



Region IX
Office of Audit Services
50 United Nations Plaza
Room 171
San Francisco, CA 94102

October 23, 2003
Report Number: A-10-03-00004

Ms. Cathie Furman, RN, MHA
Vice President, Quality and Compliance
Virginia Mason Medical Center
1100 Ninth Avenue, Mail Stop GB-ADM
Seattle, Washington 98111

Dear Ms. Furman:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's report entitled "Review of Medicare Outlier Payments Made to Virginia Mason Medical Center for the period August 1, 2000 through December 31, 2001." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

The objective of our review was to determine whether Virginia Mason Medical Center's outpatient claims with outlier payments were billed to Medicare in accordance with applicable laws and regulations. Our review included Medicare outpatient prospective payment system claims with outlier payments made to Virginia Mason Medical Center for services rendered during the period August 1, 2000 through December 31, 2001.

The Centers for Medicare & Medicaid Services implemented a prospective payment system for hospital outpatient services as required by the Balanced Budget Act of 1997. The Balanced Budget Refinement Act of 1999 established major provisions that affected the development and implementation of an outpatient prospective payment system. One of the provisions required that the Centers for Medicare & Medicaid Services make outlier payments to hospitals to cover some of the additional costs of providing outpatient care that exceeded established thresholds. The outpatient prospective payment system became effective for outpatient services provided on or after August 1, 2000.

Based on our review of 34 selected outpatient prospective payment system claims, we found that Virginia Mason Medical Center incorrectly billed Medicare on 30 claims. The billing errors included both overpayments and underpayments. Twenty-six claims were overpaid by \$55,143 and four claims were underpaid by \$10,512, resulting in a net overpayment of \$44,631.

We recommend that Virginia Mason Medical Center: (1) strengthen its billing procedures and periodically monitor claims to ensure outpatient services are billed to Medicare correctly, (2) resubmit the claims found to be in error to the FI for payment adjustments, and (3) perform an internal review of all outpatient prospective payment system outlier claims for services rendered during the period August 1, 2000 through March 31, 2002 and resubmit the claims to

Page 2 – Ms. Cathie Furman

the FI for adjustments, as applicable. In a written response to our draft report, Virginia Mason Medical Center generally concurred with our findings and recommendations.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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), Office of Inspector General 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-10-03-00004 in all correspondence relating to this report.

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

John Hammarlund, Acting Regional Administrator
Centers for Medicare and Medicaid Services, Region X
Department of Health and Human Services
2201 Sixth Avenue, MS-40
Seattle, Washington, 98121-2500

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE OUTLIER
PAYMENTS MADE TO VIRGINIA
MASON MEDICAL CENTER
FOR THE PERIOD
AUGUST 1, 2000 THROUGH
DECEMBER 31, 2001**



**OCTOBER 2003
A-10-03-00004**

Office of Inspector General

<http://oig.hhs.gov/>

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In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.





Region IX
Office of Audit Services
50 United Nations Plaza
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Report Number: A-10-03-00004

Ms. Cathie Furman, RN, MHA
Vice President, Quality and Compliance
Virginia Mason Medical Center
1100 Ninth Avenue, Mail Stop GB-ADM
Seattle, Washington 98111

Dear Ms. Furman:

This report provides the results of our review of the outpatient prospective payment system (OPPS) claims with Medicare outlier payments made to Virginia Mason Medical Center (the Medical Center), Seattle, Washington, for services provided August 1, 2000 through December 31, 2001.

OBJECTIVE

The objective of our review was to determine whether the Medical Center's outpatient claims with outlier payments were billed to Medicare in accordance with applicable laws and regulations.

SUMMARY OF FINDINGS

Based on our review of 34 selected OPPS claims, we found that the Medical Center incorrectly billed Medicare on 30 claims. Due to the billing errors, the Medical Center was overpaid a net amount of \$44,631. The billing errors occurred because the Medical Center did not correctly implement the OPPS requirements when billing Medicare for outpatient services.

RECOMMENDATIONS

We recommend that the Medical Center: (1) strengthen its billing procedures and periodically monitor claims to ensure outpatient services are billed to Medicare correctly, (2) resubmit the claims found to be in error to the fiscal intermediary (FI) for payment adjustments, and (3) perform an internal review of all OPPS outlier claims for services rendered during the period August 1, 2000 through March 31, 2002¹ and resubmit the claims to the FI for adjustments, as applicable.

