151, and all 4 outpatient claims had billing errors, resulting in overpayments totaling \$13,260. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$254,411, consisting of \$241,151 in net overpayments for the 37 incorrectly billed inpatient claims and \$13,260 in overpayments for the 4 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with part of our first recommendation and described actions that it had taken to address our second recommendation. Specifically, the Hospital disagreed with our findings on 15 inpatient claims, consisting of \$78,758 in questioned costs, in which we stated that the Hospital should have billed the claims as outpatient with observation services. The Hospital stated, "...we don't believe the pre-existing medical problems and other extenuating circumstances associated with these patients, as documented in the medical records, were fully considered in the review of these cases." The Hospital agreed with our findings on the remaining 26 incorrectly billed claims and said that it would refund \$175,653.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether specified claims met medical necessity requirements. The contractor examined all of the medical records and documentation originally submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractor's conclusions, we determined that the 15 inpatient claims should have been billed as outpatient with observation services.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System.....	1
Hospital Claims at Risk for Incorrect Billing	1
Medicare Requirements for Hospital Claims and Payments	2
The University of Kansas Hospital	2
OBJECTIVE, SCOPE, AND METHODOLOGY	3
Objective	3
Scope.....	3
Methodology.....	3
FINDINGS AND RECOMMENDATIONS	4
BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS	4
Incorrectly Billed as Inpatient.....	5
Incorrect Diagnosis-Related Groups.....	5
Incorrectly Billed as Separate Inpatient Stay.....	6
Incorrect Discharge Status	6
Manufacturer Credits for Replaced Medical Devices Not Reported	7
Incorrectly Billed as Inpatient Acute Care.....	7
Incorrectly Billed for an Incarcerated Beneficiary	7
BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS INVOLVING MANUFACTURER CREDITS FOR REPLACED MEDICAL DEVICES NOT REPORTED	8
RECOMMENDATIONS	8
AUDITEE COMMENTS	8
OFFICE OF INSPECTOR GENERAL RESPONSE	9
APPENDIXES	
A: RESULTS OF REVIEW BY RISK AREA	
B: AUDITEE COMMENTS	

INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with permanent kidney 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.

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, 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) 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. 106-113.¹ 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.² All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis techniques. Examples of these types of claims at risk for noncompliance included the following:

¹ In 2009, SCHIP was formally redesignated as the Children's Health Insurance Program.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level DRGs,
- inpatient claims paid in excess of charges,
- inpatient transfers, and
- inpatient and outpatient manufacturer credits for replaced medical devices.

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

This review is part of a series of OIG reviews of Medicare payments to hospitals for sampled 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, sections 1815(a) and 1833(e) of the Act preclude 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.

The University of Kansas Hospital

The University of Kansas Hospital (the Hospital) is a 606-bed short term hospital located in Kansas City, Kansas. Medicare paid the Hospital approximately \$308 million for 18,374 inpatient and 176,138 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2009 and 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 sampled claims.

Scope

Our audit covered \$2,075,188 in Medicare payments to the Hospital for 79 claims that we judgmentally sampled as potentially at risk for billing errors. These claims consisted of 75 inpatient and 4 outpatient claims with dates of service in CYs 2009 and 2010.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and used medical review on a sampled number of claims 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 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 at the Hospital during October and November 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with Medicare contractor officials to gain an understanding of Medicare requirements for billing claims;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;
- obtained information on known credits for replaced medical devices from the device manufacturers for CYs 2009 and 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;

- judgmentally sampled 79 claims (75 inpatient and 4 outpatient) for detailed review;
- 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;
- submitted the Hospital's medical records for 18 claims to an independent medical review contractor to determine whether the claims met medical necessity 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; and
- discussed the results of our review with Hospital officials on November 30, 2012.

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.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 38 of the 79 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 41 claims, resulting in net overpayments totaling \$254,411 for CYs 2009 and 2010. Specifically, 37 inpatient claims had billing errors, resulting in net overpayments totaling \$241,151, and all 4 outpatient claims had billing errors, resulting in overpayments totaling \$13,260. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix A.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 37 of the 75 sampled inpatient claims that we reviewed. These errors resulted in net overpayments totaling \$241,151.

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."

