Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF YALE-NEW HAVEN HOSPITAL FOR 2010 AND 2011

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

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October 2014
A-01-13-00502

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

Yale-New Haven Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately $1.7 million over 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 hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals $148 billion, which represents 43 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 Yale-New Haven Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected 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.

The Hospital is a 1,541-bed acute care hospital located in New Haven, Connecticut. Medicare paid the Hospital approximately $554 million for 29,135 inpatient and 212,915 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered $3,874,659 in Medicare payments to the Hospital for 192 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 144 inpatient and 48 outpatient claims with dates of service in CY 2010 or CY 2011.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 79 of the 192 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 113 claims, resulting in overpayments of $1,708,552 for CYs 2010 and 2011. Specifically, 100 inpatient claims had billing errors, resulting in overpayments of $1,596,312, and 13 outpatient claims had billing errors, resulting in overpayments of $112,240. 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.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor $1,708,552, consisting of $1,596,312 in overpayments for 100 incorrectly billed inpatient claims and $112,240 in overpayments for 13 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

YALE-NEW HAVEN HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital concurred with our findings and recommendations regarding inpatient claims incorrectly billed as separate inpatient stays and incorrectly billed outpatient evaluation and management services. The Hospital also agreed with our findings related to 18 short-stay claims incorrectly billed as inpatient.

However, the Hospital disagreed that it incorrectly billed the remaining 56 short-stay claims that we identified as incorrectly billed as inpatient. The Hospital stated that it plans to appeal those determinations. With regard to the two claims billed with incorrect DRG codes, the Hospital agreed with one determination but disagreed with the other and said it plans to appeal.

The Hospital disagreed with our findings related to inpatient and outpatient claims with unreported medical device credits. The Hospital stated that prior to the commencement of our audit it had already identified incorrectly billed claims involving medical device credits and processed a voluntary refund to its Medicare administrative contractor (MAC).

We maintain that the erroneous claims identified in this report did not comply with Medicare billing requirements. We acknowledge that the Hospital refunded erroneous medical device credit claims; however, it continues to be listed in the report because it reflects our findings and the refund was made after the review began.

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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 hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals $148 billion, which represents 43 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

Our objective was to determine whether Yale-New Haven Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected 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 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, 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.[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 short stays,
- inpatient claims paid greater than charges,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient same-day discharge and readmission,
- inpatient claims billed with high severity level DRG codes, and
- outpatient claims billed with evaluation and management (E&M) services.

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

Medicare payments may not be made for items and 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" (the Social Security Act (the Act), § 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).

Yale-New Haven Hospital

The Hospital is a 1,541-bed acute care hospital located in New Haven, Connecticut. Medicare paid the Hospital approximately $554 million for 29,135 inpatient and 212,915 outpatient claims

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

for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $3,874,659 in Medicare payments to the Hospital for 192 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 144 inpatient and 48 outpatient claims. We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 75 claims to focused medical review to determine whether the services were medically necessary. 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 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 A contains the details of our scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 79 of the 192 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 113 claims, resulting in overpayments of $1,708,552 for CYs 2010 and 2011. Specifically, 100 inpatient claims had billing errors, resulting in overpayments of $1,596,312, and 13 outpatient claims had billing errors, resulting in overpayments of $112,240. 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. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 100 of 144 selected inpatient claims, which resulted in overpayments of $1,596,312.

Incorrectly Billed as Inpatient

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" (the Act, § 1862(a)(1)(A)).

For 74 of the 144 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed either as outpatient or as outpatient with observation services.

The Hospital had limited processes in place during our audit period to review short-stay claims. Hospital officials stated that the Hospital has since implemented an audit process to review all short stays prior to billing. As a result of these errors, the Hospital received overpayments of $1,467,056.[2]

Manufacturer Credits for Replaced Medical Devices 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 device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). Federal regulations state: "All payments to providers of services must be based on the reasonable cost of services …" (42 CFR § 413.9). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code "FD" (chapter 3, § 100.8).

For 20 of the 144 selected claims, the Hospital received reportable medical device credits from manufacturers for replaced devices but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required. The Hospital attributed these errors to gaps in its policies and procedures. As a result of these errors, the Hospital received overpayments of $93,883.

