Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF UNIVERSITY OF TENNESSEE MEDICAL CENTER FOR 2013 AND 2014

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

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Assistant Inspector General
for Audit Services

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Office of Inspector General

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EXECUTIVE SUMMARY

The University of Tennessee Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of at least $41,771 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 were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2014, Medicare paid hospitals $159 billion, which represents 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.

Our objective was to determine whether University of Tennessee 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 under the inpatient prospective payment system. 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 581-bed hospital located in Knoxville, Tennessee. According to CMS's National Claims History data, the Hospital received approximately $207 million for 12,641 inpatient and 93,649 outpatient claims Medicare paid on behalf of beneficiaries during CYs 2013 and 2014.

Our audit covered $13,650,002 in Medicare payments to the Hospital for 1,584 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 236 paid claims with payments totaling $3,348,960. These claims consisted of 117 inpatient and 119 outpatient claims with paid dates during the audit period.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 219 of the 236 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 17 claims, resulting in overpayments of $41,771. Specifically, 3 inpatient claims had billing errors, resulting in overpayments of $14,481, and 14 outpatient claims had billing errors, resulting in overpayments of $27,290.

These overpayments 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.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare program $41,771 in overpayments for the audit period for claims that it incorrectly billed and

- strengthen controls to ensure full compliance with Medicare billing requirements.

UNIVERSITY OF TENNESSEE MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed with our first recommendation and said that it had refunded $41,771 to Medicare. The Hospital also discussed actions that it has taken regarding our second recommendation.

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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 were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2014, Medicare paid hospitals $159 billion, which represents 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

Our objective was to determine whether the University of Tennessee 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 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. 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 and outpatient manufacturer credits for replaced medical devices,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims paid in excess of charges,
- outpatient claims paid in excess of $25,000, and
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day).

For 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, payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 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 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). In addition, the Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

The University of Tennessee Medical Center

The Hospital is a 581-bed hospital located in Knoxville, Tennessee. According to CMS's National Claims History (NCH) data, the Hospital received approximately $207 million for

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

12,641 inpatient and 93,649 outpatient claims Medicare paid on behalf of beneficiaries during CYs 2013 and 2014.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $13,650,002 in Medicare payments to the Hospital for 1,584 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 236 paid claims with payments totaling $3,348,960. These claims consisted of 117 inpatient and 119 outpatient claims with paid dates during the audit period. We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals.

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.

For the details of our audit scope and methodology, see Appendix A.

FINDINGS

The Hospital complied with Medicare billing requirements for 219 of the 236 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 17 claims, resulting in overpayments of $41,771 for the audit period. Specifically, 3 inpatient claims had billing errors, resulting in overpayments of $14,481, and 14 outpatient claims had billing errors, resulting in overpayments of $27,290. These overpayments 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.

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 3 of 117 selected inpatient claims, which resulted in overpayments of $14,481.

Incorrectly Billed Discharge Codes

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 Act, § 1862(a)(1)(A)). A hospital may bill only for services

provided (the Manual, chapter 3, § 10) and must process claims accurately, promptly, and correctly (the Manual, chapter 1, § 80.3.2.2).

For 2 of 117 selected inpatient claims, the Hospital billed Medicare with incorrect discharge codes. The incorrect codes were billed as a result of human error. As a result of these errors, the Hospital received overpayments of $14,056.

Manufacturer Credits for Replaced Medical Devices Not Obtained

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). 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" (the Manual, chapter 3, § 100.8).

The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements in additional detail (Pub. No. 15-1). 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).

For 1 of 117 selected inpatient claims, the Hospital did not seek to minimize its costs for a replaced medical device. Doctors replaced the patient's right atrial lead, which was not suitable for reuse according to medical record documentation. However, the Hospital may have been eligible to receive a replacement lead at no charge. Documentation that the Hospital received from the lead's manufacturer showed that the lead was ineligible for a warranty credit because the Hospital did not return it to the manufacturer for analysis. Therefore, the manufacturer could not perform an analysis to determine whether the device was eligible for a credit. As a result of this error, the Hospital received an overpayment of $425.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 14 of 119 sampled outpatient claims. These errors resulted in overpayments of $27,290.