According to Chapter 1, section 10, of the *CMS Benefit Policy Manual*, factors that determine whether an inpatient admission is medically necessary include:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;
- the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- the availability of diagnostic procedures at the time when and at the location where the patient presents.

The *Benefit Policy Manual* also states that admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital.

For 15 of 75 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient with observation services. Our medical reviewer determined that inpatient admission was not medically necessary for these beneficiaries. In one case, the medical reviewer stated, "[t]he services planned at the time of admission ... were of the intensity that could have been safely provided at the observation level."

These errors occurred because the Hospital did not have effective controls to ensure that it billed Medicare correctly. As a result of these errors, the Hospital received overpayments totaling \$78,758.³

Incorrect Diagnosis-Related Groups

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that "... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Chapter 1, section 80.3.2.2, of the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

³ The Hospital may bill Medicare Part B for some services related to some of these incorrect Medicare Part A claims. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the Medicare administrative contractor before we prepared our report for issuance.

For 5 of 75 sampled inpatient claims, the Hospital submitted claims to Medicare with incorrect DRGs. For example, for one claim, the Hospital used the DRG for a “cardiac defibrillator implant without cardiac catheterization with major complication/comorbidity,” rather than using the DRG for a “cardiac defibrillator implant without cardiac catheterization without major complication/comorbidity.” The Hospital stated that these errors occurred due to human error in coding diagnosis codes that were not supported by medical records, resulting in incorrect DRGs. As a result of these errors, the Hospital received overpayments totaling \$70,817.

Incorrectly Billed as Separate Inpatient Stay

The Manual, chapter 3, section 40.2.5, states:

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

For 12 of 75 sampled inpatient claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. For 10 of the 12 claims, the Hospital identified the errors. For the remaining two claims, our medical reviewer identified the errors. These errors occurred because the Hospital did not have effective controls to ensure that it billed Medicare correctly. As a result of these errors, the Hospital received net overpayments totaling \$55,677.

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 skilled nursing facility (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 1 of 75 sampled inpatient claims, the Hospital incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. Specifically, the Hospital coded the discharge status as “discharged to home” instead of “discharged to a skilled nursing facility.” Thus, the Hospital received the full DRG payment instead of the graduated per diem payment it would have received if it had correctly coded the patient’s discharge status. The Hospital stated that this error occurred due to human error. As a result of this error, the Hospital received an overpayment of \$14,568.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations (42 CFR § 412.89) 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 a 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 bill correctly for a replacement device that was provided with a credit, the hospital must code its Medicare claims with a combination of condition code 49 or 50, along with value code “FD.”

For 2 of 75 sampled inpatient claims, the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claims with the proper condition and value codes to reduce payments as required. The Hospital stated that these overpayments occurred due to what it described as the highly complex process through which the Hospital identified and billed for device credits. The Hospital added that this process depended highly on information provided from the medical device vendors and said that the Hospital has had weak communication with these vendors. As a result of these errors, the Hospital received overpayments totaling \$10,080.

Incorrectly Billed as Inpatient Acute Care

Federal regulations (42 CFR § 412.23(b)) exclude rehabilitation hospitals from the inpatient hospital prospective payment system and require that rehabilitation claims be billed to the inpatient rehabilitation prospective payment system.

For 1 of 75 sampled inpatient claims, the Hospital incorrectly billed Medicare for a beneficiary stay that should have been billed as a rehabilitation claim. This error occurred because the Hospital did not have effective controls to ensure that it billed Medicare correctly. As a result of this error, the Hospital received an overpayment of \$8,108.

Incorrectly Billed for an Incarcerated Beneficiary

Pursuant to section 1862 of the Act and Federal regulations (42 CFR § 411.4), Medicare generally does not pay for services rendered to incarcerated beneficiaries. Chapter 1, section 10.4, of the Manual states: “CMS presumes that a State or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare’s policy is to deny payment for items and services furnished to beneficiaries in State or local government custody.”

For 1 of 75 sampled inpatient claims, the Hospital incorrectly submitted a claim to Medicare for a beneficiary who, according to the medical records, was incarcerated at the time of admission. The Hospital stated that this error occurred due to human error. As a result of this error, the Hospital received an overpayment of \$3,143.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS INVOLVING MANUFACTURER CREDITS FOR REPLACED MEDICAL DEVICES 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, chapter 4, section 61.3, 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. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.