¹ Effective April 1, 2002, the Centers for Medicare & Medicaid Services revised its methodology for determining outlier reimbursement.

THE MEDICAL CENTER’S COMMENTS

In a written response to our draft report, the Medical Center generally concurred with our findings and recommendations. The complete text of the Medical Center’s comments is included as an appendix to this report. An attachment provided by the Medical Center to its comments, including suggested revisions to the draft report, is not appended.

INTRODUCTION

BACKGROUND

Medicare Payment Regulations

The Balanced Budget Act of 1997 mandated that the Centers for Medicare & Medicaid Services (CMS) implement a Medicare prospective payment system for hospital outpatient services. As such, CMS implemented the OPSS. With the exception of certain services, CMS calculated payments for services under OPSS by packaging services into Ambulatory Payment Classification (APC) groups. Services within an APC were determined to be clinically similar and required similar resources. In this respect, some services, such as anesthesia, supplies, certain drugs, and use of recovery and observation rooms are packaged in APCs and not paid separately. The OPSS became effective for outpatient services provided on or after August 1, 2000.

The Balanced Budget Refinement Act of 1999 established major provisions that affected the development and implementation of OPSS. One of the provisions required that CMS make outlier payments to hospitals to cover some of the additional costs of providing outpatient care that exceeded established thresholds. Another provision established transitional pass-through payments for certain medical devices, drugs and biologicals by specifying the types of items for which the additional payments must be made. For drugs and biologicals, pass-through payments were determined based on 95 percent of the average wholesale price for the eligible drug or biological. Devices eligible for pass-through payments were reimbursed on the basis of the provider’s charge for the eligible device reduced to cost by use of the hospital’s cost-to-charge ratio.

Hospitals’ Responsibility

Hospitals were required to submit Medicare claims to the FI on standard UB-92 claim forms. Claim information reported by hospitals on the UB-92 needs to be correct to ensure proper and timely Medicare reimbursement. Incorrect data, including incorrect billable units and/or billing devices and drugs which are eligible for pass-through payments as packaged services, may cause the Medicare claims processing system to generate outlier payments that are not warranted.

Virginia Mason Medical Center

The Medical Center, located in Seattle, Washington, was established in 1920 with a vision to provide a single place where patients could receive comprehensive medical care for virtually any medical problem or need. At the time of our audit, the Medical Center was a private, non-profit organization offering a system of integrated health services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether the Medical Center's outpatient claims with outlier payments were billed to Medicare in accordance with applicable laws and regulations.

Scope

Our review included Medicare OPPS claims with outlier payments made to the Medical Center for services rendered during the period August 1, 2000 through December 31, 2001. We limited consideration of the internal control structure to those controls concerning the accumulation of charges, preparation of bills for outpatient services, and submission of Medicare claims. The objective of our review did not require an understanding or assessment of the complete internal control structure at the Medical Center.

Methodology

To accomplish our objective, we:

- Used CMS's National Claims History file to identify 199 Medicare OPPS claims with outlier payments totaling \$1,026,200 made to the Medical Center for services rendered during the period August 1, 2000 through December 31, 2001. For each of the 199 claims, the outlier payment was \$2,000 or more and represented at least 90 percent of the total claim paid amount.
- Selected 35 paid claims from the 199 claims identified based on a risk analysis. For the 35 claims, Medicare payments totaled \$286,160. Of this amount, \$272,891 represented outlier payments. We found that 6 of the 35 claims had been resubmitted to the FI and adjusted. One of the six adjusted claims had been canceled and resubmitted as an inpatient claim. Thus, we reviewed the 34 outpatient claims with the total paid amount of \$279,297.
- Obtained an understanding of the Medical Center's procedures for accumulating charges, preparing outpatient bills, and submitting Medicare claims.

- Obtained supporting billing and medical records for the selected claims from the Medical Center and independently re-priced the claims.
- Utilized assistance from the FI to review some medical records in order to determine whether all the services were billed in accordance with the OPPS provisions.

