

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW
OF TUFTS MEDICAL CENTER
FOR CALENDAR YEARS
2009 AND 2010**

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Regional Inspector General**

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Office of Inspector General

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EXECUTIVE SUMMARY

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays 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, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Tufts Medical Center (the Hospital) is a 415-bed acute care facility located in Boston, Massachusetts. Medicare paid the Hospital approximately \$260 million for 12,929 inpatient and 208,712 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$4,145,876 in Medicare payments to the Hospital for 326 claims that we judgmentally selected as potentially at risk for billing errors. These 326 claims consisted of 250 inpatient and 76 outpatient claims. This report does not address audit results for 117 inpatient claims, valued at \$1,297,337, that we originally selected for review. These claims require further evaluation by medical review personnel.

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

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 78 of the 209 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 131 claims, resulting in net overpayments totaling \$695,142 for CYs 2009 through 2010. Specifically, 70 inpatient claims had billing errors, resulting in overpayments totaling \$596,212, and 61 outpatient claims had billing errors, resulting in net overpayments totaling \$98,930. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements within the selected risk areas.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$695,142, consisting of \$596,212 in overpayments for 70 incorrectly billed inpatient claims and \$98,930 in overpayments for 61 incorrectly billed outpatient 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, the Hospital concurred with the majority of our findings and recommendations but disagreed in these three areas:

- **Inpatient Short Stays:** The Hospital stated that it disagrees that it billed 16 claims incorrectly. For these claims, we maintain that the stays did not meet the medical necessity requirements for an inpatient admission.
- **Outpatient Claims Billed With Modifiers:** The Hospital stated that it disagrees that it incorrectly billed 12 claims, related to right heart catheterizations (RHC) and heart biopsy procedures performed during the same patient session. The Hospital stated that it believes that performing both a RHC and a heart biopsy are critical to monitoring post heart transplant patients to identify, as early as possible, any indication of life-threatening tissue rejection. We maintain that the Hospital incorrectly appended modifier -59 to the HCPCS code representing the RHC when this procedure was already included in the payment for the heart biopsy. In these instances, Medicare does not pay for a RHC unless it is separate and distinct (e.g., different session or different encounter) from the heart biopsy. The assumption that a bundled service (i.e., RHC) would be reasonable and necessary in the absence of the primary service (i.e., heart biopsy) has no bearing on whether the bundled service should be reported as separate and distinct, nor does the fact that the Hospital may have added some additional steps or different components that are not required by the primary service.

- **Outpatient Manufacturer Credits for Replaced Medical Devices:** The Hospital stated that it disagrees with our finding related to obtaining and reporting a credit for one of the replaced devices that we identified as an error. For this claim, the Hospital stated that it had recently received a partial credit from the manufacturer and provided us with the documentation to support the credit. We agree that the credit does not meet the Medicare reporting requirements and have adjusted our finding accordingly.

The Hospital 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 the Hospital's efforts to implement stronger controls. The Hospital's comments are included in their entirety as Appendix B.

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INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

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

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays 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, 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) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.¹ The OPPS is effective for services furnished on or after August 1, 2000. 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.² All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Payments at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and

¹ In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

analysis techniques. Examples of these types of claims at risk for noncompliance included the following:

- inpatient short stays,
- inpatient psychiatric facility (IPF) emergency department adjustments,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient transfers,
- inpatient claims billed with high severity level DRG codes,
- inpatient and outpatient claims paid in excess of charges,
- inpatient same-day discharges and readmissions,
- outpatient claims billed with modifiers, and
- outpatient dental services.

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.”

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that 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.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

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

Tufts Medical Center

Tufts Medical Center (the Hospital) is a 415-bed acute care hospital located in Boston, Massachusetts. Medicare paid the Hospital approximately \$260 million for 12,929 inpatient and 208,712 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

Scope

Our audit covered \$4,145,876 in Medicare payments to the Hospital for 326 claims that we judgmentally selected as potentially at risk for billing errors. These 326 claims consisted of 250 inpatient and 76 outpatient claims. Of these 326 claims, 324 had dates of service in CYs 2009 and 2010. Two of the claims (involving replacement medical devices) had dates of service in CYs 2008 and 2011.