Incorrectly Billed Claims With Incorrect Codes or Modifier

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 Act, § 1862(a)(1)(A)). Hospitals are required to complete claims

accurately so that Medicare contractors may process them correctly and promptly (the Manual, Pub. No. 100-04, chapter 1, § 80.3.2.2).

The Manual states that "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)" (the Manual, chapter 23, § 20.9).

For 11 of 119 selected outpatient claims, the Hospital submitted claims to Medicare containing incorrect HCPCS codes or improper use of modifier -59. For 3 of the 11 claims, the Hospital stated that the use of incorrect HCPCS codes occurred because of human error. For three additional claims, the medical record did not support the Hospital's use of modifier -59. For the remaining five claims, the Hospital did not provide its coders with adequate guidance on the use of specific HCPCS codes or the use of modifier -59.

As a result of these 11 errors, the Hospital received overpayments of $9,490.

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, 2014, the Manual states when a hospital furnishes a new replacement device received without cost or with a credit of 50 percent or more of the cost of a new replacement from a manufacturer, due to warranty, recall, or field action, the hospital must report the amount of the device credit in the amount portion for value code "FD" and report either condition codes 49 or 50. The Medicare payment is reduced by the amount of the device credit for specified procedure codes reported with value code "FD" (the Manual, chapter 4 § 61.3).

For 3 of 119 selected outpatient claims, the Hospital inappropriately billed Medicare for replaced medical devices. On all three claims, the Hospital received a warranty credit equal to 50 percent or greater of the replacement device invoiced price but did not report the "FD" value or condition code on its claims to Medicare. These errors occurred because the Hospital did not have a process in place for identifying medical device warranty credits. As a result of these three errors, the Hospital received overpayments of $17,800.

OVERALL OVERPAYMENTS

On the basis of our sample results, the Hospital received overpayments of at least $41,771 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program $41,771 in overpayments for the audit period for claims that it incorrectly billed and

- strengthen controls to ensure full compliance with Medicare billing requirements.

UNIVERSITY OF TENNESSEE MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed with our first recommendation and said that it had refunded $41,771 to Medicare. The Hospital also discussed actions that it has taken regarding our second recommendation. The Hospital's corrective actions included: educating staff on choosing the correct discharge code, implementing processes and procedures for seeking manufacturer credit for replaced medical devices, and educating staff on the proper use of modifier -59.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $13,650,002 in Medicare payments to the Hospital for 1,584 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 236 paid claims with payments totaling $3,348,960. These claims consisted of 117 inpatient and 119 outpatient claims that had dates of service during the audit period.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and determined whether services were coded correctly.

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 NCH 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 April and June 2015.

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 NCH file for the audit period;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- randomly selected 236 claims (117 inpatient and 119 outpatient) paid in CYs 2013 and 2014 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;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- reviewed the remittance advices the Hospital provided to determine the charges reimbursed by Medicare;
- 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 the 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 objective.

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was inpatient and outpatient claims paid to the Hospital during CYs 2013 and 2014, for services provided to Medicare beneficiaries.

SAMPLING FRAME

According to CMS's NCH data, Medicare paid the Hospital $125,599,552 for 7,818 inpatient and 24,681 outpatient claims for services Medicare paid on behalf of beneficiaries during the audit period.

Inpatient Claims

According to CMS's NCH data, Medicare paid the Hospital $96,069,599 for 7,818 inpatient claims in 23 high-risk areas.

From these 23 high-risk areas, we selected claims from 3 high-risk areas consisting of 3,645 claims totaling $47,676,443 for further refinement. 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 Medicare issue, but included such procedures as removing claims with certain patient discharge status codes and revenue codes. We also considered such things as certain vulnerable diagnosis codes and procedure codes. We also removed all $0 paid claims, claims under review by the Recovery Audit Contractor as of March 23, 2015, and all duplicated claims within individual high-risk areas.

Our filtering and analysis resulted in a sample frame of 1,005 unique inpatient Medicare claims totaling $10,321,743.