Our review was conducted in accordance with generally accepted government auditing standards. The audit was performed from January through July 2003 with fieldwork conducted at the Medical Center in Seattle, Washington.

FINDINGS AND RECOMMENDATIONS

Based on our review of the 34 OPPS claims, we found that the Medical Center incorrectly billed Medicare on 30 claims with 38 errors, which included:

- 13 instances in which the Medical Center did not properly bill for drug charges;
- 15 instances in which the Medical Center did not properly bill surgical procedures, chemotherapy infusions and radiology therapies; and
- 10 instances in which the Medical Center did not identify medical devices that required the use of specific HCFA (Health Care Financing Administration) Common Procedure Coding System (HCPCS) codes for proper payment.

The billing errors included both overpayments and underpayments. Twenty-six claims were overpaid by \$55,143 and four claims were underpaid by \$10,512, resulting in a net overpayment of \$44,631². These errors occurred because the Medical Center did not correctly implement the OPPS requirements when billing Medicare for outpatient services.

We recommend that the Medical Center: (1) strengthen its billing procedures and periodically monitor claims to ensure outpatient services are billed to Medicare correctly, (2) resubmit the claims found to be in error to the FI for payment adjustments, and (3) perform an internal review of all OPPS outlier claims for services rendered during the period August 1, 2000 through March 31, 2002³ and resubmit the claims to the FI for adjustments, as applicable.

In a written response to our draft report, the Medical Center generally concurred with our findings and recommendations. The Medical Center's comments are summarized below and included as an appendix to this report. An attachment provided by the Medical Center to its comments, including suggested revisions to the draft report, is not appended.

² Because some claims had multiple errors, we were not able to determine the net effect of the billing errors for each error category.

³ Effective April 1, 2002, CMS revised its methodology for determining outlier reimbursement.

DRUGS BILLED IN ERROR

We found that 13 of the 30 error claims involved instances in which drug dosages dispensed were not accurately converted to billable units. For 10 of the 13 claims, the drugs were billed as packaged services that are required by Medicare to be billed under specific HCPCS. In addition, for 3 claims the HCPCS codes billed were not appropriate for the drugs administered to the patients.

Drug Billed With Incorrect Number of Billable Units

For 13 OPPS claims, the Medical Center incorrectly indicated the number of drug units dispensed when billing Medicare. The billing errors occurred because the Medical Center did not correctly implement the OPPS requirement concerning the number of units to use when billing Medicare for drugs.

Prior to OPPS, the billing unit did not impact the amount paid because the Medicare payment was calculated using billed charges rather than the number of billing units. When OPPS was implemented, Medicare regulations required providers to bill the number of units that reflected the actual dosage of the drug administered to the patient.

For example, on one of the claims reviewed, the Medical Center billed eight vials of Infliximab as one unit. Billing one unit of this drug generated an APC payment of \$54 and an outlier payment of \$4,814. However, for this claim, the Medical Center should have used milligrams as the billing units. The medical records indicated that 800 milligrams was administered. For Medicare reimbursement, the administration of a 10-milligram dosage of Infliximab is equivalent to 1 billable unit. Submitting the claim with the correct number of billing units, 80 units, would have generated an APC payment of \$4,334 and no outlier payment. Thus, understating the billing units on the OPPS claim resulted in an understated APC payment and an unnecessary outlier payment.

Drugs Billed as Packaged Services

For 10 of the 13 OPPS claims, the Medical Center incorrectly billed drugs as packaged services under revenue code center (RCC) 250. Under OPPS, these drugs should have been billed with the appropriate HCPCS codes under RCC 636 and paid as separate APCs. A separate APC payment is not calculated for drugs grouped under RCC 250; however, if the charges exceed the APC payment with which they are associated, an outlier payment may be generated.

For example, the Medical Center billed one unit of the drug Porfimer sodium under RCC 250. However, this drug should have been billed separately with a HCPCS code J9600. Under Medicare OPPS regulations, reimbursement for Porfimer sodium was based on a dosage of 75 milligrams. Based on the medical records, 150 milligrams was administered; thus, 2 units should have been billed. As depicted in the table below, billing the correct number of units of Porfimer sodium with its assigned HCPCS code would have resulted in no outlier payment, and a total payment significantly less than the original payment.