This report does not address audit results for 117 inpatient claims, valued at \$1,297,337, that we originally selected for review. These claims require further evaluation by medical review personnel. Therefore, we based our review upon a reduced sample of 209 claims, covering \$2,848,539 in Medicare payments to the Hospital.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected only a limited number of claims to focused medical review to determine whether the services were medically necessary.

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. Our review enabled us to establish 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 at the Hospital during February and March 2012.

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 for CYs 2009 and 2010;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2008 through 2011;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 326 claims (250 inpatient and 76 outpatient) for detailed review and subsequently removed 117 inpatient claims, valued at \$1,297,337, for further evaluation by medical review personnel;
- 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;
- used CMS's Medicare contractor medical review staff to determine whether a limited selection of sampled claims met medical necessity requirements;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- requested that the Medicare contractor provide an educational session in the form of a webinar to the Hospital addressing the Medicare requirements for inpatient, outpatient, and observation status;
- calculated the correct payments for those claims requiring adjustments; 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 objective.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 78 of the 209 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 131 claims, resulting in net overpayments totaling \$695,142 for CYs 2009 and 2010. Specifically, 70 inpatient claims had billing errors, resulting in overpayments totaling \$596,212, and 61 outpatient claims had billing errors, resulting in net overpayments totaling \$98,930. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements within the selected risk areas.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 70 of the 133 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$596,212.

Inpatient Short Stays

Section 1862(a)(1)(A) of the Act states that 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.”

For 48 of the 59 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital stated the majority of the errors occurred because of ongoing changes to the case management department and human error. As a result of these errors, the Hospital received overpayments totaling \$478,842.

Inpatient Psychiatric Facility Emergency Department Adjustments

Pursuant to 42 CFR § 412.424, 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. 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.

The Manual, chapter 3, section 190.6.4.1, states that source-of-admission code “D” is reported by an IPF to identify patients who have been transferred to the IPF from the same hospital. The

IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For all of the nine sampled claims, the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to the IPF upon discharge from the Hospital's acute-care section. The Hospital stated these errors occurred because there were no controls specific to source-of-admission code "D." As a result of these errors, the Hospital received overpayments totaling \$970.

Inpatient Manufacturer Credits for Replaced Medical Devices

Federal regulations (42 CFR § 412.89) 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 credit for the cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

The Manual, chapter 3, section 100.8, states that to bill correctly for a replacement device that was provided with a credit, hospitals must use the combination of condition code 49 or 50, along with value code "FD."

For 2 of the 17 sampled claims, the Hospital received a reportable medical device credit from a manufacturer for a replaced device, but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required. The Hospital stated these errors occurred because of a lack of coordination between various departments and human error. As a result of these errors, the Hospital received overpayments totaling \$28,339.

Inpatient Transfers

Federal regulations (42 CFR § 412.4(b)) state that a discharge of a hospital inpatient is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge. A discharge of a hospital inpatient is also considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(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 all of the seven 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 hospital, inpatient rehabilitation facility, or to a home under a written plan of care for the provision of home health services. However, the Hospital incorrectly coded the discharge status to home; thus, the Hospital should have received the per diem payment instead of the full DRG. Officials from the Hospital stated that these

errors occurred because of human error and its “pre-bill validation program” did not cover all coded cases. As a result of these errors, the Hospital received overpayments totaling \$41,875.

Inpatient Claims Billed With High Severity Level Diagnosis-Related Group Codes

Section 1862(a)(1)(A) of the Act states that 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.” In addition, the Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately”

For 2 of the 14 sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated these errors occurred due to human error. As a result of these errors, the Hospital received overpayments totaling \$29,008.

Inpatient Claims Paid in Excess of Charges

Section 1862(a)(1)(A) of the Act states that 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.” In addition, the Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately”

For 1 of the 12 sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated the error occurred due to human error. As a result of this error, the Hospital received an overpayment of \$11,604.

Inpatient Same-Day Discharges and Readmissions

The Manual, chapter 3, section 40.2.5, 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.

