

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF RHODE ISLAND
HOSPITAL FOR CALENDAR
YEARS 2010 AND 2011**

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**Michael Armstrong
Regional Inspector General**

**December 2012
A-01-12-00510**

Office of Inspector General

<http://oig.hhs.gov>

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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.

Rhode Island Hospital (the Hospital) is a 719 bed acute care facility located in Providence, Rhode Island. Medicare paid the Hospital approximately \$291 million for 23,988 inpatient and 92,749 outpatient claims for services provided to beneficiaries during calendar years (CY) 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$2,399,541 in Medicare payments to the Hospital for 233 claims that we judgmentally selected as potentially at risk for billing errors. These 233 claims consisted of 113 inpatient and 120 outpatient claims.

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 148 of the 233 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 85 claims resulting in overpayments totaling \$214,059 for CYs 2010 and 2011. Specifically, 23 inpatient claims had billing errors, resulting in net overpayments totaling \$152,238, and 62 outpatient claims had billing errors, resulting in net overpayments totaling \$61,821. Overpayments occurred primarily at the Hospital because of human error, the inconsistent application of existing internal controls to prevent incorrect billing of Medicare claims and the failure to fully understand the Medicare billing requirements within the selected risk areas.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$214,059, consisting of \$152,238 in overpayments for 23 incorrectly billed inpatient claims and \$61,821 in overpayments for 62 incorrectly billed outpatient claims, and
- continue to strengthen controls to ensure full compliance with Medicare requirements.

RHODE ISLAND HOSPITAL COMMENTS

In written comments on our draft report, the Hospital generally concurred with our findings. However, although the Hospital generally concurred with our findings related to short stay claims, it stated that “this is an area where greater CMS clarification is required as legitimate disagreements exists.” The Hospital’s comments are included in their entirety as the Appendix.

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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. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

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.

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 analysis of claims. Examples of the types of claims at risk for noncompliance include the following:

- inpatient short stays,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient transfers,
- outpatient claims billed with observation services that resulted in outlier payments,
- outpatient claims billed with evaluation and management (E&M) services, and
- outpatient claims billed with intensity modulated radiation therapy (IMRT) planning 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 and 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.

Rhode Island Hospital

Rhode Island Hospital (the Hospital) is a 719 bed acute care facility located in Providence, Rhode Island. Medicare paid the Hospital approximately \$291 million for 23,988 inpatient and 92,749 outpatient claims for services provided to beneficiaries during calendar years (CY) 2010 and 2011 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 \$2,399,541 in Medicare payments to the Hospital for 233 claims that we judgmentally selected as potentially at risk for billing errors. These 233 claims had dates of service in CYs 2010 and 2011 and consisted of 113 inpatient and 120 outpatient claims.

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 April 2012 through June 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 2010 and 2011;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2010 and 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 233 claims (113 inpatient and 120 outpatient) for detailed review;
- 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 selected 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;
- discussed the incorrectly billed claims with Hospital 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 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 148 of the 233 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 85 claims resulting in overpayments totaling \$214,059 for CYs 2010 and 2011. Specifically, 23 inpatient claims had billing errors, resulting in overpayments totaling \$152,238, and 62 outpatient claims had billing errors, resulting in overpayments totaling \$61,821. Overpayments occurred primarily at the Hospital because of human error, the inconsistent application of existing internal controls to prevent incorrect billing of Medicare claims and the failure to fully understand the Medicare billing requirements within the selected risk areas.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 23 of the 113 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$152,238.

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 14 of the 50 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 attributed the patient admission errors either to human error and the lack of clarity in federal guidelines regarding medical necessary admission, which negatively impacted physician training on “level of care” documentation. As a result, the Hospital received overpayments totaling \$82,685.

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.”

Prudent Buyer Principle

Pursuant to 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services” The CMS *Provider Reimbursement Manual*, part I, section 2102.1, states:

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

Section 2103 of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example:

Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full

or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.

For 6 of the 14 sampled claims, the Hospital received reportable credits for replaced devices but did not adjust its claims with the proper value code (4 claims) or did not obtain credits for replaced devices that were available under the terms of the manufacturers' warranties (2 errors). The Hospital attributed these errors to lack of vendor cooperation, inconsistent application of controls designed to identify, obtain, and properly report credits from device manufacturers and miscommunication between different departments coordinating device credits. As a result, the Hospital received overpayments totaling \$45,490.

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 a 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 three of the four sampled claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to other facilities. For these claims, the Hospital should have coded the discharge status as a transfer to another facility. The Hospital stated that two of these errors occurred because the coding staff did not identify the disposition status information in the discharge plans and physician orders. For the remaining error, the Hospital stated that the patient decided to seek alternative health care services at another facility without the Hospital's knowledge. As a result, the Hospital received overpayments totaling \$24,063.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 62 of 120 sampled outpatient claims, which resulted in overpayments totaling \$61,821.

Outpatient Manufacturer Credits for Replaced Medical Devices

Federal regulations (42 CFR § 419.45) require a reduction in the outpatient prospective payment system 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.

Billing Requirements for Medical Device Credits

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, explains how a provider should report no-cost and reduced-cost devices under the OPSS. 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.

Prudent Buyer Principle

Pursuant to 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services” The CMS *Provider Reimbursement Manual*, part I, section 2102.1, states:

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

Section 2103 of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties.

For 5 of the 13 sampled claims, the Hospital received reportable credits for replaced devices but did not properly report the “FB” modifier or reduced charges on the claims (4 errors) or did not obtain credits for replaced devices that were available under the terms of the manufacturer’s warranty (1 error). The Hospital stated that these errors occurred because of human error, the failure of the vendors to timely and appropriately communicate some credits, inconsistent application of controls designed to identify, obtain, and properly report credits from device manufacturers and miscommunication between different department coordinating device credits. As a result, the Hospital received overpayments totaling \$37,400.