Description	Billed as Packaged (RCC 250)	Billed with HCPCS (RCC 636)
Units Billed	1	2
APC Payment	\$ 41	\$ 4,550
Outlier Payment	\$ 7,390	\$ 0
Total Medicare Payment	\$ 7,431	\$ 4,550

Drugs Billed with Incorrect HCPCS Codes

For three claims in our sample, the Medical Center incorrectly billed inappropriate HCPCS codes for the drugs administered to the beneficiaries.

For example, on one claim, the Medical Center billed one unit of the drug Doxorubicin under HCPCS J9000, which generated an APC payment of \$14 and an outlier payment of \$2,514. However, the medical records indicated that 65 milligrams of the drug Doxil was administered. For Medicare reimbursement, the administration of a 10-milligram dosage of the drug Doxil was equivalent to 1 billable unit and should be billed with HCPCS code J9001. Accordingly, the Medical Center should have billed 7 units under J9001, which would have generated a \$1,908 APC payment for this drug, and no outlier payment. Thus, billing the incorrect HCPCS code and understating the billing units on the OPSS claim resulted in an understated APC payment and an unwarranted outlier payment.

MEDICAL PROCEDURES BILLED IN ERROR

Of 30 incorrectly billed claims, we found 15 instances (claims) in which the Medical Center billed Medicare for medical procedures in error: 9 surgical procedures, 4 chemotherapy infusions and 2 radiology/radiation therapies.

Surgical Procedures

For nine OPSS claims, the Medical Center incorrectly billed the surgical procedures by (1) using incorrect HCPCS codes, and/or (2) not identifying multiple surgical procedures performed with specific HCPCS codes. Medicare requires hospitals to separately identify on the claim each surgical procedure performed with its specific HCPCS code in order to be paid accurately. Under OPSS, many surgical procedures and treatments have individually assigned APCs, which identify payments based on specific treatments provided to the patients. Payment for services under OPSS is calculated based on these APC groups.

Not separately identifying all surgical procedures performed has an effect on the APC and outlier payment. For example, on one claim, the Medical Center billed a HCPCS code for removal of a skin lesion. However, the medical records indicated that a skin split graft and resection of facial tumor were performed on both the left and right sites. Thus, the claim should have included four separate HCPCS codes. Because the Medical Center billed an incorrect HCPCS code and did not separately identify all surgical procedures performed, it received payment of \$4,024, which

included \$262 for an APC payment and \$3,762 for an outlier payment. Correctly billing all surgical procedures performed would have generated a payment of \$2,315, which would include a \$931 APC payment and a \$1,384 outlier payment. As illustrated, the lower APC payment resulted in a higher outlier payment and a total overpayment of \$1,709.

Chemotherapy Infusion

For four OPPS claims, the Medical Center billed inappropriate HCPCS codes and an incorrect number of units for chemotherapy infusions provided to the patients.

For example, on one claim, the Medical Center billed 37 units under HCPCS code Q0081 (infusion therapy using other than chemotherapeutic drugs), which resulted in an \$821 APC payment. However, the medical records supported that chemotherapy by infusion was provided, which should have been billed on a per visit basis under HCPCS Q0084 as required by Medicare. The correct billing of two units under the HCPCS code Q0084 would have resulted in an APC payment of \$84. Thus, overstating the billing units and using an inappropriate HCPCS code resulted in an overstated APC payment. We did not separately quantify the overpayments related to this type of error because these claims contained other type of errors and the nature of the outlier calculation did not support this level of analysis.

Radiation Oncology/Radiology Treatment

For two OPPS claims reviewed, the Medical Center incorrectly understated the number of billing units for the radiation oncology and radiology treatments.

On one claim, the Medical Center billed one unit for radiation treatment delivery and one unit for radiation physics, which resulted in an APC payment of \$94 and an outlier payment of \$3,065. However, the medical records indicated that 14 and 4 services, respectively, were provided; thus, 14 and 4 units should have been billed. Billing the correct number of units would have resulted in an APC payment of \$980 and no outlier payment. The understatement of the billing units resulted in a lower APC payment and a net overpayment of \$2,179.

MEDICAL DEVICES BILLED IN ERROR

For 10 claims reviewed, the Medical Center billed medical devices as packaged services rather than under appropriate HCPCS codes as required by Medicare. In addition, the medical records did not support the medical devices billed on 2 of the 10 claims.

