Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF UNIVERSITY OF CINCINNATI MEDICAL CENTER FOR CALENDAR YEARS 2010 AND 2011

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

Brian P. Ritchie
Assistant Inspector General

June 2014
A-05-12-00080

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

University of Cincinnati Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated net overpayments of at least $9.8 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 certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals $151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

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

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is a 695-bed acute care teaching hospital located in Cincinnati, Ohio. Medicare paid the Hospital approximately $256 million for 16,674 inpatient and 98,043 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered $22,811,691 in Medicare payments to the Hospital for 2,742 claims that were potentially at risk for billing errors. We selected a stratified random sample of 228 claims with payments totaling $3,259,968 for review. These 228 claims had dates of service in CY 2010 or 2011 and consisted of 169 inpatient and 59 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 101 of the 228 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 127 claims, resulting in net overpayments of $603,267 for CYs 2010 and 2011 (audit period). Specifically, 96 inpatient claims had billing errors, resulting in net overpayments of $599,866, and 31 outpatient claims had billing errors, resulting in net

overpayments of $3,401. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received net overpayments totaling at least $9,818,296 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor $9,818,296 (of which $603,267 was net overpayments identified in our sample) in estimated net overpayments for CYs 2010 and 2011 that it incorrectly billed, and

- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF CINCINNATI MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital disagreed with our first recommendation. Concerning our second recommendation, the Hospital discussed steps it had taken or planned to take to strengthen its internal controls to ensure compliance with Medicare billing requirements.

OFFICE OF INSPECTOR GENERAL RESPONSE

After considering the Hospital's comments and supporting schedules, we've adjusted our sample results accordingly to reduce the total number of errors originally reported in our draft report from 128 to 127. We calculated a new statistical estimation and recommend that the Hospital repay the estimated amount of $9,818,296 for CYs 2010 and 2011.

TABLE OF CONTENTS

APPENDIXES

INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals $151 billion, which represents 45 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 University of Cincinnati Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Medicare Program

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

CMS contracts with Medicare Administrative Contractors (MAC) 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. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

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 in excess of charges,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient transfers,
- inpatient psychiatric facility (IPF) emergency department adjustments,
- inpatient claim for blood clotting factor drugs,
- outpatient claims with payments greater than $25,000,
- outpatient claims billed with evaluation and management (E&M) services, and
- outpatient claims billed for Doxorubicin Hydrochloride.

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 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 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)).

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

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).

University of Cincinnati Medical Center

University of Cincinnati Medical Center (the Hospital) is a 695-bed acute care teaching hospital located in Cincinnati, Ohio. Medicare paid the Hospital approximately $256 million for 16,674 inpatient and 98,043 outpatient claims 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 $22,811,691 in Medicare payments to the Hospital for 2,742 claims that were potentially at risk for billing errors. We selected a stratified random sample of 228 claims with payments totaling $3,259,968 for review. These 228 claims had dates of service in CY 2010 or 2011 and consisted of 169 inpatient and 59 outpatient claims.

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 submitted 110 claims to focused medical review to determine whether the services met medical necessity and coding requirements. 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.

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

FINDINGS

The Hospital complied with Medicare billing requirements for 101 of the 228 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 127 claims, resulting in net overpayments of $603,267 for CYs 2010 and 2011 (audit period). Specifically, 96 inpatient claims had billing errors, resulting in net overpayments of $599,866, and 31 outpatient claims[2] had billing errors, resulting in net overpayments of $3,401. 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.

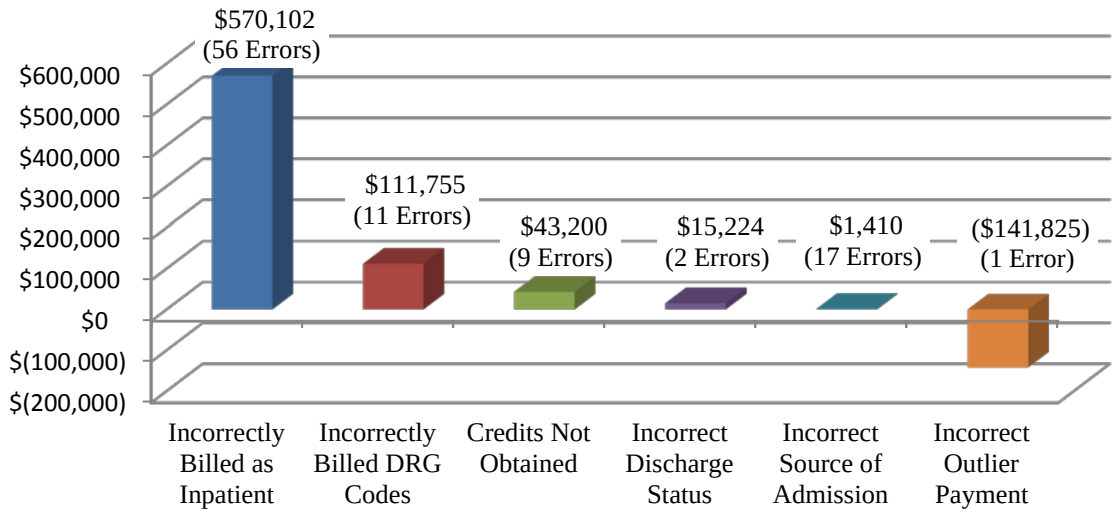
[2] Of the 31 outpatient claims, 2 had errors but no monetary effect.

On the basis of our sample results, we estimated that the Hospital received net overpayments totaling at least $9,818,296 for the audit period. Please 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 96 of 169 sampled inpatient claims, which resulted in net overpayments of $599,866 as shown in Figure 1 below.

Figure 1: Inpatient Billing Errors



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)).

The *Medicare Benefit Policy Manual* states that

> An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.
>
> The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark. . . . (T)he decision to admit a patient is a complex medical judgment which can be made only after the physician has

> considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.
>
> Factors to be considered when making the decision to admit include such things as: 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. (Pub. No. 100-02, chapter 1, § 10).

For 56 of the 169 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services. The Hospital did not have adequate controls in place to ensure that the evaluation and treatment met the Medicare coverage criteria for acute inpatient hospitalization for the incorrectly billed claims. Specifically, for 7 of the 56 claims for which the hospital agreed to, it identified lack of documentation to support the clinical decision of the physician to admit the patient, physician receptiveness to the involvement of RN Case Managers, and interpretation of third party vendor services as weaknesses in existing internal controls. The Hospital has since developed a decision making guide, added a Medical Director to support the case management process, and identified training for RN case managers to strengthen its existing internal controls. As a result of these errors, the Hospital received overpayments of $570,102.[3]

Incorrectly Billed Diagnosis-Related Group Codes

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

For 11 of the 169 sampled claims, the Hospital billed Medicare for an incorrect DRG code. The Hospital agreed that 7 of the 11 were billed in error due to human error. As a result of these errors, the Hospital received overpayments of $111,755.

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

[3] 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. Until these Medicare Part B services are billed by the hospital and adjudicated by the Medicare administrative contractor, we do not have enough information to determine the effect on the overpayment amount. The Hospital should contact its MAC for rebilling instructions.

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).

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).

The PRM further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties (part I, § 2103.A). The PRM provides the following example: "Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment." (part I, § 2103.C.4)

For 9 of the 169 sampled claims, the Hospital did not obtain a credit for a replaced device for which a credit was available under the terms of the manufacturer's warranty. Hospital officials did not concur with our findings citing that we applied an incorrect standard and, therefore, did not assign causes for these errors. The Hospital further stated that device manufacturers bear an equal part of the responsibility for these types of errors. As a result of these errors, the Hospital received overpayments of $43,200.

Incorrect Discharge Status

Hospitals must bill inpatient discharges as transfers when (1) the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge or (2) 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 (b) and (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 2 of the 169 sampled claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers. For these claims, the Hospital should have coded the discharge status either as a transfer to another acute care hospital (1 claim) or to a skilled nursing facility (1 claim). However, the Hospital incorrectly coded the discharge statuses to home; therefore, the Hospital should have received the per diem payment instead of the full DRG. The

Hospital officials stated the errors were isolated, and were due to the medical record documentation either not indicating that the beneficiary was being transferred to another hospital or conflicted with the beneficiary's discharge plan, respectively. As a result of these errors, the Hospital received overpayments of $15,224.

