

**JAN 15 2003**

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

CIN: A-01-02-00507

Ms. Deborah Carey Johnson
Chief Operating Officer
Eastern Maine Medical Center
489 State Street
Bangor, Maine 04401

Dear Ms. Johnson:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "*Review of Outlier Payments Made to Eastern Maine Medical Center Under the Outpatient Prospective Payment System for the Period August 1, 2000 Through June 30, 2001*". A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

The HHS action official named below will make the final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS' reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Report Number A-01-02-00507 in all correspondence relating to this report.

Sincerely yours,

Michael J. Armstrong
Regional Inspector General
For Audit Services

Enclosures-as stated

Direct Reply to HHS Action Official:

Lynda Silva, Acting Regional Administrator
Centers for Medicare and Medicaid Services – Region I
U.S. Department of Health and Human Services
John F. Kennedy Federal Building, Room 2325
Boston, MA 02203-0003

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTLIER PAYMENTS
MADE TO EASTERN MAINE MEDICAL
CENTER UNDER THE OUTPATIENT
PROSPECTIVE PAYMENT SYSTEM
FOR THE PERIOD AUGUST 1, 2000
THROUGH JUNE 30, 2001**



JANET REHNQUIST
Inspector General

JANUARY 2003
A01-02-00507

Office of Inspector General

<http://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 OIG's Office of Audit Services (OAS) provides all 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 in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

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 in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

Background

The Balanced Budget Act of 1997 mandated that the Centers for Medicare & Medicaid Services (CMS) implement a Medicare outpatient prospective payment system (OPPS) for hospitals effective August 1, 2000. One of the major provisions of OPPS requires that CMS make an outlier payment to hospitals to cover some of the additional cost of providing care that exceeds established thresholds.

Objective

The objective of our review was to determine whether outpatient claims with outlier payments were billed in accordance with Medicare laws and regulations. Our review included outlier payments valued at \$1,546,891 to Eastern Maine Medical Center (EMMC) for services rendered during the period August 1, 2000 through June 30, 2001.

Results of Review

The claims data submitted by providers must be accurate and supported to ensure proper Medicare reimbursement. We reviewed 33 OPPS claims with outlier payments totaling \$208,250 (13 percent of the total value of outlier payments). We found that EMMC billed the incorrect number of units of services for each one of the reviewed claims. As a result of the billing errors, we determined that EMMC received a net overpayment of \$53,091 for the 33 outlier claims selected for review. Based on our discussion with EMMC, the cause of the errors was attributed to a conversion problem in the hospital's billing system when it implemented OPPS. Accordingly, we believe there is a significant risk that payment errors were made for the remaining outlier payments of \$1,338,641 processed during this period.

Recommendations

We recommend that EMMC: (1) improve its billing controls by ensuring that adjustments to the billing system produce only the desired outcomes; (2) conduct an internal review of all OPPS outlier claims to ensure claims for which units were erroneously changed to one from a multiple of one are resubmitted accurately for dates of service August 1, 2000 through March 31, 2002; and (3) initiate adjustments with its FI to reimburse Medicare the \$53,091 in net overpayments identified through the OIG review and any overpayments identified through EMMC's subsequent internal review.

EMMC's Comments

In its response to our draft report, EMMC agreed with our findings and recommendations.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
OBJECTIVE, SCOPE AND METHODOLOGY	1
FINDINGS AND RECOMMENDATIONS	2
Billing Errors Result in Incorrect Payments	2
System Adjustment Causes Billing Errors	3
Conclusion	3
RECOMMENDATIONS	4
EMMC's Response To Draft Report	4
APPENDIX	

INTRODUCTION

BACKGROUND

The Balanced Budget Act of 1997 (BBA) mandated that the Centers for Medicare and Medicaid Services (CMS) implement a Medicare prospective payment system for hospital outpatient services. As such, CMS implemented the outpatient prospective payment system (OPPS). With the exception of certain services, payment for services under OPPS is now calculated based on grouping services into ambulatory payment classification (APC) groups. Services within an APC are clinically similar and require similar resources. In this respect, some services such as anesthesia, supplies, certain drugs, and the use of operating, recovery and observation rooms are packaged in APCs and not paid separately. The BBA also allowed for the establishment of outlier adjustments, in a budget neutral manner, to ensure “equitable payments”. The OPPS became effective for services provided on or after August 1, 2000.

The Balanced Budget Refinement Act of 1999 (BBRA) further delineated the requirements for outlier payments to hospitals to cover some of the additional cost of providing care that exceed thresholds established by the Secretary. These payments in total can be no more than 2.5 percent of total nationwide program payments for outpatient hospital services for each year before 2004. Outlier payments are determined by: (1) calculating the costs related to the OPPS services on the claim by multiplying the total charges for covered OPPS services by an outpatient cost-to-charge ratio; (2) determining whether these costs exceed 2.5 times the OPPS payments; and (3) if costs exceed 2.5 times the OPPS payments, the outlier payment is calculated as 75 percent of the amount by which the costs exceed the OPPS payments.