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 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 4 of the 144 selected claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. Hospital officials stated that these errors occurred due to human error. As a result of these errors, the Hospital received overpayments of $28,820.

[2] The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. 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 and adjudicated by the Medicare administrative contractor prior to the issuance of our report.

Incorrectly Billed Diagnosis-Related Group Codes

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" (the Act, § 1862(a)(1)(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 2 of the 144 selected claims, the Hospital billed Medicare for incorrect DRG codes. Hospital officials stated that these errors occurred due to human error. As a result of these errors, the Hospital received overpayments of $6,553.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 13 of 48 selected outpatient claims, which resulted in overpayments of $112,240.

Manufacturer Credits for Replaced Medical Devices 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 the 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). 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.[3]

For 6 of the 48 selected claims, the Hospital received full credit for replaced devices but did not properly report the "FB" modifier and reduced charges on its claims. The Hospital attributed these errors to gaps in its policies and procedures. As a result of these errors, the Hospital received overpayments of $111,725.

Incorrectly Billed Evaluation and Management 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)). The Manual states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure (chapter 12, § 30.6.6(B)).

For 7 of the 48 selected claims, the Hospital incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. Hospital officials stated that these errors occurred

[3] CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

primarily because clinical and coding staff did not follow Medicare requirements for billing E&M services. As a result of these errors, the Hospital received overpayments of $515.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $1,708,552, consisting of $1,596,312 in overpayments for 100 incorrectly billed inpatient claims and $112,240 in overpayments for 13 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

YALE-NEW HAVEN HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital concurred with our findings and recommendations regarding inpatient claims incorrectly billed as separate inpatient stays and incorrectly billed outpatient E&M services. The Hospital also agreed with our findings related to 18 short-stay claims incorrectly billed as inpatient.

However, the Hospital disagreed that it incorrectly billed the remaining 56 short-stay claims that we identified as incorrectly billed as inpatient. The Hospital stated that it plans to appeal those determinations. With regard to the two claims billed with incorrect DRG codes, the Hospital agreed with one determination but disagreed with the other and said it plans an appeal.

The Hospital disagreed with our findings related to inpatient and outpatient claims with unreported medical device credits. The Hospital stated that prior to the commencement of our audit it had already identified incorrectly billed claims involving medical device credits and processed a voluntary refund to its MAC.

We maintain that the erroneous claims identified in this report did not comply with Medicare billing requirements. We acknowledge that the Hospital refunded erroneous medical device credit claims; however, it continues to be listed in the report because it reflects our findings and the refund was made after the review began.

The Hospital also stated that it has developed corrective action plans to address the identified errors for which it is in agreement. We acknowledge the Hospital's efforts to implement stronger controls.

The Hospital's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $3,874,659 in Medicare payments to the Hospital for 192 claims that we judgmentally selected as potentially at risk for billing errors consisting of 144 inpatient and 48 outpatient claims with dates of service in CY 2010 or CY 2011.

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 subjected 75 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient 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.

Our fieldwork included contacting the Hospital in New Haven, Connecticut, from January 2013 through March 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2010 and 2011;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2010 and 2011;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 192 claims (144 inpatient and 48 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected 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 selected claims;

- requested that the Hospital conduct its own review of the selected 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 75 selected 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.

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: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Short Stays	78	$1,550,069	63	$1,297,660
Claims Paid Greater Than Charges	14	191,210	9	151,759
Manufacturer Credits for Replaced Medical Devices	39	1,736,876	20	93,883
Same-Day Discharge and Readmission	4	28,820	4	28,820
Claims Billed With High Severity Level Diagnosis-Related Group Codes	9	96,647	4	24,190
Inpatient Totals	**144**	**$3,603,622**	**100**	**$1,596,312**
Outpatient				
Manufacturer Credits for Replaced Medical Devices	11	$267,946	6	$111,725
Claims Billed With Evaluation and Management Services	37	3,091	7	515
Outpatient Totals	**48**	**$271,037**	**13**	**$112,240**
Inpatient and Outpatient Totals	**192**	**$3,874,659**	**113**	**$1,708,552**

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.