Incorrect Source-of-Admission Code

CMS increases the Federal per diem rate for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department (42 CFR § 412.424). The Manual states that CMS makes this additional payment regardless of whether the beneficiary used emergency department services; however, the IPF should not receive the additional payment if the beneficiary was discharged from the acute care section of the same hospital (chapter 3, § 190.6.4). The Manual also states that IPFs report source-of-admission code "D" to identify patients who have been transferred to the IPF from the same hospital (chapter 3, § 190.6.4.1). An IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 17 of the 169 sampled claims, the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to its IPF upon discharge from its acute care section. Hospital officials stated that the errors were caused by staff misinterpretation of billing requirements for when to report source-of-admission code "D." As a result of these errors, the Hospital received overpayments of $1,410.

Incorrect Charges Resulting in an Incorrect Outlier Payment

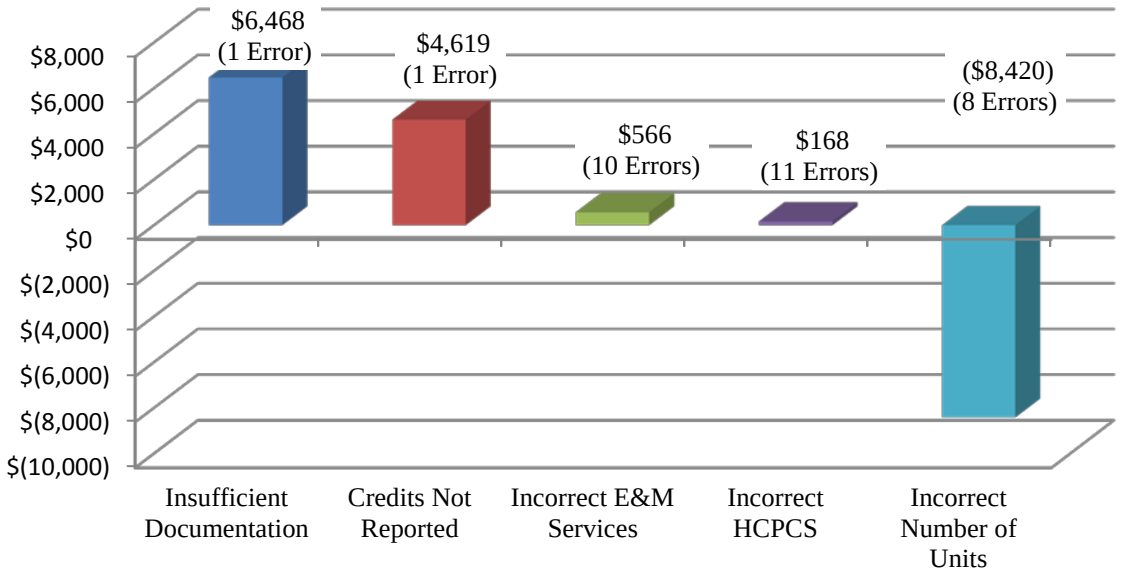
The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(a)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 1 of the 169 sampled claims, the Hospital submitted a claim to Medicare with incorrect charges that resulted in an incorrect outlier payment. Specifically, the Hospital used revenue center code 250 instead of revenue center code 636, which caused the clotting factor charges to be included in the cost outlier computations. Hospital officials stated that an upgrade to its claim scrubber caused an already established system edit to stop working appropriately, thus preventing this claim from being held for manual review. As a result of this error, the Hospital was underpaid $141,825.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 31 of 59 sampled outpatient claims, which resulted in net overpayments of $3,401 as shown in Figure 2 below.

Figure 2: Outpatient Billing Errors



Insufficiently Documented Services

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

For 1 of the 59 sampled claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record. Hospital officials attributed this to an isolated instance of human error. As a result of this error, the Hospital received an overpayment of $6,468.

Manufacturer Credit for a Replaced Medical Device Not Reported

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of 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(a)). 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.[4]

[4] 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). 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 1 of the 59 sampled claims, the Hospital received full credit for a replaced device but did not properly report the "FB" modifier and reduced charges on its claim. Hospital officials stated that the error occurred because the Hospital did not have a process for identifying when a qualifying credit for a replaced device was received and communicating the credit receipt to the appropriate hospital personnel. As a result of this error, the Hospital received an overpayment of $4,619.

Incorrectly Billed Evaluation and Management Services

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 10 of the 59 sampled 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 attributed these errors to either hospital staff insufficiently documenting in the medical record the "reason for visit," coding staff did not always understand the billing requirements for when E&M services are separately billable, or human error. As a result of these errors, the Hospital received overpayments of $566.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

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: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 11 of the 59 sampled claims, the Hospital submitted the claims to Medicare with incorrect HCPCS codes.[5] Hospital officials stated that these errors were primarily attributed to human error. As a result of these errors, the Hospital received overpayments of $168.

Incorrectly Billed Number of Units

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: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2). The Manual also states: "It is … of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug … that was used in the care of the patient" (chapter 17 § 90.2.A). If the provider is billing for a drug, according to the Manual, "[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4…." (chapter 17, § 70).

[5] Of the 11 sampled claims, submitting incorrect HCPCS codes on 2 claims did not create a monetary effect.

For 8 of the 59 sampled claims, the Hospital submitted claims to Medicare with an incorrect number of units for Nplate[6] (Romiplostim) and Doxil[7] (Doxorubicin Hydrochloride). Hospital officials stated that this occurred because of a systemic error within a former billing system that caused an incorrect number of units to be billed. As a result of these errors, the Hospital was underpaid $8,420.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received net overpayments totaling at least $9,818,296 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $9,818,296 (of which $603,267 was net overpayments identified in our sample) in estimated net overpayments for CYs 2010 and 2011 that it incorrectly billed, and

- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF CINCINNATI MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital disagreed with our first recommendation. Concerning our second recommendation, the Hospital discussed steps it had taken or planned to take to strengthen its internal controls to ensure compliance with Medicare billing requirements.

The Hospital's response is included as Appendix E. We excluded supporting schedules from the Hospital's response because it included personally identifiable information. Below is a summary of the Hospital's comments as well as our response to those comments.

Contested Determinations of Claims

Of the 128 claims originally identified in our draft report as being improperly billed, the Hospital agreed with 65 and contested that it improperly billed the remaining 63 claims. The Hospital stated that it will appeal our findings for these 63 claims.

Incorrectly Billed as Inpatient and Incorrectly Billed Diagnosis-Related Group Codes

For 50 of the 63 claims, the Hospital believed that our medical review contractor failed to apply the correct Medicare standard for determining inpatient admission. In addition, the Hospital contended that its due process rights were violated citing that it was denied both an inquiry to the medical review contractor regarding their determinations and a re-review by the medical review contractor

[6] Nplate is a man-made protein used to treat low-blood platelet counts in adults.

[7] Doxil is a drug used in cancer chemotherapy.

based on that inquiry. Finally, the Hospital cited 2 of the 50 contested claims found to be incorrectly billed as inpatient as having inpatient-only procedures and as such could not have been billed as outpatient.

On 4 of the 63 claims, the Hospital does not concur that an incorrect DRG was billed.

Manufacturer Credits for a Replaced Medical Device Not Obtained

For 9 of the 63 claims, the Hospital stated that we incorrectly applied CMS's prudent buyer principles as defined in the PRM to the inpatient medical device credit claims.

Statistical Sampling

The Hospital stated that our use of the phrase "stratified random sample" within our draft report implied that we randomly selected all 228 claims within our sample when, in fact, its understanding is that only a portion of the 228 claims were randomly sampled. The Hospital additionally stated that our use of stratification created a bias toward including claims likely to have overpayments and, by design, judgmentally excluded claims likely to have underpayments.

The Hospital stated that it was never informed of our rationale for using an overall sample size of 228 claims or our rationale for the sample sizes used within the individual strata. The Hospital further believes that the use of such small sample sizes within each stratum increases the risk that even the lower limit of the confidence interval overstates the overpayment amount.