Eastern Maine Medical Center (EMMC) is located in Bangor, Maine and has served communities throughout central, eastern, and northern Maine for more than a century. The EMMC had 1,759 outpatient claims with outlier payments of \$1,546,891 for services provided from August 1, 2000 through June 30, 2001.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine whether outpatient claims with outlier payments were billed in accordance with Medicare laws and regulations. Our review included OPPS outlier payments to EMMC for services rendered during the period August 1, 2000 through June 30, 2001.

To accomplish our objective, we:

- Used CMS’s National Claims History file to identify 1,759 paid outpatient claims with outlier payments totaling \$1,546,891 made to EMMC for services rendered during the period August 1, 2000 through June 30, 2001.
- Analyzed each of EMMC’s outlier claims for our audit period to identify high-risk claims, such as those where the outlier payment represented a significant percentage of the total payment of the claim. On this basis, we selected a judgmental sample of 33 claims with outlier payments of \$208,250 out of a total paid amount of \$229,414 for review.

- Held discussions with EMMC’s billing and compliance personnel to obtain an understanding of EMMC’s procedures for accumulating charges, creating outpatient bills, and submitting Medicare claims.
- Utilized medical review staff from the Office of Inspector General (OIG) – Office of Audit Services to review medical records in order to determine whether services were medically necessary and appropriate.

We limited consideration of the internal control structure to those controls concerning the accumulation of charges, the creation of outpatient bills, and the submission of Medicare claims. The objective of our review did not require an understanding or assessment of the complete internal control structure at the hospital.

We conducted our audit during the period of February 2002 through May 2002 at the EMMC in Bangor, Maine and the Boston Regional Office of the OIG. On December 2, 2002, we provided EMMC with a copy of our draft report. The hospital’s written comments are included as an appendix to this report.

FINDINGS AND RECOMMENDATIONS

We reviewed a judgmental sample of 33 OPPS claims with outlier payments totaling \$208,250. For the 33 OPPS claims selected for review, we found that EMMC billed all 33 claims incorrectly resulting in incorrect Medicare reimbursement totaling \$53,091. Based on our discussion with EMMC, the cause of the errors was attributed to a conversion problem in the hospital’s billing system when it implemented OPPS. Accordingly, we believe there is a significant risk that payment errors were made for the remaining outlier payments of \$1,338,641 processed during this period.

Billing Errors Result in Incorrect Payments

For 28 of the 33 selected claims, we determined EMMC received overpayments of \$59,470 because the hospital incorrectly billed the number of units for services and supplies, primarily drugs. For the remaining 5 claims, we determined EMMC was underpaid \$6,379 because the hospital did not receive the APC reimbursement it was entitled to due to incorrectly billed units. For these claims, the reimbursement related to the APCs for the missing units exceeded the excessive outlier payment received.

With respect to drugs and biologicals, Medicare requires providers to bill the number of units that reflects the actual dosage of the drug furnished to the patient. The following example illustrates the effect on the APC and outlier reimbursement due to billing multiple units of drugs as one unit.

- *For 1 claim, EMMC billed for 1 unit of the drug IVIG. For Medicare reimbursement, the administration of a 5-gram dosage of this drug is equivalent to 1 billable unit. The hospital charges for this claim, however, were based on the administration of 30 grams of IVIG. Our review of the medical records substantiated that 30 grams of the drug were provided to the beneficiary. Accordingly, the hospital should have billed for 6 units to properly convert 30 grams of the drug to 6 billable units. As a result of billing multiple units as 1 unit, the hospital received an APC payment of \$272 for the 1 unit of the drug instead of the correct APC payment of \$1,636 for 6 units of the drug. As shown in the calculation below, the*

correct billing of 6 units results in a considerably higher APC payment and, as a result, a significantly reduced outlier payment.

OPPS OUTLIER CALCULATION	Correct Units	Single Units
Total Charges for all OPSS Services:	\$ 13,650	\$ 13,650
OPSS Cost to Charge Ratio	0.58500	0.58500
Adjusted Cost of OPSS Services	\$ 7,985	\$ 7,985
Total APC Payments:	\$ 1,715	\$ 351
2.5 times the APC payments	\$ 4,288	\$ 877
(Adjusted Cost) Less (2.5 x APC Payment)	\$ 3,697	\$ 7,108
Outlier Payment (75% of the difference)	\$ 2,773	\$ 5,331
REIMBURSEMENT CALCULATION		
APC Payment	\$ 1,715	\$ 351
Coinsurance	\$ (241)	\$ (75)
Outlier Payment	\$ 2,773	\$ 5,331
TOTAL PROVIDER REIMB	\$ 4,247	\$ 5,607
Difference	\$ 1,360	

Because payments for OPSS outliers are based on a comparison of the charges for OPSS services to the total APC payments for the claim, the incorrect billing of units results in insufficient APC payments and excessive or unwarranted outlier payments. As shown above, the billing of 1 unit rather than 6 units of the drug IVIG for this claim results in an overpayment of \$1,360 to the hospital.