For the four sampled outpatient claims, the Hospital received manufacturer credits for replaced devices but did not report the modifier -FB or reduced charges on its claims. The Hospital stated that these overpayments occurred due to what it described as the highly complex process through which the Hospital identified and billed for device credits. The Hospital added that this process depended highly on information provided from the medical device vendors and said that the Hospital has had weak communication with these vendors. As a result of these errors, the Hospital received overpayments totaling \$13,260.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$254,411, consisting of \$241,151 in net overpayments for the 37 incorrectly billed inpatient claims and \$13,260 in overpayments for the 4 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital described actions that it had taken to address our second recommendation and stated that it is committed to strengthening its internal controls.

The Hospital agreed with part of our first recommendation. Specifically, the Hospital disagreed with our findings on 15 inpatient claims, consisting of \$78,758 in questioned costs, in which we stated that the Hospital should have billed the claims as outpatient with observation services. The Hospital stated, "...we don't believe the pre-existing medical problems and other

extenuating circumstances associated with these patients, as documented in the medical records, were fully considered in the review of these cases.” The Hospital agreed with our findings on the remaining 26 incorrectly billed claims and said that it would refund \$175,653.

The Hospital’s comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital’s comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether specified claims met medical necessity requirements. The contractor examined all of the medical records and documentation originally submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractor’s conclusions, we determined that the 15 inpatient claims should have been billed as outpatient with observation services.

APPENDIXES

APPENDIX A: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Under / Over-payments	Value of Net Over-payments
Inpatient				
Same Day Discharges and Readmissions	16	\$326,513	14	\$75,841
Short Stays	15	69,845	15	69,845
Claims Paid in Excess of Charges	18	613,907	4	59,961
Transfers	1	38,296	1	14,568
Claims Billed With High Severity Level Diagnosis-Related Group Codes	22	871,282	1	10,856
Manufacturer Credits for Replaced Medical Devices	3	128,162	2	10,080
Inpatient Totals	75	\$2,048,005	37	\$241,151
Outpatient				
Manufacturer Credits for Replaced Medical Devices	4	\$27,184	4	\$13,260
Outpatient Totals	4	\$27,184	4	\$13,260
Inpatient and Outpatient Totals	79	\$2,075,188	41	\$254,411

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 University of Kansas 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 B: AUDITEE COMMENTS

THE UNIVERSITY OF KANSAS HOSPITAL

April 5, 2013

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Re: Report Number: A-07-11-01105

Dear Mr. Cogley:

This letter responds to the U.S. Department of Health and Human Services, Office of Inspector General's (OIG) draft report entitled Medicare Compliance Review of University of Kansas Hospital for Calendar years 2009 and 2010.

The objective of the audit was to determine whether the University of Kansas Hospital (Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims. The audit covered \$2,075,188 in Medicare payments to the Hospital for 79 claims, which consisted of 75 inpatient and 4 outpatient claims. These claims were judgmentally selected by the OIG and identified as potentially at risk for billing errors based on risk areas identified through prior OIG reviews at other hospitals.

Through this review, the OIG concluded the Hospital complied with Medicare billing requirements for 38 of the 79 claims reviewed. However, the auditors found the Hospital did not fully comply with Medicare billing requirements for the remaining 41 claims, resulting in net overpayments totaling \$254,411 for calendar years 2009 – 2010. It was specifically noted 37 inpatient claims had billing errors, resulting in net overpayments of \$241,151, and 4 outpatient claims had billing errors, resulting in overpayments of \$13,260.

We have reviewed the audit findings and recommendations detailed in the draft report. A summary of our responses by finding follows.

Incorrectly Billed as Inpatient

For 15 of 75 sampled inpatient claims, the OIG concluded the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient with observation services. Specifically, it was noted the OIG's medical reviewer determined inpatient admission was not medically necessary for these beneficiaries.

The OIG recommended the Hospital refund to the Medicare contractor \$78,758 and the Hospital strengthen controls to ensure full compliance with Medicare requirements.