Finally, the Hospital said that our sample frame included several claims that the Recovery Audit Contractor (RAC) had also reviewed and requested that we reconsider the decision to "extrapolate" and modify the recommended recovery accordingly.

OFFICE OF INSPECTOR GENERAL RESPONSE

After considering the Hospital's comments and supporting schedules, we've adjusted our sample results accordingly to reduce the total number of errors originally reported in our draft report from 128 to 127.[8] We calculated a new statistical estimation and recommend that the Hospital repay the estimated amount of $9,818,296 for CYs 2010 and 2011.

[8] We removed claims from our sample frame that, at the time, were under review by the RAC prior to drawing our sample. However, because of timing differences and changes in the Medicare Administrative Contractor's claim control number due to claim adjustments, some claims in both our sample frame and our sample were subsequently identified as being under RAC review. To prevent repaying Medicare twice for claims we audited, we treated each of the RAC claims in our sample as non-errors and calculated a new statistical estimate. By treating these claims as non-errors, we reduced the sample error rate that was statistically applied to the sampling frame.

Contested Determinations of Claims

Incorrectly Billed as Inpatient and Incorrectly Billed Diagnosis-Related Group Codes

We submitted these claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Each case that was denied was reviewed by two clinicians - one of them being a physician. We continue to stand by those determinations. The Hospital maintains its appeal rights. In those instances where the Hospital disagrees with the results, the Hospital should contest these disallowances with the CMS action official, and finally, the last recourse is the appeals process.

Manufacturer Credits for a Replaced Medical Device Not Obtained

Although CMS's prudent buyer principles are discussed in the PRM, which reflects CMS's instructions on preparing cost reports, the principle remains a valid and unambiguous interpretation of Medicare reimbursement policy and specifically, the regulation at 42 CFR § 412.89.

Statistical Sampling

Federal courts have established the use of statistical sampling and estimation as a viable audit technique.[9] Questioning whether the sample could have been more precise or optimal does not indicate that our methodology was invalid.[10] We properly executed our statistical sampling methodology in that we have defined our sampling frame and sample unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and applied the correct formulas for the estimation.

With respect to sample size, the Medicare Program Integrity Manual indicates that it is neither possible nor desirable to specify a minimum sample size that applies to all situations. A challenge to the validity of the sample that is sometimes made is that the particular sample size is too small to yield meaningful results. Such a challenge is without merit as it fails to take into account all of the other factors that are involved in the sample design. As sample sizes decrease so does the estimated overpayment amount at the lower limit of the confidence interval; thus giving the benefit of a smaller sample to the Medicare provider.[11]

Furthermore, our use of statistical sampling by no means removes the Hospital's right to appeal the individual determinations on which the estimation is based through the normal appeals process.[12]

---

[9] Chaves County Home Health Service, Inc. v. Sullivan, 931 F.2d 914 (D.C. Cir. 1991).

[10] Miniet v. Sebelius, No. 10-24127-CIV (S.D. Fla. 2012).

[11] Schuldt Chiropractic Wellness Center v. Sebelius, No. 8:13CV4 (D. Neb. 2014).

[12] Pruchniewski v. Leavitt, No. 08:04-CV-2200-T-23TBM (M.D. Fla 2006).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $22,811,691 in Medicare payments to the Hospital for 2,742 claims that were potentially at risk for billing errors. We selected a stratified random sample of 228 claims with payments totaling $3,259,968 for review. These 228 claims had dates of service in CY 2010 or 2011 (audit period) and consisted of 169 inpatient and 59 outpatient claims.

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 submitted 110 claims to focused medical review to determine whether the services met medical necessity and coding requirements.

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

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

We conducted our fieldwork from November 2012 through July 2013.

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 the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 228 claims (169 inpatient and 59 outpatient) totaling $3,259,968 for detailed review (Appendixes B and C);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;

- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;

- reviewed the Hospital's procedures for submitting Medicare claims;

- used an independent medical review contractor to determine whether 110 sampled claims met medical necessity and coding requirements;

- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;

- calculated the correct payments for those claims requiring adjustments;

- used the results of the sample review to calculate the estimated Medicare overpayments to the Hospital (Appendix C); and

- discussed the results of our review with Hospital officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

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

SAMPLING FRAME

Medicare paid the Hospital $255,595,726 for 16,674 inpatient and 98,043 outpatient claims for services provided to beneficiaries during the audit period based on CMS's National Claims History data.

We downloaded claims from the National Claims History database totaling $148,019,293 for 8,241 inpatient and 26,852 outpatient claims in 19 risk areas. From these 19 areas, we selected 11 consisting of 25,788 claims totaling $96,128,407 for further review.

We performed data analysis of the claims within each of the 11 risk areas. For risk areas one and two, we removed claims with payment amounts less than $3,000.

We then removed the following:

- all $0 paid claims,
- all claims under review by the Recovery Audit Contractor, and
- all duplicated claims within individual risk areas.

We assigned each claim that appeared in multiple risk areas to just one area based on the following hierarchy: Inpatient Manufacturer Credits for Replaced Medical Devices; Inpatient Claims Billed With High-Severity-Level DRG Codes; Inpatient Short Stays, and Inpatient Claims Paid in Excess of Charges. This resulting database contained 2,742 unique Medicare claims in 11 risk areas totaling $22,811,691 from which we drew our sample.

Risk Area	Number of Claims	Amount of Payments
1. Inpatient Short Stays	1,697	$15,000,010
2. Inpatient Claims Billed With High-Severity-Level DRG Codes	469	5,662,392
3. Outpatient Claims Billed With Evaluation and Management Services	498	100,303
4. Inpatient Claims Paid in Excess of Charges	30	925,992
5. Inpatient Psychiatric Facility Emergency Department Adjustments	17	54,583
6. Outpatient Claims With Payments Greater Than $25,000	8	386,698
7. Inpatient Manufacturer Credits for Replaced Medical Devices	9	317,857
8. Outpatient Manufacturer Credits for Replaced Medical Devices	3	37,276
9. Outpatient Claims Billed for Doxorubicin Hydrochloride	8	39,902
10. Inpatient Transfers	2	44,049
11. Inpatient Claims for Blood Clotting Factor Drugs	1	242,629
Total	**2,742**	**$22,811,691**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into 11 strata based on the risk area.

SAMPLE SIZE

We selected 228 claims for review as follows:

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Short Stays	1,697	60
2	Inpatient Claims Billed With High-Severity-Level DRG Codes	469	50
3	Outpatient Claims Billed With Evaluation and Management Services	498	40
4	Inpatient Claims Paid in Excess of Charges	30	30
5	Inpatient Psychiatric Facility Emergency Department Adjustments	17	17
6	Outpatient Claims With Payments Greater Than $25,000	8	8
7	Inpatient Manufacturer Credits for Replaced Medical Devices	9	9
8	Outpatient Manufacturer Credits for Replaced Medical Devices	3	3
9	Outpatient Claims Billed for Doxorubicin Hydrochloride	8	8
10	Inpatient Transfers	2	2
11	Inpatient Claims for Blood Clotting Factor Drugs	1	1
	Total	**2,742**	**228**

SOURCE OF RANDOM NUMBERS

We generated the random numbers with 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 one through three. After generating the random numbers for these strata, we selected the corresponding frame items. We selected all claims in strata 4 through 11.