For one of the three sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated the error occurred because not all Medicare same-day readmissions were sent to case management for review. As a result of this error, the Hospital received an overpayment of \$5,574.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 61 of the 76 sampled outpatient claims that we reviewed. These errors resulted in net overpayments totaling \$98,930.

Outpatient Claims Billed With Modifiers

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. In addition, the Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately”

The Manual, chapter 23, section 20.9.1.1(B), states: “The ‘-59’ modifier is used to indicate a distinct procedural service ... this may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).”

The Manual, chapter 12, section 30.6.6(B), states that a Medicare contractor pays for an evaluation and management (E&M) service that is significant, separately identifiable, and above and beyond the usual preoperative work of the procedure.

For 42 of the 51 sampled claims, the Hospital incorrectly billed Medicare with the following types of errors:

- HCPCS codes, related primarily to cardiac catheterization and heart biopsy procedures, appended with modifier -59, which were already included in the payments for other services or procedures billed on the same claim (20 errors),
- E&M services, related primarily to eye injection, cystoscopy procedures, and psychiatric visits, that were not significant, separately identifiable, and above and beyond the usual preoperative work of the procedures (8 errors),
- procedures related to eye procedures that were insufficiently documented in the medical record (8 errors), and
- incorrect HCPCS codes for the types of procedures provided (6 errors).

Several of the claims billed in error contained more than one type of error. The Hospital stated the errors primarily occurred due to a misunderstanding of the Medicare billing requirements for the use of modifiers -59 and -25. As a result of these errors, the Hospital received overpayments totaling \$32,011.

Outpatient Claims Paid in Excess of Charges

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. In addition, the Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately” Chapter 4, section 20.4 states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For all of the nine sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes (five errors) or incorrect units of service (four errors). The majority of errors resulted from a single Hospital department. The Hospital stated the errors primarily occurred because of coding and data entry errors. As a result of these errors, the Hospital received net overpayments totaling \$8,037.

Outpatient Billing for Dental Services

Section 1862(a)(12) of the Act states that no payment may be made under part A or part B for any expenses incurred for items or services “where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth”

For all of the six sampled claims, the Hospital incorrectly billed Medicare for the treatment or removal of teeth. The Hospital stated these overpayments occurred because there were no internal controls in place related to billing of claims to Medicare for outpatient dental services. As a result of these errors, the Hospital received overpayments totaling \$6,918.

Outpatient Manufacturer Credits for Replaced Medical Devices

Federal regulations (42 CFR § 419.45) 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.

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPPS. 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. 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 four of the five sampled claims, the Hospital received full credit for replaced devices but did not report the “FB” modifier and reduced charges on its claims. The Hospital stated these overpayments occurred because it did not have procedures in place for coordinating functions among the various departments (accounts payable, electrophysiology laboratory, and patient financial services). As a result of these errors, the Hospital received overpayments totaling \$51,964.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$695,142, consisting of \$596,212 in overpayments for 70 incorrectly billed inpatient claims and \$98,930 in overpayments for 61 incorrectly billed outpatient 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, the Hospital concurred with the majority of our findings and recommendations but disagreed in these three areas:

- **Inpatient Short Stays:** The Hospital stated that it disagrees that it billed 16 claims incorrectly. For these claims, we maintain that the stays did not meet the medical necessity requirements for an inpatient admission.
- **Outpatient Claims Billed With Modifiers:** The Hospital stated that it disagrees that it incorrectly billed 12 claims, related to right heart catheterizations (RHC) and heart biopsy procedures performed during the same patient session. The Hospital stated that it believes that performing both a RHC and a heart biopsy are critical to monitoring post heart transplant patients to identify, as early as possible, any indication of life-threatening tissue rejection. We maintain that the Hospital incorrectly appended modifier -59 to the HCPCS code representing the RHC when this procedure was already included in the payment for the heart biopsy. In these instances, Medicare does not pay for a RHC unless it is separate and distinct (e.g., different session or different encounter) from the heart biopsy. The assumption that a bundled service (i.e., RHC) would be reasonable and necessary in the absence of the primary service (i.e., heart biopsy) has no bearing on whether the bundled service should be reported as separate and distinct, nor does the fact that the Hospital may have added some additional steps or different components that are not required by the primary service.
- **Outpatient Manufacturer Credits for Replaced Medical Devices:** The Hospital stated that it disagrees with our finding related to obtaining and reporting a credit for one of the replaced devices that we identified as an error. For this claim, the Hospital stated that it had recently received a partial credit from the manufacturer and provided us with the documentation to support the credit. We agree that the credit does not meet the Medicare reporting requirements and have adjusted our finding accordingly.

