

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
FOLLOWUP REVIEW OF
TUFTS MEDICAL CENTER**

*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 2013
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Office of Inspector General

<https://oig.hhs.gov>

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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

Tufts Medical Center did not fully comply with Medicare requirements for billing inpatient services, resulting in overpayments of \$1,086,047 over 2 years.

WHY WE DID THIS REVIEW

A previous Office of Inspector General review found that Tufts Medical Center (Tufts) did not fully comply with Medicare requirements for billing selected inpatient and outpatient claims. The incorrectly billed claims included Medicare Part A inpatient short stays and same-day discharge and readmission claims for calendar years (CY) 2009 and 2010. The previous report did not address audit results for 117 inpatient claims (115 short stays and 2 same day discharge and readmissions) because these claims required further evaluation by medical review personnel. Our current review covers these 117 claims.

The objective of this review was to determine whether Tufts complied with Medicare requirements for billing inpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, intended to be payment in full to Tufts for all inpatient costs associated with the beneficiary's stay.

Tufts is a 415-bed acute care hospital located in Boston, Massachusetts. Medicare paid Tufts approximately \$251 million for 10,752 inpatient and 199,540 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our current audit covered \$1,290,693 in Medicare payments to Tufts for 117 inpatient claims.

WHAT WE FOUND

Tufts complied with Medicare billing requirements for 9 of the 117 inpatient claims we reviewed. However, Tufts did not fully comply with Medicare billing requirements for the remaining 108 claims, resulting in overpayments of \$1,086,047 for CYs 2009 and 2010. Tufts did not provide a cause because it did not agree with these billing errors.

WHAT WE RECOMMEND

We recommend that Tufts:

- refund to the Medicare contractor \$1,086,047 in overpayments for 108 incorrectly billed inpatient claims and

- strengthen controls to ensure full compliance with Medicare requirements.

TUFTS MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Tufts disagreed with our findings and recommendations and stated that it intends to appeal the claims at issue. We maintain the claims did not comply with Medicare billing requirements.

Tufts also stated that it is committed to complying with all regulations and standards governing Federal health care programs, improving internal controls, and proactively auditing and monitoring to minimize the risk of errors.

We acknowledge Tufts' efforts to implement stronger controls.

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INTRODUCTION

WHY WE DID THIS REVIEW

A previous Office of Inspector General review found that Tufts Medical Center (Tufts) did not fully comply with Medicare requirements for billing selected inpatient and outpatient claims.¹ The incorrectly billed claims included Medicare Part A inpatient short stays and same-day discharge and readmissions for calendar years (CY) 2009 and 2010. The previous report did not address audit results for 117 inpatient claims (115 short stays and 2 same day discharge and readmissions) because these claims required further evaluation by medical review personnel. Our current review covers these 117 claims.

OBJECTIVE

Our objective was to determine whether Tufts complied with Medicare requirements for billing inpatient services on selected claims.

BACKGROUND

The Medicare Program

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

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Tufts Medical Center

Tufts is a 415-bed acute care hospital located in Boston, Massachusetts. Medicare paid Tufts approximately \$251 million for 10,752 inpatient and 199,540 outpatient claims for services

¹ In November 2012, we issued a report entitled *Medicare Compliance Review of Tufts Medical Center for Calendar Years 2009 and 2010* (A-01-12-00503).

provided to beneficiaries during CYs 2009 and 2010 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our current review covered \$1,290,693 in Medicare payments to Tufts for 117 Medicare Part A inpatient short stays and same-day discharge and readmissions with dates of service in CYs 2009 and 2010.

We focused our review primarily on inpatient short-stay claims that we identified as a result of our prior OIG review at Tufts. We removed the 115 inpatient claims for short stays and the 2 same-day discharge and readmissions from the previous review because they required further evaluation.

We evaluated compliance with selected billing requirements and subjected all 117 inpatient claims to focused medical review to determine whether the services were medically necessary.

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

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

Appendix A contains the details of our scope and methodology.

FINDINGS

Tufts complied with Medicare billing requirements for 9 of the 117 inpatient claims we reviewed. However, Tufts did not fully comply with Medicare billing requirements for the remaining 108 claims, resulting in overpayments of \$1,086,047 for CYs 2009 and 2010. Tufts did not provide a cause because it did not agree with these billing errors.

For the results of our review by risk area, see Appendix B.