ESTIMATION METHODOLOGY

We used the OIG/ OAS statistical software to calculate our estimates. We used the lower-limit of the 90-percent confidence interval to estimate the amount of improper Medicare payments in our sampling frame during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Net Over-payments in Sample
1	1,697	$15,000,010	60	$635,352	43	$398,698
2	469	5,662,392	50	567,970	17	130,473
3	498	100,303	40	7,660	20**	674
4*	30	925,992	30	925,992	7	152,686
5*	17	54,583	17	54,583	17	1,410
6*	8	386,698	8	386,698	2	7,344
7*	9	317,857	9	317,857	9	43,200
8*	3	37,276	3	37,276	1	4,619
9*	8	39,902	8	39,902	8	(9,236)
10*	2	44,049	2	44,049	2	15,224
11*	1	242,629	1	242,629	1	(141,825)
Total	**2,742**	**$22,811,691**	**228**	**$3,259,968**	**127**	**$603,267**

***** We reviewed all claims in this stratum.

** Of these 20 incorrectly billed claims, 2 had no monetary effect.

ESTIMATES

Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	$12,582,149
Lower Limit	9,818,296
Upper Limit	15,346,001

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Under/ Over-payments	Value of Net Over-payments
Inpatient				
Short Stays	60***	$635,352	43	$398,698
Claims Paid in Excess of Charges	30	925,992	7	152,686
Claims Billed With High-Severity-Level Diagnosis-Related Group Codes	50***	567,970	17	130,473
Manufacturer Credits for Replaced Medical Devices	9	317,857	9	43,200
Transfers	2	44,049	2	15,224
Psychiatric Facility Emergency Department Adjustments	17	54,583	17	1,410
Claim for Blood Clotting Factor Drugs	1	242,629	1	(141,825)
Inpatient Totals	**169**	**$2,788,432**	**96**	**$599,866**
Outpatient				
Claims With Payments Greater Than $25,000	8	386,698	2	7,344
Manufacturer Credits for Replaced Medical Devices	3	37,276	1	4,619
Claims Billed With Evaluation and Management Services	40	7,660	20**	674
Claims Billed for Doxorubicin Hydrochloride	8	39,902	8	(9,236)
Outpatient Totals	**59**	**$471,536**	**31**	**$3,401**
Inpatient and Outpatient Totals	**228**	**$3,259,968**	**127**	**$603,267**

*** We submitted these claims to a focused medical review to determine whether the services met medical necessity and coding requirements.

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 University of Cincinnati Medical Center. 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.

UC Health

3200 Burnet Ave
Cincinnati, OH 45229
513 585 7600

December 20, 2013

Via FedEx and Electronic Submission via E-Mail

Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

RE: **OIG Draft Report Number A-05-12-00080**
Response of University of Cincinnati Medical Center

Dear Ms. Fulcher:

Please accept this correspondence on behalf of University of Cincinnati Medical Center ("UCMC" or "Hospital") and UC Health, the not-for-profit parent corporation of UCMC. UCMC appreciates the opportunity to provide comments on the U.S. Department of Health and Human Services, Office of the Inspector General ("OIG") draft report entitled *Medicare Compliance Review of University of Cincinnati Medical Center for Calendar Years 2010 and 2011* ("Draft Report"). UCMC is committed to compliance with all regulations and standards governing its participation in Federal health care programs, improving its internal controls, and proactively auditing and monitoring to minimize the risk of errors in the claims UCMC submits to Federal health care programs. We appreciate the opportunity to improve our internal controls and processes afforded by this audit.

UCMC's responses to the OIG's specific findings and recommendations are set forth below. We acknowledge and appreciate the cooperative efforts of the OIG auditors who worked on this audit and the professional and courteous interactions our staff had with the OIG auditors.

OIG Objective, Summary of Findings and Recommendations and UCMC's Comments

OIG Objective

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

OIG Summary of Findings

The Hospital complied with Medicare billing requirements for 100 of the 228 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 128 claims, resulting in net overpayments of $608,342 for CYs 2010 and 2011 (audit period). Specifically, 97 inpatient claims had billing errors, resulting in net overpayments of $604,941,

and 31 outpatient claims had billing errors, resulting in new overpayments of $3,401. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received net overpayments of at least $9,978,054 for the audit period.

OIG Recommendations

We recommend that the Hospital:

- refund to the Medicare contractor $9,978,054 (of which was $608,342 was net overpayments identified in our sample) in estimated net overpayments for CYs 2010 and 2011 that it incorrectly billed, and

- strengthen controls to ensure full compliance with Medicare requirements.

UCMC Comments

UCMC is and always has been committed to operating in compliance with applicable laws and regulations. UCMC will continue to strengthen its internal controls in order to ensure full compliance with Medicare billing requirements. UCMC is committed to accurate submission of claims to the Medicare program and conducts auditing, monitoring, and educational activities on a regular basis on those topics. UCMC will continue to make accurate claim submission a priority in its compliance program.

As an initial matter, we have two technical corrections to the OIG's Draft Report. First, on page 3 of the Draft Report, in the first paragraph in the section entitled "How We Conducted this Review," the OIG states, "We selected a stratified random sample of 228 claims…." However, it is UCMC's understanding that only the sample claims in Risk Areas A-C were randomly selected and that the sample claims in Risk Areas D-K were judgmentally selected.

Second, in Appendix B of the Draft Report, in the section entitled "Sampling Frame," the OIG stated that it removed claims with payment amounts less than $3000 from strata one and two and

> "…then removed the following:
>
> - all $0 paid claims,
> - all claims under review by the Recovery Audit Contractor, and
> - all duplicated claims within individual risk areas."

However, during UCMC's exit conference with the OIG auditors, the OIG also noted that it removed claims where the discharge disposition on the claim was "expired" (discharge disposition code 20) or "left against medical advice or discontinued care" (discharge disposition code 7). In Sample claims B-35 and D-30, the OIG's medical reviewer noted that the beneficiaries left against medical advice, but then denied the claims anyway. These claims should have been removed from the sample. In addition, while

the OIG indicated that it removed all claims under review by the RAC, in stratum 1, our internal audit found 21 of the 1,697 inpatient accounts had previously been audited by the RAC and in stratum 2, our internal audit identified 5 of the 469 inpatient accounts had previously been audited by the RAC. The inclusion of claims that should have been excluded according to the OIG's own description of its sampling process significantly calls into question the validity of the decision to extrapolate and the process undertaken by the OIG to do so.

As set forth below, UCMC contests numerous findings in the OIG's Draft Report as well as the OIG's decision to use extrapolation in this audit. With respect to those identified overpayments which UCMC does not dispute, UCMC will take the appropriate actions to refund any overpayments received, taking into consideration that the total amount refunded may vary based upon factors raised in this response which may impact the actual amount due to the Medicare program. UCMC will work with the OIG, CMS, and the Medicare Administrative Contractor to refund the undisputed overpayments. While UCMC vehemently disagrees with the OIG's findings with respect to a number of the claims in this audit (details set forth below), UCMC takes any findings of potential errors in its Medicare claims very seriously and welcomes the opportunity to improve its processes to ensure continued compliance with applicable laws and regulations.

For the reasons set forth in this response, UCMC strongly opposes the OIG's recommendation that UCMC refund $9,978,054. None of the OIG's findings in the Draft Report allege that UCMC provided or billed Medicare for any medically unnecessary services or for services not rendered. To the contrary, the services provided to the Medicare beneficiaries whose claims were selected for review in this audit were medically necessary and appropriate. The OIG's findings relate to technical requirements for billing Medicare, not to the appropriateness or quality of the services provided by UCMC.

The review that the OIG designed and implemented fails to provide reliable information for the stated objective. The OIG designed a review that judgmentally included claims likely to have overpayments and judgmentally excluded claims likely to have underpayments. Consequently, it is not surprising that upon implementation, the OIG found more claims with overpayments than claims with underpayments. If the OIG had designed and implemented a review that did not have these judgmental biases, then its findings of a total overpayment amount would have been less and might even have presented a total underpayment amount. There is no way to determine the correct amount of overpayments or underpayments for UCMC from the claims that were reviewed.

This judgmental inclusion occurred when the OIG defined groups of claims that it calls strata. As the OIG has acknowledged, each stratum corresponds to a type of claim that it considers likely to have overpayments. The OIG defined no stratum that corresponds to a type of claim that it considers likely to have underpayments. Once the strata were defined in this way, a random selection of claims from within each stratum does not remedy the OIG's bias toward a finding of overpayments. A judgmental selection of claims from within each stratum would have led to the same general finding. As an exacerbating factor, the extrapolation from the sample to the population for each stratum greatly multiplies, in terms of dollars, the biased finding of overpayments.

If the OIG had designed and implemented a review to achieve its stated objective, then it would have defined stratum that allowed for the equally likely inclusion of claims that may have underpayments or overpayments. The OIG cannot conclude whether or not the UCMC complied with Medicare

requirements for billing inpatient and outpatient services on selected types of claims, because it has no information whether such types of claims were present in excluded strata.