Devices Eligible for Pass-Through Payments

For 10 claims reviewed, the Medical Center billed medical devices as packaged services. However, these devices were eligible for pass-through payments and should have been billed under appropriate HCPCS codes as required by Medicare OPPS regulations. Medical devices such as pacemakers, pulse generators, implantable pumps, and catheters were commonly billed in this manner.

For one claim, the Medical Center billed \$34,573 for three medical devices (one pacemaker and two pacemaker leads) as packaged services. Under Medicare regulations, these devices were assigned specific HCPCS codes and were eligible for additional pass-through payments. The table below illustrates the impact on the Medicare payment amounts when the medical devices eligible for pass-through payment were billed as packaged services.

Description	Billed as Packaged	Billed with HCPCS Codes
APC Payment	\$ 1,778	\$ 1,778
Pass-Through Payment	\$ 0	\$30,249
Outlier Payment	\$25,501	\$ 0
Total Medicare Payment	\$27,279	\$32,027

As depicted in the table above, incorrectly billing the assigned HCPCS-coded devices as packaged services resulted in an unwarranted outlier payment and no pass-through payment. Consequently, the Medical Center was underpaid \$4,748 on this claim.

Devices Not Supported by Medical Records

For 2 of the 10 claims, the medical records did not support the distribution of medical devices that were billed as packaged services on the Medicare claims. The Medical Center indicated that, based on its internal review, the devices were not implanted and should not have been billed. Because these two claims had other types of billing errors, we were not able to determine the impact on the pass-through and outlier payments specific to this billing error.

RECOMMENDATIONS

We recommend that the Medical Center:

- Strengthen its billing procedures and periodically monitor claims to ensure outpatient services are billed to Medicare correctly.
- Resubmit the claims found to be in error to the FI for payment adjustments.
- Perform an internal review of all OPPS outlier claims for services rendered during period August 1, 2000 through March 31, 2002, focusing on the billing deficiencies identified in this report, and resubmit the claims to the FI for adjustments, as applicable.

THE MEDICAL CENTER’S COMMENTS AND OIG RESPONSE

The Medical Center’s Comments

In a letter dated August 21, 2003, the Medical Center concurred with our recommendations by indicating that it (1) is developing a monitoring system for claims and remittances in the outpatient billing processes, (2) has resubmitted to the fiscal intermediary the 30 claims billed

incorrectly, and (3) is initiating review of its OPPS outlier claims. In addition, the Medical Center indicated that (1) many of the issues identified in the audit are attributable to or were compounded in part by frequent changes in the OPPS requirements imposed by CMS, and (2) the implementation of OPPS was a significant operational challenge.

The complete text of the Medical Center's comments is included as an appendix to this report. An attachment provided by the Medical Center to its comments, including suggested revisions to the draft report, is not appended.

OIG Response

We acknowledge that the OPPS was a new system during the period we reviewed and a learning process was taking place for both providers and intermediaries. As part of our auditing function, we review new HHS systems to identify vulnerabilities. Our findings are reported to enhance efforts for system and program improvements.

* * * * *

To facilitate identification, please refer to report number A-10-03-00004 in all correspondence relating to this report.

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

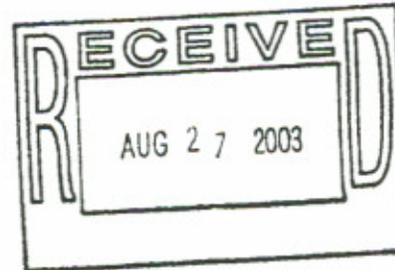
APPENDIX

VIRGINIA
MASON

Medical Center

August 21, 2003

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health and Human Services
Region IX
50 United Nations Plaza, Room 171
San Francisco, CA 94102



RE: Response to Medicare Outlier Payment Report Number: A-10-03-00004

Dear Ms. Ahlstrand:

We have reviewed the Office of Inspector General (OIG) draft audit report entitled "Review of Medicare Outlier Payments Made to Virginia Mason Medical Center for the period August 1, 2000 through December 31, 2001", under the outpatient prospective payment system (OPPS). Virginia Mason Medical Center (VMMC) appreciates the opportunity to respond to this report.