The Hospital 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 the Hospital's efforts to

implement stronger controls. The Hospital's comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A: RISK AREAS REVIEWED AND BILLING ERRORS

Risk Area	Sampled Claims	Value Of Sampled Claims	Claims With Over-payments	Value Of Over-payments
Inpatient short stays	59	\$617,582	48	\$478,842
Inpatient transfers	7	109,715	7	41,875
Inpatient claims billed with high-severity-level diagnosis-related group codes	14	250,350	2	29,008
Inpatient manufacturer credits for replaced medical devices	17	618,135	2	28,339
Inpatient claims paid in excess of charges	12	324,681	1	11,604
Inpatient same-day discharges and readmissions	3	74,769	1	5,574
Inpatient psychiatric facility emergency department adjustments	9	115,358	9	970
Inpatient hospital-acquired conditions and present-on-admission indicator reporting	10	277,775	0	0
Inpatient claims with payments greater than \$100,000	2	206,553	0	0
Inpatient Totals	133	\$2,594,918	70	\$596,212
Outpatient manufacturer credits for replaced medical devices	5	\$87,963	4	\$51,964
Outpatient claims billed with modifiers	51	102,713	42	32,011
Outpatient claims paid in excess of charges	9	41,126	9	8,037
Outpatient billing for dental services	6	6,918	6	6,918
Outpatient claims billed with J codes	5	14,901	0	0
Outpatient Totals	76	\$253,621	61	\$98,930
Inpatient and Outpatient Totals	209	\$2,848,539	131	\$695,142

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hospital for Tufts University
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October 26, 2012

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Boston, MA 02203

Report Number: A-01-12-00503

Dear Mr. Armstrong:

Tufts Medical Center (the "Hospital") appreciates the opportunity to comment on the Government's report. The Hospital 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.

The Hospital's responses to the Government's specific recommendations are set forth below. Unless otherwise stated, the Hospital accepts the Government's findings and is processing the necessary adjustments through its Medicare Administrative Contractor, NHIC.

Inpatient Short Stays: The Hospital identified 32 claims from the OIG's sample that did not meet the criteria for an inpatient admission due to the fact that the physician order or the medical record contained ambiguities. The Hospital fully appreciates and recognizes the need to clearly document the physician's decision making process. The Hospital has and will continue to educate appropriate staff and physicians on Medicare regulations and guidance in this area. In addition, the Hospital is committed to forming a committee comprised of case managers and physicians who will be responsible for reviewing inpatient determinations and evaluating the documentation in the medical record.

The Hospital respectfully disagrees with the Government's assertion that inpatient stays were inappropriate in the other 16 cases and believes that, for each, the medical record supports the criteria for inpatient admission. CMS recognizes in its own guidance that the decision to admit a patient is a complex medical judgment that calls for the consideration of many factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and outpatients, the hospital's by-laws and admission policies, and the relative appropriateness of treatment in each setting. The Hospital evaluated national screening criteria, evidence-based practice, clinical judgment and consideration of the beneficiary's medical history and presenting condition for each of these claims, and it is the Hospital's position that each claim met the criteria for inpatient admission.



Inpatient Psychiatric Facility Emergency Department Adjustments: Once identified as an issue by the Government, the Hospital took immediate steps to evaluate its Inpatient Admitting and Registration process, prepared a detailed procedure to ensure that the proper source-of-admission code is used for all inpatients at registration, and trained all Admitting staff on that procedure. The Hospital also took steps to identify and adjust other claims that did not properly reflect the source-of-admission code “D.”

Inpatient and Outpatient Credits for Replaced Medical Devices: For one device that the Government believed we should have requested a credit but had not, the Hospital recently received that credit and the vendor confirmed that the partial credit did not meet Medicare reporting requirements.