Stated less abstractedly, the OIG did not consider whether the UCMC has erred, in an abundance of caution for certain types of claims, by incorrectly submitting and receiving less payment than Medicare should have paid. For example, the OIG did not include in its review claims submitted for outpatient observation services that actually should have been billed as inpatient claims, nor did the OIG include claims submitted as lower-level DRGs that actually should have been billed as higher-level DRGs.

The bias of this particular review by the OIG becomes more apparent when considered over a longer time period of similar reviews. The OIG's continuous approach of judgmentally including claims likely to have overpayments and judgmentally excluding claims likely to have underpayments can induce facilities such as the UCMC to under-submit claims for their services. Given the effectively punitive nature of extrapolation, it may be better for a facility to receive an underpayment for a service by submitting an outpatient observation claim rather than taking the risk of submitting an inpatient claim and having it found, without merit, to be incorrect and used as a basis for an improper, extrapolated overpayment amount. A contribution to this under-submission effect is the implication of the OIG's judgmental selection and multiplicative extrapolation in this review.

We also note that the OIG has never articulated its rationale for using an overall sample size of 228 claims or for the sample sizes in the three individual strata (stratum 1 – 60 claims; stratum 2 – 50 claims; stratum 3 – 40 claims). The OIG's own Self Disclosure Protocol requires that the sample size be at least 100: "The size of the sample reviewed to reach the estimate of the damages. The sample size must be at least 100 claims." (see OIG's Provider Self-Disclosure Protocol, updated April 17, 2013, available at http://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf, page 8 (last accessed December 16, 2013) In addition to being inconsistent with the OIG's own position as to what an appropriate sample size is, the use of such small sample sizes in each stratum increases the risk that even the lower bound of the confidence interval overstates the overpayment amount.

UCMC disagrees with the OIG's findings with respect to a number of the claims the OIG found to have been billed in error and believes that the OIG applied incorrect standards in denying many of the claims in this audit. In addition, for the reasons set forth throughout this response, it is UCMC's position that the decision to extrapolate as well as the actual extrapolation calculation was improper. UCMC respectfully submits that the decision to extrapolate should be reconsidered and the recommended refund modified accordingly.

FINDINGS AND COMMENTS

INPATIENT CLAIMS

Incorrectly Billed as Inpatient

OIG Finding

For 57 of the 169 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services. The Hospital did not have adequate controls in place to ensure that

the evaluation and treatment met Medicare coverage criteria for acute inpatient hospitalization for the incorrectly billed claims. Specifically, for 7 of the 57 claims for which the hospital agreed to, it identified lack of documentation to support the clinical decision of the physician to admit the patient, physician receptiveness to the involvement of RN Case Managers, and interpretation of third party vendor services as weaknesses in existing internal controls. The Hospital has since developed a decision making guide, added a Medical Director to support the case management process, and identified training for RN case managers to strengthen its existing internal controls. As a result of these errors, the Hospital received overpayments of $575,177.

UCMC Comments:

UCMC concurred with the OIG's findings with respect to Sample claims A-2, A-25, A-26, A-28, D-13, D-15, and D-30 that the care could have been provided in an alternate setting. UCMC took a number of steps in order to strengthen its existing internal controls related to this risk area. UCMC required all of its RN Case Managers to attend a webinar training session presented by McKesson regarding the use of InterQual guidelines in order to minimize the variation in interpretation of the InterQual guidelines among the RN case managers. In addition, in order to further minimize the variation in interpretations of the InterQual criteria, the manager of UCMC's Care Management Department is conducting routine audits of the quality of the RN Case Manager reviews and following up with staff on noted variations in order to further improve this process. And recently, to educate UCMC personnel and physicians about Medicare's new rule for determining the appropriateness of inpatient hospital admissions under the new "two midnights" rule, UCMC has: (1) trained case management staff on the new rule; (2) communicated the new rule to all physicians on UCMC's medical staff; (3) made changes to the electronic medical record system and how to clearly document inpatient versus observation status; and (4) presented information about the new rule to business managers and chairs of the departments of UCMC's affiliated physician group.

UCMC also added a Medical Director to support the case management process and to improve physician receptiveness to the involvement of the RN Case Managers. Finally, UCMC developed a policy to guide RN decision-making on when to utilize the services of the third party vendor for the second level physician reviews. That policy was previously provided to the OIG.

We have internally calculated the amount that UCMC should have been paid for the Part B services for Sample claims A-2, A-25, A-26, A-28, D-13, D-15, and D-30 and have refunded to the Medicare Administrative Contractor, CGS, the difference between what UCMC was paid and what UCMC should have been paid for these claims.

UCMC respectfully disagrees with the findings of the OIG and its medical review vendor regarding the following Sample claims: A-1; A-3; A-4; A-5; A-7; A-8; A-9; A-11; A-12; A-13; A-14; A-16; A-17; A-21; A-23; A-24; A-27; A-29; A-31; A-33; A-34; A-36; A-38; A-40; A-42; A-43; A-44; A-45; A-47; A-48; A-49; A-50; A-51; A-53; A-55; A-56; A-57; A-59; A-60; B-6; B-13; B-14; B-16; B-19; B-21; B-28; B-35; B-41; B-44; and B-45. UCMC intends to appeal the denial of these 50 claims. Moreover, we noted that Sample claims A-59 and B-16 included procedures that were on the inpatient-only list and could not have been billed as outpatient services.

Additional UCMC Comments

During the time period relevant to the claims in this audit, the Medicare Benefit Policy Manual, Chapter 1, Section 10, defined "Inpatient"[1] as

> a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark....

There is no mention of or citation to this definition in the Draft Report. Instead, as we pointed out during the exit conference and our response to the OIG's position paper, there is a reference to and quote from the Social Security Act about medical necessity, which reference is both (1) misleading to readers and (2) a mischaracterization of the nature of the errors found by the OIG's vendor. There was no finding of lack of medical necessity in any of the denied claims in this audit; rather, for these 57 claims, the OIG's vendor concluded that the beneficiaries could have been treated as outpatients rather than inpatients. UCMC disputes the OIG's conclusion in the majority of the claims and contends that the Hospital utilized the then-current definition of "inpatient" in determining whether to admit a patient to the hospital. Based on our self-audit, again using the definition in the Medicare Benefit Policy Manual, we found that all but seven of the 57 claims met this definition.

Moreover, based on the information that the OIG did provide UCMC from its medical review vendor, it appears that the OIG's medical review vendor, in making its findings, improperly utilized and relied on information that was not available to UCMC's physicians at the time of the decisions to admit. This is inconsistent with CMS's longstanding policy as articulated in the Medicare Benefit Policy Manual:

> Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, ***QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission***, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.

Medicare Benefit Policy Manual, Internet-Only Manual, Publication 100-02, Chapter 1, Section 10 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf at page 9, last accessed December 2, 2013 (emphasis added)).

[1] This definition of "inpatient" is now obsolete and was replaced with a new definition effective October 1, 2013, that provides, in pertinent part, "Surgical procedures, diagnostic tests, and other treatment are generally appropriate for inpatient admission and inpatient hospital payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights." 42 CFR §412.3(e)(1)

This longstanding policy is reiterated in recent Frequently Asked Questions published by CMS: "CMS' longstanding guidance has been that Medicare review contractors should evaluate the physician's expectation ***based on the information available to the admitting practitioner at the time of the inpatient admission***." (CMS FAQs dated November 4, 2013, available at: http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf (last accessed December 2, 2013) (emphasis added).

Despite this longstanding CMS policy, the document entitled *Medical Professional Reviewer Report* that the OIG provided to UCMC clearly indicates that Maximus Federal Services, Inc., the OIG's medical review vendor, frequently referred to information not available to UCMC's physicians at the time the admission decisions were made. As examples: in Sample claim A-1, the beneficiary had cellulitis and there was a concern about sepsis. The beneficiary's high white blood cell count was treated aggressively with IV antibiotics, and the physician admitted the beneficiary as an inpatient. The Maximus reviewer noted and relied on the fact that blood cultures were negative (a fact not known or available at the time the admission decision was made) to deny the claim. In Sample claim A-4, the beneficiary was transferred to UCMC with syncope, severe headache and blood in spinal fluid, and there was concern about a possible subarachnoid hemorrhage. The repeat lumbar puncture again revealed blood. But the Maximus reviewer denied the claim because later testing ruled out this potential neurologic catastrophe. And in Sample claim A-13, the beneficiary was hypoxic, tachypneic, and hypertensive and was placed on ventilatory support at the time the physician made the admission decision. The beneficiary improved more rapidly than expected, and the Maximus reviewer denied the claim because the next day the "vital signs were stable." These are just three of the many examples we identified where the Maximus reviewer referred to and relied upon information not known by the physician at the time the admission decision was made to deny the claim. This reference to and reliance on information not available to the UCMC physician at the time of the admission decision is inconsistent with CMS's longstanding policy and is improper.