Hospital Response

We disagree with the medical necessity determinations of the OIG's medical reviewer and we plan to appeal the denials associated with these findings. While we welcome opportunities to examine and challenge our current processes, we believe the Hospital's medical necessity

determination processes are compliant with Medicare requirements and operating effectively. Furthermore, we believe these 15 cases met the criteria for inpatient admission.

CMS guidance states medical necessity is a “complex medical judgment which can be made only after the physician has considered a number of factors...”¹ Reviewers, like physicians, shall consider, in their review of the medical record, any pre-existing medical problems or extenuating circumstances that made admission of the beneficiary medically necessary.² We appreciate the difficulty of performing a medical necessity review without the benefit of personally examining a patient at the time of service; however, we don't believe the pre-existing medical problems and other extenuating circumstances associated with these patients, as documented in the medical records, were fully considered in the review of these cases.

As required by the Medicare Conditions of Participation, the Hospital has developed a Utilization Review Plan and has implemented an active utilization review process. This process includes concurrent reviews of patient admissions and continued patient stays by utilization review professionals utilizing InterQual, a widely accepted utilization screening criteria. Cases not meeting InterQual criteria are referred to independent, skilled and experienced physician advisors for concurrent assessment. Because the concept of medical necessity is based on a “complex medical judgment” rather than a definitive set of criteria, with the assistance of our physician advisors we educate our medical staff on this concept, the treating physician's role in the utilization review process and the importance of thorough medical record documentation on an ongoing basis.

Incorrect Diagnosis-Related Groups

For 5 of 75 sampled inpatient claims, the OIG concluded the Hospital submitted claims to Medicare with incorrect DRGs. The OIG recommended the Hospital refund to the Medicare contractor \$70,817 and the Hospital strengthen controls to ensure full compliance with Medicare requirements.

Hospital Response

We agree with the OIG's findings and have submitted corrected claims to the Medicare contractor, Wisconsin Physician Services. We recognize coding is a technical and interpretive science, which may result in differences of opinion, and can be subject to human error. In acknowledgment of this complexity, several key controls have been incorporated into our coding process for many years. These include the employment of certified coders, the provision of ongoing professional education to our coding staff, the implementation of coding systems to support coding accuracy and the performance of supervisory and independent concurrent and retrospective coding reviews. Since the 2009 – 2010 time-frame, when the selected claims were coded and billed, the Hospital has expanded coverage provided by its clinical documentation specialists. As a result, more accounts are subject to independent review than in previous years. In addition, focused education was provided to the coders and clinical documentation specialists in response to these findings.

Incorrectly Billed as Separate Inpatient Stay

For 12 of 75 sampled inpatient claims, the OIG concluded the Hospital billed Medicare separately for related discharges and readmissions within the same day. The OIG recommended the Hospital refund to the Medicare contractor \$55,677 and the Hospital strengthen controls to ensure full compliance with Medicare requirements.

¹ MBPM Chpt 1 §10

² MPIM Chpt 6 §6.5.2(A)

Hospital Response

We agree with the OIG's findings and have submitted corrected claims to the Medicare contractor, Wisconsin Physician Services. The Hospital's process for reviewing and billing same day discharges and readmissions has been refined since the 2009 – 2010 time-frame, when the selected claims were billed. The clinical condition of patients, who are discharged and subsequently readmitted on the same day or within a short time thereafter, is subject to review by the Hospital's physician advisors to help us determine if the second admission is clinically related to the first admission. If appropriate, claims are combined before billing when a discharge and readmission are determined to be clinically related. In addition, system reports have been created, which enable our patient financial services representatives to identify same day discharges and readmissions for further review. Finally, from a quality perspective, the Hospital has created a task force focused on the reduction of preventable patient readmissions.

Incorrect Discharge Status

For 1 of 75 sampled inpatient claims, the OIG concluded the Hospital incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. The OIG recommended the Hospital refund to the Medicare contractor \$14,568 and the Hospital strengthen controls to ensure full compliance with Medicare requirements.