System Adjustment Causes Billing Errors

Prior to OPSS, EMMC recorded units of service for the use of operating rooms (OR), Revenue Center Code (RCC) 360, based on an interval of 30 minutes per unit and applied its standard OR charge to the number of units to determine total charges. With the start of OPSS, EMMC continued to record OR charges in full, however, the hospital adjusted its automated billing system to convert multiple units of OR service to 1 unit. The system adjustment for recording OR services did not impact OPSS payments because OR services are packaged into APCs rather than paid separately. However, EMMC inadvertently applied the adjustment to all RCC line items containing multiple units, including pass-through drugs that qualify for separate APC payments. Consequently, each time multiple units of drugs were administered the billing system generated the charges based on multiple units but reduced the number of units to 1. Because the calculation of an outlier payment for OPSS is contingent, in part, on the total APC payments for the units billed, understated units could result in excessive or unwarranted outlier payments.

Conclusion

As discussed, we identified a weakness in EMMC's billing controls that resulted in excessive or unwarranted outlier payments to the hospital, particularly for those claims containing pass through drugs. Although our review was limited to a sample of 33 OPSS claims with outlier payments, our analysis of claims and discussions with EMMC officials demonstrated the billing weakness affected all OPSS claims with multiple units. From August 2000 through June 2001, EMMC received payment for 1,759 OPSS claims that included outliers valued at \$1,546,891. Due to the high risk of incorrectly billed claims, we believe additional outlier overpayments have occurred. In addition,

although non-outlier OPPS claims were outside the scope of our review, it is possible these claims also contained billing errors related to the condition stated in our report. If so, EMMC may not have received APC reimbursement to which it is entitled.

RECOMMENDATIONS

We recommend that EMMC:

- Improve its billing controls by ensuring that adjustments to the billing system produce only the desired outcomes.
- Conduct an internal review of all OPPS outlier claims to ensure claims for which the units were erroneously changed to one from a multiple of one are resubmitted accurately for dates of service August 1, 2000 through March 31, 2002.¹
- Initiate adjustments with its FI to reimburse Medicare for: (1) the \$53,091 in net overpayments identified through the OIG review; and (2) any overpayments identified through EMMC's subsequent internal review.

EMMC's Response To Draft Report

The EMMC agreed with our findings and recommendations. Since the error was identified in July 2001, EMMC has enhanced its education for billing personnel to ensure claims are billed properly. The EMMC has also reviewed and rebilled all the selected claims as well as all other claims possibly affected to ensure the appropriate billing. Finally, through the rebilling process, EMMC has ensured the Fiscal Intermediary recovered the \$53,091 in overpayments associated with the selected claims. The full text of EMMC's comments is included as the appendix to this report.

¹ Beginning April 1, 2002, CMS revised calculations for determining outlier reimbursement.

APPENDIX



January 2, 2003

Michael J. Armstrong
Regional Inspector General For Audit Services
Department of Health & Human Services/
Office of Inspector General
Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203

Dear Mr. Armstrong:

Thank you for your recent letter of December 2, 2002 and the draft report entitled "Review of Outlier Payments Made to Eastern Maine Medical Center under the Prospective System for the Period August 1, 2000 Through June 30, 2001". We appreciated the opportunity to participate in this national initiative and agree with the findings and recommendations included in your report.

The major finding of the audit determined that the units of services and supplies, primarily drugs, had been changed from the actual number to a unit of 1. As described in the report, this was an inadvertent extension of the change in billing process incorporated to appropriately charge the units of service for the Operating Rooms.

The error was identified in July 2001 and immediately corrected. Since we had been underpaid on the claim basis, the billing personnel accepted the payment shortfalls. It was not until the Outlier Review that the impact of the error and the understanding of the resultant overpayment was realized.

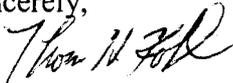
Based on your recommendations, the following actions have taken place:

- ✓ The system error had been corrected in July 2001 and education of billing personnel was enhanced to assure claims processed into the Blast system correspond to Billing and Departmental procedures.

- ✓ All the accounts identified from your office have been reviewed and rebilled as necessary. In addition, an Information System report has been reviewed for all Medicare accounts for the possibility of other accounts being affected. The billing for two devices were identified as inappropriate due to missing passthrough codes and they were also rebilled.
- ✓ Through the rebilling process, the Intermediary has recovered all the overpayments due to include the \$53,091.00 identified in your report.

We appreciate the opportunity to participate in this national initiative to protect the Medicare Trust Fund. Please let us know if there is any further information you need. If you wish to speak to me in person, I can be reached at 207-973-5100.

Sincerely,



Thomas H. Kohl, CPA
Director of Corporate Compliance and Internal Audit for
Eastern Maine Healthcare

THK/amw