The OIG has not permitted UCMC to discuss or inquire about the findings by the OIG's external medical review vendor regarding these claims. In the OIG's Internal Control Questionnaire, the OIG informed UCMC: "We have provided you with the medical review results for your informational and educational purposes. As such, *there is no mechanism in our medical review contract for re-review*." (emphasis added) As a result, UCMC does not know how the OIG's medical review vendor determined whether a patient was appropriate for inpatient admission or what definition of inpatient was used, and there apparently is no mechanism even for the OIG to request that its vendor re-review a particular claim or to query whether certain information was considered by the medical review vendor in making its determinations. The OIG's decision to contract so narrowly for the services of the medical review vendor so as to prevent any kind of discussion or interaction with the OIG or its vendor substantially and materially impacts UCMC's due process rights and its ability to adequately defend itself in this audit for which the OIG is demanding nearly $10,000,000. Since the vast majority ($8.6 million) of the $9.9 million extrapolated overpayment amount is related to these claims with respect to which UCMC is being denied access to relevant information, we respectfully request that the OIG not extrapolate the overpayment amount from these claims.

By not exercising sufficient control and oversight of its medical review vendor to ensure that CMS policy was adhered to in the review of UCMC claims, we believe that the OIG failed to meet the requirements set forth in the Government Auditing Standards section for quality control:

3.82 Each audit organization performing audits in accordance with GAGAS must:

> a. establish and maintain a system of quality control that is designed to provide the audit organization with *reasonable assurance that the organization and its personnel comply with professional standards and applicable legal and regulatory requirements*….

Government Auditing Standards, 2011 Revision, section 3.82 (emphasis added). The OIG failed to demonstrate that it has a system of quality control in place to ensure that its contracted vendor complied with applicable standards for medical review. Accordingly, the medical review vendor's results are flawed and should not be relied on or adopted by the OIG. The flawed findings also should not be used to estimate an overpayment to the universe of claims as the OIG has proposed to do in its Draft Report. The OIG's failure to ensure the quality control of its subcontracted medical review process and the obvious errors in the medical review vendor's findings certainly call into question the reliability of the OIG's findings in this risk area. At a minimum, this is reason enough to not extrapolate in this risk area from the findings of the medical review vendor.

Extrapolation to the universe of claims is also inappropriate for a number of other reasons. First, since the finding in each claim depends on physician judgment and is very fact-specific to the particular beneficiary at issue, extrapolation is unsuitable for these claims. Second, the OIG has not even calculated the correct amount of the overpayment it alleges that UCMC received for the 57 claims in this risk area. We know for a fact that the individual claim overpayment amounts used in the extrapolation calculation are incorrect because the OIG acknowledged as much in footnote 2 of the Draft Report:

> 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. Until these Medicare Part B services are billed by the hospital and adjudicated by the Medicare administrative contractor, *we do not have enough information to determine the effect on the overpayment amount.* The Hospital should contact its MAC for rebilling instructions.

(emphasis added). The OIG *does not have enough information to determine* the effect of billing Part B on the claims, and yet the OIG proceeded to use the amounts it essentially acknowledges are incorrect in its extrapolation calculation. The gross amount of the overpayment cannot and should not be used. The net amount (i.e., the <u>actual</u> amount) of the overpayment, after offsetting the amount of Part B payments due, must be used in the extrapolation calculation. Interestingly, we note that that the OIG did use the net amount of the overpayment (after calculating what UCMC should have been paid) for the other claims in the audit subject to extrapolation (for example, see Sample claims B-5, B-47, B-50, D-4, D-18, D-22, and D-26, where the OIG determined the claims were not coded properly and only included the payment differential between what UCMC coded and what the OIG determined it should have been coded as in the extrapolation calculation). If the OIG cannot determine how to calculate the Part B amount in order to determine the correct net overpayment for each claim it believes was erroneously billed as inpatient, then, in fairness to UCMC, extrapolation should not be used for these claims. To dismiss the obvious inaccuracy of its enormous extrapolation calculation in a footnote and allow the $9.978 million dollar figure to stand, knowing the "splash" such a number will make in the health care press and the criticism that will be unfairly and improperly directed at UCMC, is unconscionable and demonstrates a lack of integrity, a quality in which the OIG normally prides itself.

This case also is inappropriate for extrapolation because the errors were isolated in nature and did not demonstrate a high and sustained error rate (as required under Section 1893(f)(3) of the Social Security Act, which provides that "a Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise **unless the Secretary determines that … there is a sustained or high level of payment error**…."[2] (emphasis added)). There is also no assertion by the OIG that medically unnecessary services were provided, or that UCMC billed Medicare for services not provided. Rather, the bulk of the $9.978 million extrapolated overpayment amount is based on the OIG's medical review vendor's unreviewable determination that patients were seen in the wrong site of service — that they should have been outpatient instead of inpatient. Medically necessary services were rendered to Medicare beneficiaries during these hospital stays, but the OIG seeks to improperly deny 100% of the payment for those services because its vendor determined that the services could have been provided in an outpatient setting instead. Hindsight is, of course, 20/20, but, as explained above, that is not the standard set forth in the Medicare Benefit Policy Manual under which these claims should have been reviewed and to which UCMC should be held. In all but seven of the claims reviewed, UCMC's determination of inpatient status complied with the Medicare Benefit Policy Manual definition of "inpatient".

Incorrectly Billed Diagnosis-Related Group Codes

OIG Finding

For 11 of the 169 sampled claims, the Hospital billed Medicare for an incorrect DRG code. The Hospital agreed that 7 of the 11 were billed in error due to human error. As a result of these errors, the Hospital received overpayments of $111,755.

UCMC Comments

UCMC concurs with the OIG's findings with respect to the following seven Sample claims: B-5, B-47, B-50, D-4, D-18, D-22, and D-26 and has refunded to the Medicare Administrative Contractor, CGS, the overpayments UCMC received for those seven claims. Since UCMC determined that the probable cause of these seven errors was primarily human error, UCMC is focusing its efforts on training and education of coding staff, specifically on the targeted DRGs where there were errors. In addition, UCMC is increasing the number of cases included in its coding audits and will focus on the specific DRGs involved in these claims in selecting the additional cases to be audited. Furthermore, in October 2012 (after the end of the audit period), UCMC implemented an electronic medical record system, which is helping to improve documentation of care provided in the Hospital. UCMC also has increased its efforts to improve clinical documentation with a new Medical Director, who has oversight for the internal controls for clinical documentation improvement.

UCMC does not concur with the OIG's determination that A-18, B-4, B-20, and B-22 were billed using the incorrect DRG codes. UCMC intends to appeal the denial of those four claims.

[2] While the OIG may argue that it is not a Medicare contractor and that therefore, this section of the Social Security Act is inapplicable, such an argument is without merit since it will be a Medicare contractor, not the OIG, that will be charged with implementing the OIG's recommendation to recoup the extrapolated overpayment. The section of the Social Security Act cited above is, indeed, applicable to this audit, and the OIG has failed to even allege the existence of a high rate of error let alone document any findings that a high rate of error exists before it extrapolated the findings of its sampled claims to a broader universe of claims.

Manufacturer Credits for Replaced Medical Devices Not Obtained

OIG Finding

For 9 of the 169 sampled claims, the Hospital did not obtain a credit for a replaced device for which a credit was available under the terms of the manufacturer's warranty. Hospital officials stated that the errors occurred because it had not established appropriate contacts at the device manufacturers to facilitate communication and sharing of information. The Hospital further stated that device manufacturers bear an equal part of the responsibility for these types of errors. As a result of these errors, the Hospital received overpayments of $43,200.