Outpatient Claims Billed With Observation Services That Resulted in Outlier Payments

The Manual, chapter 4, section 290.1, states: “Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services” Chapter 4, section 290.2.2, states: “Observation time begins at the clock time documented in the patient’s medical record, which coincides with the time that observation care is initiated in accordance with a physician’s order. Hospitals should not report, as observation care, services

that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4 to 6 hours), which should be billed as recovery room services.”

For 37 of the 45 sampled claims, the Hospital incorrectly billed observation hours on claims submitted to Medicare, resulting in incorrect outlier payments. For 21 claims, the Hospital overstated the hours of observation because it did not allow for the normal recovery period expected postoperatively. For 16 claims, the medical records did not contain an order for the observation level of care. As a result, the Hospital received overpayments totaling \$20,474.

Outpatient Claims Billed With Evaluation and Management Services

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

For 3 of the 28 sampled claims, the Hospital incorrectly billed Medicare for E&M services that were part of the usual preoperative and postoperative care associated with the procedure. The Hospital attributed the errors to inadequate documentation of E&M services. As a result, the Hospital received overpayments totaling \$173.

Outpatient Intensity Modulated Radiation Therapy Planning Services

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, section 200.3.2, requires that certain services should not be billed when they are performed as part of developing an IMRT plan.

For 17 of the 19 sampled claims, the Hospital incorrectly billed Medicare for services that were performed as part of developing an IMRT plan. These errors occurred because Hospital personnel relied on contradicting professional association guidance and thus were unaware or did not fully understand the IMRT billing requirements, and consequently the Hospital did not have controls in place to prevent incorrect IMRT coding. As a result, the Hospital received overpayments totaling \$3,774.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$214,059, consisting of \$152,238 in overpayments for 23 incorrectly billed inpatient claims and \$61,821 in overpayments for 62 incorrectly billed outpatient claims, and
- continue to strengthen controls to ensure full compliance with Medicare requirements.

RHODE ISLAND HOSPITAL COMMENTS

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations. However, although the Hospital generally concurred with our findings related to short stay claims, it stated that “this is an area where greater CMS clarification is required as legitimate disagreements exists.” The Hospital’s comments are included in their entirety as the Appendix.

APPENDIX



November 26, 2012

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Re: Report Number: A-01-12-00510

Dear Mr. Armstrong:

Rhode Island Hospital (RIH) is in receipt of the October 25, 2012 draft report provided by the Department of Health and Human Services, Office of Inspector General (OIG) entitled "Medicare Compliance Review of Rhode Island Hospital for Calendar Years 2010 and 2011." Prior to the issuance of this report, in separate communication RIH provided the OIG with some suggested revisions to the report contents primarily relating to Hospital attributions. We generally agree with the findings outlined in the report; RIH has processed the recommended refunds and will continue to take actions to strengthen existing controls relating to Medicare billing requirements.

RIH takes its compliance responsibilities quite seriously. We are gratified that this audit, which emphasized high risk Medicare billing vulnerabilities in complex areas, found a very low claims error rate. In our opinion, a strong system of internal controls currently exists. Nevertheless, the audit identified areas in which we need to enhance our existing controls, improve our employee training and obtain greater clarification regarding complex Medicare billing requirements.

In response to the report's specific recommendations:

Inpatient Short Stays – RIH generally concurs with your findings relating to the 14 cases but as we expressed to the OIG audit staff and NHIC Corp.¹ Medical Review staff, this is an area where greater CMS clarification is required as legitimate disagreement exists. We note that since our meeting to review the inpatient short stay claims, NHIC Corp. issued on September 6, 2012 clarifying guidance entitled "Inpatient Admission vs. Outpatient Observation." RIH has enhanced our existing physician training program to reflect NHIC's guidance.

¹ Medicare Administration Contractor, Jurisdiction 14 A/B MAC

Inpatient and Outpatient Manufacturer Credits for Replaced Devices – RIH concurs with your findings. Prior to this audit RIH had developed operational procedures to track credits received for replacement devices. We have since enhanced these procedures to address those areas of vulnerability detected by the OIG. The enhanced procedures emphasize appropriate coding guidelines, hospital departmental responsibility and vendor accountability. As stated to the OIG by other hospitals, we support federal efforts to require medical device distributors and manufacturers to submit quarterly information, to a secure central data repository, on those replacement devices entitled to a credit. The vendor database would enhance hospital efficiency and increase compliance.

Inpatient Transfer – The appropriateness of discharge disposition coding is regularly reviewed by RIH management; the three errors found related to human error and a decision made by a patient but not communicated to RIH. The staff involved have been retrained and efforts made to enhance the management review process.

Outlier Observation Payment Claims – RIH concurs with your findings; a new policy has been developed and appropriate staff trained. In addition, a process has been established to review all outlier claims containing observation charges to ensure appropriate adjustments.

Outpatient Claims With E&M Services – The physician and staff processing these three claims received additional training relating to the use of modifier 25.

Outpatient IMRT Planning Services – Staff has been retrained on Medicare billing guidelines relating to IMRT services. Automated procedures have been established to suspend for review procedure claims with IMRT planning codes. Also, RIH is supporting national efforts to obtain greater clarity regarding the applicable CMS billing guidelines.

We appreciate the support, cooperation and professionalism exhibited by the OIG audit team who performed this examination. If you have any questions, please don't hesitate to contact me.

Sincerely,

/ Thomas Igoe /

Thomas Igoe