Outpatient Claims

According to CMS's NCH data, Medicare paid the Hospital $29,529,953 for 24,681 outpatient claims in 30 high-risk areas.

From this database, we selected claims from 3 high-risk areas consisting of 5,088 claims totaling $19,137,931 for further refinement. We performed data filtering and analysis of the claims within each of the three high-risk areas. The specific filtering and analysis steps that we performed varied depending on the Medicare issue, but included such procedures as selecting claims with certain vulnerable diagnosis codes and procedure codes. We also removed all $0 paid claims, claims under review by the Recovery Audit Contractor as of March 23, 2015, and all duplicated claims within individual high-risk areas.

Our filtering and analysis resulted in a sample frame of 579 unique outpatient Medicare claims totaling $3,328,259.

Table 1 contains the combined inpatient and outpatient sample frame by risk area.

Table 1: Sample Frame Detail by Risk Area

Stratum	Medicare Risk Area	Number of Claims	Amount of Payments
1	Inpatient Manufacturer Credits for Replaced Devices	17	$415,677
2	Low Dollar Inpatient Claims Billed with High Severity Level DRG Codes	618	4,157,019
3	High Dollar Inpatient Claims Billed with High Severity Level DRG Codes	195	3,670,351
4	Inpatient Claims Paid in Excess of Charges	175	2,078,696
5	Outpatient Claims Paid in Excess of $25,000	69	2,024,469
6	Low Dollar Outpatient Claims Billed with Modifier -59	389	432,604
7	High Dollar Outpatient Claims Billed with Modifier -59	102	546,063
8	Outpatient Manufacturer Credits for Replaced Devices	19	325,123
	Total	**1,584**	**$13,650,002**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample.

SAMPLE SIZE

We randomly selected a sample of 236 claims for review, as shown in Table 2.

Table 2: Sampled Claims

Stratum	Claims in Sample
1	17
2	35
3	35
4	30
5	40
6	30
7	30
8	19
Total Sample	**236**

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 2, 3, 4, 5, 6, and 7. After generating the random numbers for these strata, we selected the corresponding claims in each stratum. We selected all claims in strata 1 and 8.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments paid to the Hospital for the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	17	$415,677	17	$415,677	1	$425
2	618	4,157,019	35	243,628	0	0
3	195	3,670,351	35	650,829	0	0
4	175	2,078,696	30	357,783	2	14,056
5	69	2,024,469	40	1,171,234	0	0
6	389	432,604	30	30,961	3	695
7	102	546,063	30	153,725	8	8,795
8	19	325,123	19	325,123	3	17,800
Total Sample	**1,584**	**$13,650,002**	**236**	**$3,348,960**	**17**	**$41,771**

Table 4: Sample Results

Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	$139,138
Lower Limit	41,771[2]
Upper Limit	$234,054

[2] We set the lower limit to the actual error value identified in the sample.

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Inpatient Manufacturer Credits for Replaced Devices	17	$415,677	1	$425
Low Dollar Inpatient Claims Billed with High Severity Level DRG Codes	35	243,628	0	0
High Dollar Inpatient Claims Billed with High Severity DRG Codes	35	650,829	0	0
Inpatient Claims Paid in Excess of Charges	30	357,783	2	14,056
Inpatient Totals	**117**	**$1,667,917**	**3**	**$14,481**
Outpatient				
Outpatient Claims Paid in Excess of $25,000	40	$1,171,234	0	$0
Low Dollar Outpatient Claims with Bypass Modifiers	30	30,961	3	695
High Dollar Outpatient Claims with Bypass Modifiers	30	153,725	8	8,795
Outpatient Manufacturer Credits for Replaced Devices	19	325,123	3	17,800
Outpatient Totals	**119**	**$1,681,043**	**14**	**$27,290**
Inpatient and Outpatient Totals	**236**	**$3,348,960**	**17**	**$41,771**

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 TENNESSEE MEDICAL CENTER COMMENTS

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Wisdom for Your Life.