UCMC Comments

The OIG has mischaracterized UCMC's response regarding the nine inpatient claims in this risk area. UCMC did not concur with the OIG's findings and did not assign causes of errors to the nine claims since UCMC did not agree that errors occurred. UCMC's Internal Control Questionnaire response to the OIG regarding this risk area (covering both inpatient and outpatient claims) was as follows:

> In 9 out of the 10 claims reviewed, [UCMC] complied with the guidance in the Medicare Claim Processing Manual (CMS Pub. 100-04, Sec. 100.8, Replaced Devices Offered Without Cost or With Credit), which does not require the hospital to pursue manufacturers for credits on replaced devices. Medicare policy only requires that hospitals report credits actually received where the credit is more than 50% of the cost of the replacement device.

UCMC did not receive manufacturer credits for replaced medical devices for the nine sampled inpatient claims at issue. The OIG auditors applied an incorrect standard with respect to the nine inpatient medical device credit claims in this audit. The auditors seem to ignore that there is a regulation directly on point, 42 CFR § 412.89, which only requires that the hospital report credits it actually receives for medical devices that fail while under warranty or that are recalled. Instead, the auditors attempt to stretch an inapplicable manual provision involving the prudent buyer principle that is applicable to defining allowable costs for Medicare cost reports in order to create an additional obligation for hospitals, an obligation to affirmatively seek credits and to report credits even if not received, which has no basis in the Medicare regulations or Medicare claim payment guidance. Put more simply, Part I, Section 2102 of The Provider Reimbursement Manual does not apply to claims-based audits and is not applicable in this situation. As explained below, UCMC concurs that in the one outpatient claim where a qualifying credit was received and not reported, it did not comply with the applicable Medicare regulation. UCMC does not concur with the OIG that the nine inpatient claims in this Risk Area were billed in error since UCMC received no credits from manufacturers for replaced devices involved in those claims. UCMC intends to appeal the denial of those nine claims.

Incorrect Discharge Status

OIG Finding

For 2 of the 169 sampled claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers. For these claims, the Hospital should have coded the discharge status either as a transfer to another acute care hospital (1 claim) or to a skilled nursing facility (1 claim).

However, the Hospital incorrectly coded the discharge statuses to home; therefore, the Hospital should have received the per diem payment instead of the full DRG. The Hospital officials stated the errors were isolated, and were due to the medical record documentation either not indicating that the beneficiary was being transferred to another hospital or conflicted with the beneficiary's discharge plan, respectively. As a result of these errors, the Hospital received overpayments of $15,224.

UCMC Comments

UCMC concurs with the OIG's findings with respect to these two sampled claims and has refunded to the Medicare Administrative Contractor, CGS, the associated overpayments UCMC received for those two claims. However, based on our review of the records for the two claims, UCMC determined that both involved unusual situations and were not the result of any failure in UCMC's internal controls. Hospital controls functioned as expected and correct processes were followed. The errors occurred because at the time of the discharge of each of these two beneficiaries, it was not known and the medical record documentation did not indicate that the beneficiaries were going to be transferred to another hospital or sub-acute care setting. In Sample claim J-1, the patient departed UCMC in a privately owned vehicle to return to the beneficiary's home state, where the beneficiary then presented to a local hospital and was admitted. In Sample claim J-2, the medical record documentation was conflicting as to the beneficiary's discharge plan, with the social worker's notes stating that the beneficiary was being transferred to a skilled nursing facility, and the physician's discharge note stating that the beneficiary was being discharged to home.

Incorrect Source-of-Admission Code

OIG Finding

For 17 of the 169 sampled claims, the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to its IPF upon discharge from its acute care section. Hospital officials stated that the errors were caused by staff misinterpretation of billing requirements for when to report source-of-admission code "D". As a result of these errors, the Hospital received overpayments of $1,410.

UCMC Comments

UCMC concurs with the OIG's finding and has refunded to the Medicare Administrative Contractor, CGS, the overpayments UCMC received for those seventeen claims. After this error was identified, UCMC promptly implemented a systemic process to manage the accurate assignment of the source of admission code for beneficiaries who were admitted to UCMC's inpatient psychiatric facility upon discharge from the hospital's acute care setting. Also, UCMC staff was provided education on the proper use of source of admission code "D".

Incorrect Charges Resulting in an Incorrect Outlier Payment

OIG Finding

For 1 of the 169 sampled claims, the Hospital submitted a claim to Medicare with incorrect charges that resulted in an incorrect outlier payment. Specifically, the Hospital used revenue center code 250 instead

of revenue center code 636, which caused the clotting factor charges to be included in the cost outlier computations. Hospital officials stated that an upgrade to its claim scrubber caused an already established system edit to stop working appropriately, thus preventing this claim from being held for manual review. As a result of this error, the Hospital was underpaid $141,825.

UCMC Comments

UCMC concurs with the OIG's finding that UCMC was underpaid for this claim. UCMC corrected the claim scrubber to review accounts with revenue code 636 with HCPCS codes J7190 — J7196 to ensure the correct ICD9 code is used and to verify that the correct number of units has been billed. UCMC's Internal Audit department will conduct an annual audit of claims that include blood clotting factor drugs to verify compliance with Medicare billing rules and the Hospital's own guidelines which are now set forth in a departmental policy that UCMC previously provided to the OIG.

OUTPATIENT CLAIMS

Insufficiently Documented Services

OIG Finding

For 1 of the 59 sampled claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record. Hospital officials attributed this to an isolated instance of human error. As a result of this error, the Hospital received an overpayment of $6,468.

UCMC Comments

UCMC concurs with the OIG's finding and has refunded to the Medicare Administrative Contractor, CGS, the overpayment UCMC received for the claim. In reviewing the one denied claim (Sample claim F-6), we determined that the documentation for services provided on one day (October 28, 2010) of this series account could not be located. We note that among all the items and services reviewed in the 227 claims selected in this audit, this was the only item or service for which no documentation could be located. In July 2012 (after the review period), UCMC implemented its electronic medical record across the full spectrum of outpatient services, drugs and supplies provided to the patient. UCMC believes this implementation has greatly improved its medical record retention (including the maintenance, storage, and retrieval of pharmacy records, which no longer include any hard copy records) and has increased the accuracy and completeness of our medical records. UCMC recently was awarded a Stage 6 (out of 7) designation from HIMSS Analytics Hospital EMR Adoption Model, placing UCMC in the top 10 percent of all hospitals surveyed as a hospital that has achieved significant advancement in our IT environment. With the implementation of its electronic medical record, UCMC has also implemented a quality review of its documentation process.

Manufacturer Credit for a Replaced Medical Device Not Reported

OIG Finding

For 1 of the 59 sampled claims, the Hospital received full credit for a replaced device but did not properly report the "FB" modifier and reduced charges on its claim. Hospital officials stated that the

error occurred because the Hospital did not have a process for identifying when a qualifying credit for a replaced device was received and communicating the credit receipt to the appropriate hospital personnel. As a result of this error, the Hospital received an overpayment of $4,619.

UCMC Comments

UCMC concurs with the OIG's finding and has refunded to the Medicare Administrative Contractor, CGS, the overpayment UCMC received for the claim. As explained above, controls were put in place after this claim was brought to UCMC's attention during this audit. UCMC also implemented a specific charge code to identify eligible devices based on information from the vendor. When credits are received, the claim is corrected if the initial claim has already been submitted. Education has been provided to all departments involved to educate staff about the Medicare requirement and the process UCMC has implemented. UCMC has reached out to the manufacturer whose device was utilized in this claim in order to establish appropriate contacts at the company to facilitate communication and the sharing of information when a beneficiary's medical device is replaced.

Incorrectly Billed Evaluation and Management Services

OIG Finding

For 10 of the 59 sampled 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 attributed these errors to either hospital staff insufficiently documenting in the medical record the "reason for visit," coding staff did not always understand the billing requirements for when E&M services are separately billable, or human error. As a result of these errors, the Hospital received overpayments of $566.