YALE NEW HAVEN HEALTH

July 25, 2014

Mr. David Lamir
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region I
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

RE: Report Number: A-01-13-00502, Medicare Compliance Review of Yale-New Haven Hospital for Calendar Years 2010 and 2011

Dear Mr. Lamir:

We are in receipt of the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled Medicare Compliance Review of Yale-New Haven Hospital for Calendar Years 2010 and 2011. Yale-New Haven Hospital appreciates the opportunity to review and provide comments on this draft report. We are committed to ensuring that our practices comply with regulations and standards governing Federal health care programs, improving internal controls and proactively auditing and monitoring to minimize risks.

The Medicare Compliance Review sampled 192 claims across a variety of inpatient and outpatient areas. The audit concluded that 113 of the 192 claims were billed incorrectly, resulting in overpayments of $1,708,552. The recommendations contained in the report include:

- refunding the Medicare contractor $1,708,552, consisting of $1,596,312 in overpayments for 100 incorrectly billed inpatient claims and $112,240 in overpayments for 13 incorrectly billed outpatient claims, and
- strengthening controls to ensure full compliance with Medicare requirements.

During the audit, Yale-New Haven Hospital provided your office with documentation showing that overpayments totaling $192,283.08 ($80,558.08 inpatient/17 claims and $111,725 outpatient/6 claims) for medical device warranty credits were refunded to NGS on June 7, 2013. Therefore, we request that you take this into consideration and amend the draft report by recalculating the overpayment totals.

Yale-New Haven Hospital takes the OIG findings and recommendations very seriously, agrees with the OIG's findings of error on 32 of the 113 claims, and will make a refund to National Government Services (NGS), our Medicare Administrative Contractor, in the amount of $330,300.81 related to these claim errors.

However, for the remaining claims, Yale-New Haven Hospital disagrees with the OIG's determination that 58 of the 113 claims were billed incorrectly, and we dispute $1,185,968.43 of the total overpayments calculated by the OIG.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Incorrectly Billed as Inpatient

The Hospital agrees with findings on 18 of the inpatient short stay claims and will refund payment of $288,772.29 to NGS.

Yale-New Haven Hospital respectfully disagrees with the OIG findings on 56 of the inpatient short stay claims worth $1,178,284.06. Based on the clinical indications demonstrated by the patient when presenting at the hospital, which are supported by the documentation in the medical record, we believe the physician determination for admission is justified and medically necessary and we will appeal these claims. Furthermore, footnote 2 to the draft Report points out the right of the Hospital to bill under Part B for outpatient payment if the Part A inpatient claim is denied. This should result for some Medicare payment to the Hospital even if the inpatient claim is recovered. The overpayment amount, therefore, appears to be overstated because it does not take into account the payment that would be made under Part B. Even if the OIG did not reverse its findings with respect to the 56 inpatient short stay claims with which the Hospital disagrees, the Hospital respectfully requests that the overpayment be reduced because it does not reflect the amount that the Hospital could recover under Part B billing.

In addition to the pre-bill audit process referenced in the draft report, Yale-New Haven instituted numerous improvements to the utilization review process prior to the start of this audit. The Hospital has increased our physician advisor staff, devoting dedicated physician resources to the utilization review process and 24 hour a day/7 day a week physician advisor coverage. The Hospital also has 24 hour a day/7 day a week utilization review staff in the emergency department. The administration of Yale-New Haven Hospital is committed to ensure that all patients are appropriately designated to inpatient, outpatient, or observation status.

Manufacturer Credits for Replaced Medical Devices Not Reported

The Hospital agrees with findings on 2 of the medical device warranty credits claims and will refund payment of $8,060.33 to NGS.

Yale-New Haven Hospital respectfully disagrees with the OIG findings for 18 of the 20 claims regarding reportable medical device credits. As communicated to the OIG in our letter dated June 18, 2013, Yale-New Haven Hospital conducted a compliance review in 2012 of medical device warranty credits. This review resulted in a voluntary refund on June 7, 2013, to National Government Services (NGS). This refund was completed prior to this audit and the findings from our self-review should not be included as errors discovered by the OIG as a result of this audit. This refund included payment for 17 of the 20 claims, worth $80,558.08. Yale-New Haven Hospital requests that the OIG adjust the inpatient overpayment amount in the draft report from $1,596,312 to $1,515,754.60, to account for the refunds that Yale-New Haven Hospital previously made to NGS.