Hospital Response

We agree with the OIG's findings and have submitted a corrected claim to the Medicare contractor, Wisconsin Physician Services. Accurate coding of discharge status is a function of thorough medical record documentation, correct coding and patient adherence to the discharge plan. The Hospital provides training to new physicians and residents about the necessary content and importance of discharge documentation. In addition, the Hospital employs certified coders, provides ongoing professional education to our coding staff and performs supervisory and independent concurrent and retrospective coding reviews. Since 2009, when the selected claim was coded and billed, the Hospital has expanded coverage provided by its clinical documentation specialists. As a result, more accounts are subject to independent review than in previous years. In addition, focused education was provided to the coders and clinical documentation specialists in response to this finding.

Manufacturer Credits for Replaced Medical Devices Not Reported

For 2 of 75 sampled inpatient claims, the OIG concluded the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claims with the proper condition and value codes to reduce payments as required. Additionally, the OIG concluded for 4 outpatient claims, the Hospital received manufacturer credits for replaced devices but did not report the modifier –FB or reduce charges on its claims. The OIG recommended the Hospital refund to the Medicare contractor \$10,080 for the inpatient claims and \$13,260 for the outpatient claims and the Hospital strengthen controls to ensure full compliance with Medicare requirements.

Hospital Response

We agree with the OIG's findings and have submitted corrected claims to the Medicare contractor, Wisconsin Physician Services. The process through which the Hospital identifies and bills device credits is complex and highly dependent on information received from the device vendors. It is often months after an implant or device has been returned to the manufacturer before the Hospital is notified of the credit the Hospital will receive, and this credit can be provided in the form of a credit memo, an informal notation on a packing slip or the absence of an invoice. Since the 2009 – 2010 time-frame, when the selected claims were billed, the Hospital has further refined its procedures for capturing and reporting information related to device credits. This includes the development of formal, written procedures over this process, assignment of responsibility for handling and oversight of device credits to individuals within the relevant clinical areas and the compliance department, and independent review of claims involving implantable devices and credit memos associated with implantable devices.

Incorrectly Billed as Inpatient Acute Care

For 1 of 75 sampled inpatient claims, the OIG concluded the Hospital incorrectly billed Medicare for a beneficiary stay that should have been billed as a rehabilitation claim. The OIG recommended the Hospital refund to the Medicare contractor \$8,108 and the Hospital strengthen controls to ensure full compliance with Medicare requirements.

Hospital Response

We agree with the OIG's findings and have submitted a corrected claim to the Medicare contractor, Wisconsin Physician Services. This patient had been discharged from the inpatient facility and was admitted to the rehabilitation unit on the same day. When patients are discharged from the inpatient facility and readmitted to the rehabilitation unit, a new patient account is created which will be billed under the inpatient rehabilitation prospective payment system. In response to this finding, focused education was provided to the admitting representatives to reinforce this procedure.

Incorrectly Billed for an Incarcerated Beneficiary

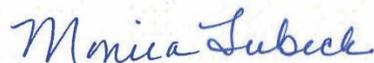
For 1 of 75 sampled inpatient claims, the OIG concluded the Hospital incorrectly billed Medicare for a beneficiary who was incarcerated at the time of admission. The OIG recommended the Hospital refund to the Medicare contractor \$3,143 and the Hospital strengthen controls to ensure full compliance with Medicare requirements.

Hospital Response

We agree with the OIG's findings and have refunded \$3,143 to the Medicare contractor, Wisconsin Physician Services. For many years, the Hospital has had controls in place to assist in the accurate capture of payer information as part of the admission process. These include the use of a dedicated trainer as well as a mentoring/shadowing process for new employees of the admitting department, the use of comprehensive registration forms in the admitting process, and the performance of periodic audits by admitting management of all department personnel. We realize identification of the correct payer for billing purposes can be challenging in situations where patients are transferred from another facility, such as skilled nursing facility or an incarceration facility, and may appear to have more than one payer source. In recognition of this complexity and in response to this finding, focused education was provided to admitting department personnel regarding the identification of the appropriate payer in situations where a Medicare beneficiary is incarcerated at the time of admission.

The University of Kansas Hospital takes these findings and compliance with Medicare billing requirements seriously. We are committed to strengthening our internal controls. If there are questions following the OIG's review of the information provided herein, please let me know so we may respond accordingly.

Sincerely,



Monica Lubeck
Sr. Director Audit and Compliance
Chief Compliance Officer