UCMC Comments

UCMC concurs with the OIG's findings and has refunded to the Medicare Administrative Contractor, CGS, the overpayments UCMC received for those ten claims. In July 2012 (after the review period), UCMC implemented its electronic medical record for outpatient services. An edit is built into the EMR to place all E/M codes posted to an account into a work queue for review and correction prior to submission of the claim. E/M levels are audited for appropriateness of the code and level. UCMC has updated the written internal procedure to assist outpatient coders in calculating the E&M level charge. In addition, the coders have received education on how to use the written procedure to calculate the correct E&M level facility charge as well as the documentation required to support each E&M level. Finally, UCMC has conducted additional education for its clinicians on the use of the E&M level facility charge calculator in the EMR system.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

OIG Findings

For 11 of the 59 sampled claims, the Hospital submitted the claims to Medicare with incorrect HCPCS codes. Hospital officials stated that these errors were primarily attributed to human error. As a result of these errors, the Hospital received overpayments of $168.

UCMC Comments

UCMC concurs with the OIG's findings and has refunded to the Medicare Administrative Contractor, CGS, the overpayments UCMC received for those eleven claims. For Sample claims C-10, C-16, C-22, C-25, C-28, C-32, C-35, C-38, C-39, C-40 and I-5, UCMC took the following remedial steps following receipt of the audit results: In July 2012 (after the review period), UCMC implemented its electronic medical record for outpatient services. An edit is built into the electronic medical record to place all E&M codes posted to an account into a work queue for review and correction prior to submission of the claim. E&M levels are audited for appropriateness of the level. UCMC has updated its written internal procedure to help outpatient coders in calculating the E&M level charge. The coders have received education on how to use the written procedure to calculate the correct E&M level facility charge and the documentation required to support each E&M level. UCMC also has conducted education for our clinicians on the use of the E&M level facility charge calculator in our electronic medical record system.

With respect to Sample claim I-5, UCMC took the following actions following the conclusion of this audit: With the implementation of its electronic medical record for outpatient services, UCMC developed and implemented a new process for monitoring revenue-generating departments, including pharmacy. UCMC now does real-time monitoring of revenue and usage

reports in those departments for charge capture reconciliation. UCMC also will conduct periodic audits to ensure that HCPCS code 96417 is being billed properly. Finally, UCMC committed to re-educating its staff responsible for coding these types of claims to ensure they are aware of the Medicare rules for billing HCPCS code 96417.

Incorrectly Billed Number of Units

OIG Findings

For 8 of the 59 sampled claims, the Hospital submitted claims to Medicare with an incorrect number of units for Nplate (Romiplostim) and Doxil (Doxorubicin Hydrochloride). Hospital officials stated that this occurred because of a systemic error within a former billing system that caused an incorrect number of units to be billed. As a result of these errors, the Hospital was underpaid $8,420.

UCMC Comments

UCMC concurs with the OIG's findings. In July 2012 (after the review period), UCMC implemented its electronic medical record across the full spectrum of outpatient services. This implementation has greatly improved UCMC's medical record process (including maintenance, storage and retrieval of records) and has increased the accuracy and completeness of medical records, including without limitation the accuracy of the number of units of drugs administered. With UCMC's new electronic medical record system, its pharmacy system is set up to charge upon administration rather than charge upon dispense. This charge upon administration model has led to improved charge capture accuracy, including increased accuracy in the number of units billed, and improved documentation. UCMC built and implemented a report that monitors the use of HCPCS Codes for drugs for which UCMC has previously been audited as well as other drugs identified by the OIG as being prone to errors. This report is monitored by the pharmacy department to validate accurate use of these HCPCS codes on pre-billed claims. In addition, UCMC's Internal Audit department, to verify compliance with Medicare billing

rules, will conduct an annual audit of drugs for which UCMC has previously been audited as well as other drugs identified by the OIG as being prone to error.

OVERALL ESTIMATE OF OVERPAYMENTS

OIG Finding

On the basis of our sample results, we estimated that the Hospital received net overpayments totaling at least $9,978,054 for the audit period.

OIG Recommendations

We recommend that the Hospital:

- refund to the Medicare contractor $9,978,054 (of which $608,342 was net overpayments identified in our sample) in estimated net overpayments for CYs 2010 and 2011 that it incorrectly billed, and

- strengthen controls to ensure full compliance with Medicare requirements.

UCMC Comments

We are very disappointed and alarmed that the OIG has determined that extrapolation (which is what the OIG has done, despite the OIG's refusal to use that word in conversations with UCMC) is appropriate in this case. For the reasons set forth in detail in this response, it is clear that this is not an appropriate case for extrapolation. First, as we have explained in detail above, the OIG has acknowledged that it is unable to determine the actual amount of the overpayment for 57 of the claims included in the $9,978,054 estimated overpayment amount (i.e., the claims the OIG determined were incorrectly billed as inpatient) since apparently the OIG does not know how to reprocess the claims for Part B payment. The OIG cannot calculate the amount of the extrapolated overpayment without knowing the actual amount UCMC was overpaid for each individual claim in the sample. The OIG's extrapolation calculation has resulted in biased findings that are too large because of a flawed definition of overpayment that did not take into account all offsets for each claim used in the extrapolation calculation. Second, the OIG has made clear to UCMC that UCMC is not permitted to ask questions about the determinations made by the OIG's medical review vendor in denying the 57 claims for having been inappropriately billed as inpatient. The OIG blames an inadequate contract with its vendor. That is not an acceptable reason. UCMC believes that the OIG's medical review vendor failed to apply the correct Medicare definition for determining whether a beneficiary was properly admitted as an inpatient. Since the bulk of the nearly $10,000,000 extrapolated overpayment amount is related to these claims that the OIG's medical review vendor denied and from which UCMC is being denied access to relevant information in violation of its due process rights, we respectfully request that the OIG not extrapolate the overpayment amount from these claims. In addition, UCMC believes that the OIG's medical review vendor considered information that was not available to UCMC's physicians at the time the admission decisions at issue were made, in violation of CMS's longstanding policy. A re-review of the claims utilizing the correct Medicare definition of "inpatient" and considering only the information that the admitting physician had available at the time of the decision to admit would yield a much lower error rate, further demonstrating that extrapolation is inappropriate.

Conclusion

It is important to note here that there are no allegations or findings in the Draft Report that UCMC billed the Medicare program for services not rendered or that UCMC provided services that were not medically necessary, nor are there any allegations or findings that poor quality care or inappropriate care was provided to Medicare beneficiaries. The OIG has taken no exception to the quality of care for the services that generated these claims.

If implemented, the nearly $10 million dollar recoupment will have a devastating effect on UCMC, and its ability to meet its missions. UCMC is the largest provider of Community Benefit in our region, totaling $150.254 million last year, which would be jeopardized by such a recoupment. A $9.978 million dollar recovery from UCMC will divert already scarce resources away from this hospital that are extremely important to the most critical healthcare missions in our community. Given the amount at stake and the devastating effect a recoupment of that magnitude will have on UCMC, UCMC will have no choice but to incur substantial expense and devote significant resources to pursue all of its appeal rights if extrapolation is utilized to estimate an overpayment amount beyond the sampled claims reviewed in this audit. We respectfully request that the OIG reconsider the findings in dispute and not extrapolate the overpayment to the universe of claims. Extrapolation, if permitted, should be postponed until all claims have been fully adjudicated on their merits. It is premature to extrapolate alleged errors at this stage because UCMC intends to contest the findings through the appeals process. The OIG has published that the overturn rate at the qualified independent contractor (QIC) level of appeal (reconsideration) is 72% for Part A denials. (Department of Health and Human Services, Office of Inspector General, "Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals," November 2012, OEI-02-10-00340). Based on this historical data, UCMC fully expects to achieve overturns of the denials in a majority of the cases. This will significantly reduce any alleged overpayment due by UCMC.

Despite the objections above, which UCMC hereby reserves, UCMC recognizes its obligations and reconfirms its commitment to appropriately interpret and bill services and appreciates the opportunity to learn from the items highlighted in the review and will continue to use the outcomes of this audit as a guideline for further process improvement.

If you require any additional information or if I can provide any further assistance, please do not hesitate to contact me.

Sincerely,

/Lee Ann Liska/

Lee Ann Liska
Chief Executive Officer
University of Cincinnati Medical Center

cc: Charles H. Pangburn, III, General Counsel, UC Health