June 3, 2016

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

Dear Ms. Pilcher:

On behalf of the University of Tennessee Medical Center ("Hospital"), we appreciate the opportunity to respond to the draft report entitled "Medicare Compliance Review of University Tennessee Medical Center for 2013-2014." We thank you for the guidance you have provided us and the professionalism of the OIG throughout the audit process.

We take compliance very seriously and hope that your audit findings demonstrate our commitment to meet regulatory requirements. It takes a concerted effort from the CEO all the way to the temporary employee to ensure that we model our corporate compliance program every day.

The University of Tennessee Medical Center concurs with the final findings. Below is our response to the specific claims in the report.

1. **Billing Errors Associated with Inpatient Claims.**

   OIG findings: The Hospital incorrectly billed Medicare for 3 of the 117 selected inpatient claims, which resulted in overpayments of $14,481.

   a. Discharge Status Codes
   With respect to these findings, the following corrective actions have been put in place:
   The health unit coordinators on each patient floor input the discharge status code into the computer system for billing purposes.

   The following education has been provided to staff:
   - An individual email has been sent to each health unit coordinator providing the definition of each discharge status code and the importance of choosing the correct code.

The University of Tennessee Medical Center
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- The employee responsible for training new health education coordinators has been given the above training information and a renewed emphasis on this subject has been initiated.
- For cases where case management has been involved, the case manager places the discharge disposition in the Case Management Section of the Depart Notification. The healthcare coordinators have been educated to verify the status here before entering the code.

b. Manufacturer Credits for Replaced Medical Devices Not Obtained.

OIG findings: For 1 of 117 selected inpatient claims, the Hospital did not seek to minimize its costs for a replaced medical device. As a result of this error, the Hospital received an overpayment of $425.

The following procedures and controls have been implemented and are effectively addressing the deficiencies identified in the audit report:

- Pertinent device data (original implant date, serial numbers, reason for explantation, etc.) is collected immediately upon explantation.
- An initial assessment as to the credit eligibility of the device is made, documented, filed with a copy sent along with the manufacturer representative.
- Explanted devices are now tracked, as is the credit eligibility of the device. Contact is made with manufacturers should no information be received about any eligible credits within a reasonable time frame.
- Upon receipt of any credits that are 50-100% of the replacement device invoiced price, the Patient Accounts department is made aware of the receipt and adjusted bills are created to process the credit back to Medicare, utilizing the appropriate value or condition code.
- Files containing the explant information, including credits, are reviewed monthly.

These processes are reviewed for efficiency, effectiveness and adjusted as needed.

2. Billing Errors Associated with Outpatient Claims

a. Manufacturer Credits for Replaced Medical Devices Not Obtained.

OIG Findings: For 3 of the 119 selected outpatient claims, the Hospital inappropriately billed Medicare for replaced medical devices. As a result of these 3 errors, the hospital received overpayments of $17,800.

The following procedures and controls have been implemented and are effectively addressing the deficiencies identified in the audit report:

Please refer to the process described in 1.b. above regarding the steps we are taking to address these issues.

b. Incorrectly Billed Claims with Incorrect Codes or Modifier

OIG Findings: The Hospital incorrectly billed Medicare for 14 of the 119 sampled outpatient claims resulting in an overpayment of $27,290.

The following procedures and controls have been implemented and are effectively addressing the deficiencies identified in the audit report:

- We have initiated mandatory coder education on modifier 59 utilizing our outside training software.
- We modified our internal auditing to place greater emphasis on the use of modifier 59. A more focused review of use of modifier 59 with GI lab procedures is included in the internal auditing emphasis.
- We have hired an external auditing vendor who conducts monthly reviews of inpatient and outpatient coding

As requested, we have refunded $41,771 to our Intermediary for each of the claims at issue.

We again thank you for the opportunity to submit this response. We are proud of our compliance measures and believe the above steps will prevent billing issues in the future. If you have further guidance on these matters, we would be happy to engage in more discussion. Please feel free to contact me by phone or email at any time.

Sincerely,

Cynthia B Marquart

Cynthia B. Marquart
Vice President, Compliance