I. Background and Proposed Revisions

The purpose of the OIG audit was to review a limited number of VMMC's OPPS outlier claims. For purposes of the audit, the OIG selected a small nonrandom sample designed specifically to capture high outlier payment claims. More specifically, the auditors initially reviewed the CMS' National Claims History file to identify 199 Medicare OPPS claims with outlier payments totaling \$1,026,200. For each of the 199 claims, the outlier payment was \$2,000 or more and represented at least 90 percent of the total claim paid amount. From these 199 claims, 35 paid claims were selected. For the 35 claims, Medicare payments totaled \$286,160. One claim was subsequently cancelled and resubmitted as inpatient. Of the 34 remaining OPPS claims, payments and outlier payments totaled \$279,297 and \$272,891 respectively. According to the report, 4 claims were paid correctly, 4 claims were underpaid by \$10,512, and 26 claims were overpaid by \$55,143 for a net overpayment of \$44,634. As of August 14, 2003, VMMC adjusted the 30 claims involving both overpayments and underpayments and resubmitted the claims to the intermediary for reprocessing.

VMMC worked closely with the OIG during its review of the initial 34 claims and intends to continue to diligently address the issues identified by the government. Many of the issues identified in the audit, however, are attributable to or were compounded in part by frequent changes in the OPPS billing requirements imposed by CMS. Most would agree that the implementation of the OPPS system was a significant operational challenge for both the government and the provider community.

In light of the OIG's approach to this audit, the time period it covers, and the magnitude of the changes required to implement OPSS, VMMC has reviewed the Summary of Findings and other sections of the draft audit report. We believe the language in the draft report fails to put the findings in an appropriate context. We have drafted revisions to the draft report to address our concerns. A redlined version of the audit report highlighting VMMC's suggested revisions is attached.

II. Recommendations and Corrective Action

Based on the audit results, the OIG recommends that VMMC

(A) strengthen its billing procedures and periodically monitor claims for payment;

(B) resubmit the 30 claims billed incorrectly; and

(C) review all OPSS outlier claims for services 8/1/00 through 3/31/02 and resubmit claims found to be incorrect to the Fiscal Intermediary (FI) for adjustments.

VMMC will abide by the OIG's recommendations in the audit report. Some of the corrective action was initiated unilaterally by VMMC prior to the audit while other measures are being diligently pursued.

Steps taken by VMMC prior to the audit include:

- In April 2002, system updates were made to improve VMMC's ability to correctly bill the units of drugs it administers to its patients.
- The frequency of routine reviews and updates to the charge description master increased from annually to quarterly in April 2002 to improve compliance with the Medicare OPSS guidelines.

Actions currently under way include:

- VMMC is developing a monitoring system for claims and remittances in the outpatient audit/billing/payment processes and considering additional enhancements to the maintenance of its charge description master.
- VMMC has resubmitted to the Fiscal Intermediary, Premera Blue Cross, the 30 claims identified in the draft audit report. In connection with the resubmission of these claims, VMMC is working with Premera to facilitate reprocessing, answer questions and gather further information about OPSS billing procedures.
- VMMC is initiating a review of its OPSS outlier claims for the period 8/1/00 to 8/31/02. Claims determined to be incorrect will be resubmitted to the FI.

- VMMC is engaged in discussions with Premera to resolve OPPS outlier payment discrepancies for claims submitted during the specified time period. Initial data to be used to identify the question has been produced.

Again, Virginia Mason Medical Center appreciates the opportunity to respond to the OIG draft audit report and is committed to compliance with Medicare billing rules and regulations. If I can be of further assistance, please do not hesitate to contact me by phone at 206-223-6182 or by email at Cathie.Furman@vmmc.org.

Sincerely,



Cathie Furman
Vice-President, Quality and Compliance
Virginia Mason Medical Center

Attachment

Cc: Bill Poppy, Sr. Vice-President, Virginia Mason Medical Center
Craig Goodrich, Vice-President, Chief Financial Officer

ACKNOWLEDGMENTS

This report was prepared under the direction of Lori A. Ahlstrand, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Jerry McGee, *Audit Manager*
Danuta Biernat, *Senior Auditor*
Bernard Urabe, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.