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 Social Security Act (the Act), §1862(a)(1)(A)).

For 107 of the 117 selected claims, Tufts incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Tufts did not provide a cause because it did not agree with these billing errors. As a result of these errors, Tufts received overpayments of \$1,073,970.²

Incorrectly Billed as a Separate Inpatient Stay

The *Medicare Claims Processing Manual* states: “When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim” (chapter 3, § 40.2.5).

For 1 of the 117 selected claims, Tufts billed Medicare separately for a related discharge and readmission within the same day. Tufts did not provide a cause because it did not agree with this billing error. As a result of this error, Tufts received an overpayment of \$12,077.

RECOMMENDATIONS

We recommend that Tufts:

- refund to the Medicare contractor \$1,086,047 in overpayments for 108 incorrectly billed inpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

TUFTS MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Tufts disagreed with our findings and recommendations and stated that it intends to appeal the claims at issue. We maintain the claims did not comply with Medicare billing requirements.

Tufts also stated that it is committed to complying with all regulations and standards governing Federal health care programs, improving internal controls, and proactively auditing and monitoring to minimize the risk of errors.

We acknowledge Tufts’ efforts to implement stronger controls. Tufts’ comments are included in their entirety as Appendix C.

² Tufts Medical Center may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our current review covered \$1,290,693 in Medicare payments to Tufts for 117 Medicare Part A inpatient short stays and same-day discharge and readmissions with dates of service in CYs 2009 and 2010.

We focused our review primarily on inpatient short-stay claims that we identified as a result of our prior OIG review at Tufts. We removed the 115 inpatient claims for short stays and the 2 same-day discharge and readmissions from the previous review because they required further evaluation.

We evaluated compliance with selected billing requirements and subjected all 117 inpatient claims to focused medical review to determine whether the services were medically necessary.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Tufts 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.

Our fieldwork included contacting Tufts, located in Boston, Massachusetts, from November 2012 through February 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Tufts' inpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 117 inpatient claims for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by Tufts to support the selected claims;
- requested that Tufts conduct its own review of the selected claims to determine whether the services were billed correctly;
- used an independent medical review contractor to determine whether all 117 selected claims met medical necessity requirements;
- discussed the incorrectly billed claims with Tufts personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Tufts officials.

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

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Areas	Selected Claims	Value Of Selected Claims	Claims With Over-payments	Value Of Over-payments
Inpatient				
Short Stays	115	\$1,211,801	106	\$1,068,330
Same-Day Discharges and Readmissions	2	\$78,892	2	\$17,717
Inpatient Totals	117	\$1,290,693	108	\$1,086,047

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at Tufts. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX C: TUFTS MEDICAL CENTER COMMENTS

The principal teaching
hospital for Tufts University
School of Medicine



800 Washington Street
Boston, Massachusetts 02111
T 617 636-5000
tuftsmedicalcenter.org

May 3, 2013

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

Report Number: A-01-12-00527

Dear Mr. Lamir:

Tufts Medical Center (the "Hospital") is in receipt of the U.S. Department of Health and Human Services, Office of Inspector General ("OIG") draft report entitled *Medicare Compliance Followup Review of Tufts Medical Center*. The Hospital appreciates the opportunity to provide written comment on the OIG report. The Hospital is committed to complying with all regulations and standards governing Federal health care programs, improving internal controls, and proactively minimizing the risk of error.

The draft report concludes the Hospital did not fully comply with billing requirements for 108 of the 117 reviewed inpatient claims as a result of inadequate controls to prevent incorrect billing of Medicare claims and not fully understanding the Medicare billing requirements related to inpatient short stays. Correspondingly, the OIG recommends the Hospital refund \$1,086,047 to the Medicare contractor, and strengthen controls to ensure full compliance with Medicare program requirements.

The Hospital respectfully disagrees with the OIG findings and recommendations and proffers that for each claim, the physician determination and criteria for admission are supported by the medical record and demonstrate medical necessity. Accordingly, while we reiterate our ongoing commitment to compliance, and our continual initiatives to improve internal controls, the Hospital intends to seek re-determination and appeal the claims at issue.

We sincerely appreciate the opportunity to respond to this draft report and learn from this experience. Please do not hesitate to contact me if you have any further questions or require additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Finkelstein".

Andrew Finkelstein, JD, CCEP
Chief Compliance Officer
Tufts Medical Center