As a result of the compliance review conducted in 2012, a complete review and revision of all processes was completed with the assistance of an external consultant. The consultant has been engaged with the hospital since January 2013 and continues supporting this work today. The Chief Compliance Officer of the health system implemented a subcommittee including all pertinent departments. Extensive education has been done with each department. Processes have been documented into a procedure checklist and are monitored monthly by the subcommittee. Additionally, the Hospital communicates regularly with the medical device manufacturers and has requested updates to their reports to include more detailed information. Recently, a full time position was approved to support the medical device warranty credit process. We continue to review our processes and improve our controls in this area.

As communicated during the audit process, Yale-New Haven Hospital disagreed with one claim, worth $5,265.00. The patient's medical device was not implanted at Yale-New Haven Hospital so we had no warranty credit to report for this device. Yale-New Haven Hospital intends to exercise its administrative appeal rights should the Centers for Medicare & Medicaid Services (CMS) ultimately decide to request payment refunds related to this claim.

Incorrectly Billed as Separate Inpatient Stays

Yale-New Haven Hospital agrees with the 4 claims referenced in the report and will refund related payment of $28,820.07 to NGS. Prior to the start of this audit, the Hospital's Utilization Management Department began performing daily reviews of a work queue consisting of admissions of patients discharged and readmitted on the same calendar day. The Utilization Management Department notifies the Hospital's Billing Department with the decision to merge or keep the accounts separate. We feel this process improved communication between departments and is working well to prevent future errors.

Incorrectly Billed Diagnosis-Related Group Codes

The Hospital agrees with the finding on one of the incorrectly billed DRG claims and will refund related payment of $4,133.47 to NGS. The Hospital has since implemented the use of PricewaterhouseCooper's (PwC) Systematic Monitoring and Review Technique (SMART) Inpatient tool, which helps analyze coding quality and correct coding errors before bills are submitted. Yale-New Haven Hospital's Health Information Management Department also works with an external vendor to conduct inpatient audits on a quarterly basis and works with PwC SMART on a yearly audit, both of which monitor DRG accuracy.

Yale-New Haven Hospital respectfully disagrees with the OIG finding that the incorrect DRG code was billed on 1 of the 2 incorrectly billed DRG claims, worth $2,419.38. In the draft report, the comment states "Hospital officials stated that these errors occurred due to human error." However, as communicated during the audit process, Yale-New Haven Hospital did not agree that this was a human error and continues to support the accuracy of the original coding because the DRG was based on the patient's presenting symptoms and not on a previously noted chronic condition. Yale-New Haven Hospital intends to exercise its administrative appeal rights should CMS ultimately decide to request payment refunds related to this claim.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Manufacturer Credits for Replaced Medical Devices Not Reported

Yale-New Haven Hospital respectfully disagrees with the OIG findings regarding 6 of the outpatient medical device credit claims. As communicated to the OIG in our letter dated June 18, 2013, Yale-New Haven Hospital conducted a compliance review in 2012 of medical device warranty credits. This review resulted in a voluntary refund on June 7, 2013 to National Government Services (NGS). This refund was completed prior to this audit and the findings from our self-review should not be included as errors discovered by the OIG as a result of this audit. This refund included payment for the 6 outpatient claims mentioned in the draft report, worth $111,725. Yale-New Haven Hospital requests that the OIG adjust the draft report outpatient overpayment amount of $112,240 to $515.00, to account for the refunds that Yale-New Haven Hospital previously made to NGS. Please refer to page 3 for the corrective actions taken in regards to the medical device credit process.

Incorrectly Billed Evaluation and Management Services

Yale-New Haven Hospital agrees with the 7 claims that were incorrectly billed for E&M services and will refund related payment of $515.00 to NGS. The coding staff that reviewed these claims have all been re-educated on the Medicare requirements for E&M services.

CONCLUSION

Yale-New Haven Hospital takes its compliance obligations seriously and is committed to ensuring we are compliant with Medicare billing rules and regulations. The Hospital extends its thanks to the OIG audit team for their cooperation and open communication during the review process. We will continue to educate our staff and conduct auditing and monitoring activities to strengthen and improve our internal controls.

Please do not hesitate to contact me if you have questions or need any additional information.

Sincerely,

Julie Hamilton

Julie Hamilton
Vice President
Chief Compliance and Privacy Officer
Yale New Haven Health System