The Hospital has also taken steps to review other credits received to ascertain whether they should be reported and adjusted in accordance with Medicare guidelines. Furthermore, the Hospital has prepared a multi-departmental policy on inpatient and outpatient medical device credits, which is under final review.

Inpatient Transfers: The Hospital has established controls that provide for increased management oversight and quality assurance in coding and validating dispositions. In addition the Hospital has implemented a collaborative process that allows the Case Management Department and coders in the Health Information Management Department to use a multidisciplinary discharge order plan as the single source document to determine the discharge status of the patient. The Hospital has also taken steps to identify and adjust other claims that did not properly reflect patient transfers.

Inpatient Claims Billed With High Severity Level Diagnosis-Related Group Codes and Inpatient Claims Paid in Excess of Charges: The Hospital has established controls to provide for increased management oversight and quality assurance in coding.

Inpatient Same-Day Discharges and Readmissions: The Hospital has created additional controls to ensure that the Case Management Department reviews all same day discharges and readmissions. Patient Financial Services will report all readmissions to Case Management. In addition, Case Management created its own daily readmission report. Together, these two reports will help ensure that both departments have up to date information on Hospital readmissions.

Outpatient Claims Billed with Modifiers: The Joint Corporate Compliance program is preparing a Position Paper on the proper use of modifiers 25 and 59 that will be distributed throughout the Hospital clinics followed by educational sessions on the subject.

For 12 claims identified by the Government as being in error (\$18,307), the Hospital strongly disagrees with the Government’s position. These 12 claims all relate to heart transplant patients and the use of modifier 59 for a right heart catheterization and a heart biopsy performed at the same session. Regardless of whether a patient is symptomatic, the Hospital strongly believes that performing **both** a right heart catheterization (RHC) and heart biopsy are critical to monitoring post heart transplant patients to identify, as early as possible, any indication of life-threatening tissue rejection. The RHC and heart biopsy provide very different and important information for clinical decision making. An RHC involves placement of a catheter in one or more right sided chambers or structures of the heart allowing measurement of heart pressures, sampling of blood to measure blood gases and measurement of cardiac output. The catheterization also provides necessary access to the interior of the heart, which is necessary



for a biopsy of the heart's tissue and avoids the need for a second entry point. The procedures are distinct from each other, requiring additional time, as well as different skill sets in performance and interpretation. Findings from both of these procedures have major clinical implications on both the necessity and risk of administering highly-toxic immunosuppressive drugs to the patient.

The Hospital asked for and received a joint statement from the Heart Failure Society of America and the International Society for Heart and Lung Transplantation, which clarifies the standard of care for managing heart transplant recipients and supports the hospital's position. As stated in its letter, these two organizations represent the vast majority of providers caring for these patients, and their respective clinical guidance documents are widely regarded as standard setting for the care of these patients. This letter was provided to the Government for its consideration.

Outpatient Claims Paid in Excess of Charges: The Hospital will provide education in those areas where errors occurred and explore the use of flags to highlight claims that were paid in excess of charges. The Hospital has also taken steps to identify and adjust other claims that were paid in excess of charges.

Outpatient Billing for Dental Services: Health Information Management established an Outpatient Dental Coding Policy. Under that policy, all claims for outpatient dental procedures with Medicare as the primary insurer will be placed on bill hold and reviewed against Medicare coverage criteria. If the service does not meet Medicare coverage criteria, the appropriate condition code or modifier will be placed on the claim before submission to Medicare. The Hospital has also taken steps to identify and adjust other outpatient dental claims that were improperly paid by the Medicare contractor.

Tufts Medical Center and the Floating Hospital for Children along with the Tufts Medical Center Physicians Organization and other affiliates (Tufts MC) is an organization recognized nationally for its quality of service. That recognition is directly attributable to the commitment of all our dedicated health care professionals, members of our support staff and the members of our research community. Tufts MC is also committed to compliance with applicable Federal and State laws and regulations and the requirements of our payers. We appreciate the opportunity to learn from and respond to the Government's Medicare compliance review.

Please do not hesitate to contact me if you have any further questions or require additional information.

Sincerely,

/Donald B Hunter/

Donald B Hunter, MBA, CFE
Chief Compliance Officer and Director of Internal Audit
Tufts Medical Center