

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
OREGON HEALTH & SCIENCE  
UNIVERSITY FOR 2010 THROUGH 2012**

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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*Oregon Health & Science University did not fully comply with Medicare requirements for billing inpatient services, resulting in overpayments of approximately \$2.4 million over 3 years.*

### WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represented 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

Our objective was to determine whether Oregon Health & Science University (OHSU) complied with Medicare requirements for billing inpatient and outpatient 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 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.

OHSU is a 572-bed acute-care hospital located in Portland, Oregon. Medicare paid OHSU approximately \$504 million for 24,249 inpatient and 390,167 outpatient claims for services provided to beneficiaries during CYs 2010 through 2012.

Our audit covered \$3,506,361 in Medicare payments to OHSU for 113 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service during CY 2010, CY 2011, or CY 2012 and consisted of 102 inpatient and 11 outpatient claims.

### WHAT WE FOUND

OHSU complied with Medicare billing requirements for 45 of the 102 inpatient claims and all 11 of the outpatient claims we reviewed. However, OHSU did not fully comply with Medicare billing requirements for 57 inpatient claims, resulting in overpayments of \$2,419,351 for CYs 2010 through 2012. These billing errors occurred primarily because OHSU did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

## **WHAT WE RECOMMEND**

We recommend that OHSU:

- refund to the Medicare contractor \$2,419,351 in overpayments for the 57 incorrectly billed inpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

## **OREGON HEALTH & SCIENCE UNIVERSITY COMMENTS**

In written comments on our draft report, OHSU agreed with our finding and recommendations and provided information on actions that it had taken to address our recommendations.

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## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represented 43 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 Oregon Health & Science University (OHSU) complied with Medicare requirements for billing inpatient and outpatient 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. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

#### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group services within

each APC group.<sup>1</sup> 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, and
- outpatient claims paid in excess of charges.

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, payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)).

Federal regulations state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

### **Oregon Health & Science University**

OHSU is a 572-bed acute-care hospital located in Portland, Oregon. Medicare paid OHSU approximately \$504 million for 24,249 inpatient and 390,167 outpatient claims for services provided to beneficiaries during CYs 2010 through 2012.<sup>2</sup>

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<sup>1</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

<sup>2</sup> These data came from CMS’s National Claims History file.

## **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$3,506,361 in Medicare payments to OHSU for 113 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service during CY 2010, CY 2011, or CY 2012 and consisted of 102 inpatient and 11 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 subjected 22 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 OHSU for Medicare reimbursement.

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

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

## **FINDING**

OHSU complied with Medicare billing requirements for 45 of the 102 inpatient claims and all 11 of the outpatient claims we reviewed. However, OHSU did not fully comply with Medicare billing requirements for 57 inpatient claims, resulting in overpayments of \$2,419,351 for CYs 2010 through 2012. These billing errors occurred primarily because OHSU did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

### **INCORRECT BILLING OF MEDICARE PART A FOR BENEFICIARY STAYS THAT SHOULD HAVE BEEN BILLED AS OUTPATIENT OR OUTPATIENT WITH OBSERVATION SERVICES**

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)).

For 57 of 102 selected inpatient claims, OHSU incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. Of the 57 claims, 21 claims related to bone marrow and peripheral blood stem cell transplantation, accounting for 77 percent of the total overpayments. OHSU attributed these patient admission errors primarily to OHSU staff’s reliance on screening tools used during the audit period that indicated that stem cell transplants were appropriate for inpatient admission; however, these tools did not make a distinction between a full stem cell transplant and a reduced-intensity transplant. Consequently, OHSU staff believed that an inpatient level of care was needed. For the remaining 36 claims, OHSU attributed the patient admission errors primarily to human error.

OHSU stated that, because of the short nature of the patient stays, case management review did not always occur. As a result of these errors, OHSU received overpayments of \$2,419,351.<sup>3</sup>

## **RECOMMENDATIONS**

We recommend that OHSU:

- refund to the Medicare contractor \$2,419,351 in overpayments for the 57 incorrectly billed inpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

## **OREGON HEALTH & SCIENCE UNIVERSITY COMMENTS**

In written comments on our draft report, OHSU agreed with our finding and recommendations and provided information on actions that it had taken to address our recommendations. OHSU's comments are included in their entirety as Appendix B.

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<sup>3</sup> OHSU 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 and adjudicated by the Medicare contractor before issuance of our report.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered \$3,506,361 in Medicare payments to OHSU for 113 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service during CY 2010, CY 2011, or CY 2012 and consisted of 102 inpatient and 11 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 subjected 22 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of OHSU'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 CMS's 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 OHSU for Medicare reimbursement.

We conducted our fieldwork at OHSU from September 2013 to June 2014.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted OHSU's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2010 through 2012;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 113 claims (102 inpatient and 11 outpatient claims) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;
- requested that OHSU conduct its own review of the selected claims to determine whether the services were billed correctly;

- reviewed the itemized bills and medical record documentation provided by OHSU to support the selected claims;
- used an independent medical review contractor to determine whether 22 selected claims met medical necessity requirements;
- discussed the incorrectly billed claims with OHSU 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 OHSU 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: OREGON HEALTH & SCIENCE UNIVERSITY COMMENTS



August 28, 2014

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RE: Report Number: A-09-13-02057

Dear Ms. Ahlstrand:

I am responding to your August 18, 2014 letter and draft report number A-09-13-02057, titled *Medicare Compliance Review of Oregon Health & Science University for Calendar Years 2010 Through 2012*. Oregon Health & Science University (OHSU) is committed to full compliance with regulations for federal healthcare programs. We appreciate the opportunity to respond to the draft report.

We understand the selection process that was used for the claims audited and are in agreement with the findings identified in the draft report. We also agree with the two recommendations in the draft report and have the following responses to those recommendations:

1. Refund to the Medicare contractor \$2,419,351 in overpayments for the 57 incorrectly billed inpatient claims:

- We have refunded the \$2,419,351 for the 57 incorrectly billed inpatient claims.

2. Strengthen controls to ensure full compliance with Medicare requirements:

- Since 21 of the 57 incorrectly billed inpatient stays involved bone marrow procedures that require a less intensive level of care, we have educated case management staff and providers regarding proper documentation and admission status classification requirements for these procedures.
- The Care Management UR Program Coordinator and one of our internal Physician Advisors have met with physician groups to discuss admission status orders requirements and admission classification.
- We have entered into a contractual partnership with a nationally respected external physician advisor company in order to have better and timely access to physician experts in the field of medical necessity, admission order requirements and admission status classification. Patients whose cases do not pass screening criteria for admission are referred to these external physician advisors for additional medical review.

- Care Management has implemented the use of an inter-rater reliability module that is intended to assure consistent and accurate use of Milliman Care Guidelines among all Case Managers. Newly hired Case Managers are now required to complete a series of web-based instructional modules that teach the proper use of the Milliman Care Guidelines. Care Management also has added 2.4 additional Case Manager FTEs which will help assure timely and consistent review of hospitalizations for the medical necessity of admission and continued stay.

These action items have improved our processes and efforts to accurately classify admission status and submit accurate claims. Again we would like to thank you for the opportunity to respond to this draft report and for the opportunity to work with the OIG staff from the San Diego, California office.

Sincerely,

/Diana Gernhart/

Diana Gernhart  
Senior VP & Chief Financial Officer, OHSU Healthcare