

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF UMASS MEMORIAL
MEDICAL CENTER
FOR CALENDAR YEARS
2010 AND 2011**

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Assistant Inspector General

February 2014
A-01-13-00503

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

UMass Memorial Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$1.6 million over more than 2 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 are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether UMass Memorial Medical Center (UMMC) 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. 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.

UMMC is a 781-bed academic medical center, partnered with the University of Massachusetts Medical School, consisting of 3 campuses in Worcester, Massachusetts. Medicare paid UMMC approximately \$510 million for 27,591 inpatient and 757,810 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$2,996,292 in Medicare payments to UMMC for 232 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 183 inpatient and 49 outpatient claims. Of the 232 claims, 227 claims had dates of service in CYs 2010 or 2011, and 5 claims (involving inpatient manufacturer credits for replaced medical devices) had dates of service in CYs 2009 or 2012.

WHAT WE FOUND

UMMC complied with Medicare billing requirements for 74 of the 232 inpatient and outpatient claims we reviewed. However, UMMC did not fully comply with Medicare billing requirements for the remaining 158 claims, resulting in overpayments of \$1,646,664 for CYs 2010 and 2011 (153 claims) and CYs 2009 and 2012 (5 claims). Specifically, 137 inpatient claims had billing

errors, resulting in overpayments of \$1,514,412, and 21 outpatient claims had billing errors, resulting in overpayments of \$132,252. These errors occurred primarily because UMMC 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 UMMC:

- refund to the Medicare contractor \$1,646,664, consisting of \$1,514,412 in overpayments for 137 incorrectly billed inpatient claims and \$132,252 in overpayments for 21 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

UMASS MEMORIAL MEDICAL CENTER COMMENTS AND OUR RESPONSE

In written comments on our draft report, UMMC concurred with most of our findings and recommendations with the following exceptions:

- UMMC concurred that in five selected claims the final discharge disposition code it reported did not accurately describe the services it provided to Medicare beneficiaries. However, UMMC stated that it disagreed with our description that for one claim a patient was discharged to a hospice because the patient was discharged to an inpatient rehabilitation facility. UMMC also stated that it disagreed with some of our descriptions of the errors associated with these five claims.
- UMMC stated that for one claim it incurred the cost of a medical device because it did not pursue a warranty or receive a manufacturer credit. UMMC expressed concern that submitting a claim with either modifier FC or FB would be inaccurate and stated that it will work with its Medicare contractor to determine the resolution of this claim.

UMMC stated that it would process the necessary adjustments through its Medicare contractor and that it would continue to monitor and strengthen existing internal controls, educate staff, and update existing policies and procedures to minimize the risk of errors.

We have updated the final report to make a technical correction that UMMC discharged a patient to an inpatient rehabilitation facility and not to a hospice. Otherwise, we maintain that our findings and recommendations are valid. We acknowledge UMMC's efforts to strengthen its compliance with Medicare requirements.

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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 are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether UMass Memorial Medical Center (UMMC) 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 (IPPS). The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

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 the services

within each APC group.¹ 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 and outpatient manufacturer credits for replaced medical devices,
- inpatient transfers,
- inpatient claims billed with high severity level DRG codes,
- inpatient same-day discharges and readmissions,
- outpatient drugs, and
- outpatient claims billed with evaluation and management (E&M) services.

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 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” (the Social Security Act (the Act), section 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (section 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 section 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, section 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, section 20.3).

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

UMass Memorial Medical Center

UMMC is a 781-bed academic medical center, partnered with the University of Massachusetts Medical School, consisting of 3 campuses in Worcester, Massachusetts. Medicare paid UMMC approximately \$510 million for 27,591 inpatient and 757,810 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$2,996,292 in Medicare payments to UMMC for 232 claims that we judgmentally selected as potentially at risk for billing errors. These 232 claims consisted of 183 inpatient and 49 outpatient claims. Of these 232 claims, 227 had dates of service in CYs 2010 or 2011, and 5 claims (involving inpatient manufacturer credits for replaced medical devices) had dates of service in CYs 2009 or 2012.² We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by UMMC for Medicare reimbursement.

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

Appendix A contains the details of our scope and methodology.

FINDINGS

UMMC complied with Medicare billing requirements for 74 of the 232 inpatient and outpatient claims we reviewed. However, UMMC did not fully comply with Medicare billing requirements for the remaining 158 claims, resulting in overpayments of \$1,646,664 for CYs 2010 and 2011 (153 claims) and CYs 2009 and 2012 (5 claims). Specifically, 137 inpatient claims had billing errors, resulting in overpayments of \$1,514,412, and 21 outpatient claims had billing errors, resulting in overpayments of \$132,252. These errors occurred primarily because UMMC did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

Appendix B summarizes (by the risk areas we reviewed) the overpayments identified in this report.

² We selected these five claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

UMMC incorrectly billed Medicare for 137 of 183 selected inpatient claims, which resulted in overpayments of \$1,514,412.

Incorrectly Billed as Inpatient

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, section 1862(a)(1)(A)).

For 125 of the 183 selected claims, UMMC incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient services or outpatient with observation. UMMC officials attributed the patient admission errors primarily to inadequate internal controls over case management for monitoring short stays. As a result of these errors, UMMC received overpayments of \$1,468,748.³

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations 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 device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR section 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code “FD” (chapter 3, section 100.8).

For 4 of the 183 selected claims, UMMC received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate value and condition codes to reduce payment as required. (The four claims had dates of service in CYs 2009 or 2012.) UMMC officials stated that the errors occurred because UMMC did not have appropriate internal control procedures for coordinating functions among various departments to ensure that it submitted claims correctly. As a result of these errors, UMMC received overpayments of \$18,796.

Incorrect Discharge Status

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 (42 CFR section 412.4 (b)). 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

³ UMMC 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 administrative contractor prior to the issuance of our report.

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 section 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 section 412.4(f)).

For 5 of the 183 selected claims, UMMC incorrectly billed Medicare for patient discharges that should have been billed as transfers to other facilities. For these claims, UMMC should have coded the discharge status either as a transfer to an acute care hospital, to home under a written plan of care for the provision of home health services, or to the psychiatric unit of a hospital. However, UMMC incorrectly coded the discharge status to home, left against medical advice, or discharged to an inpatient rehabilitation facility; therefore, UMMC should have received the per diem payment instead of the full DRG payment. UMMC officials stated that the errors occurred primarily because some of the patients left against medical advice and staff did not know that the patients entered another facility. As a result of these errors, UMMC received overpayments of \$11,419.

Incorrectly Billed Diagnosis-Related Group Codes

No Medicare payments may 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, section 1862(a)(1)(A)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, section 80.3.2.2).

For 2 of the 183 selected claims, UMMC billed Medicare for an incorrect DRG code. UMMC officials attributed this to human error. As a result of these errors, UMMC received overpayments of \$8,271.

Incorrectly Billed as Separate Inpatient Stays

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 on a single claim.

For 1 of the 183 selected claims, UMMC billed Medicare separately for a related discharge and readmission within the same day. UMMC officials attributed this to human error. As a result of this error, UMMC received an overpayment of \$7,177.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

UMMC incorrectly billed Medicare for 21 of 49 selected outpatient claims, which resulted in overpayments of \$132,252.

Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations require a reduction in the OPSS 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 (42 CFR section 419.45). 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.⁴

For 8 of the 49 selected outpatient claims, UMMC received full credit for replaced devices but did not report the “FB” modifier or reduced charges on its claims (6 claims), UMMC did not obtain a credit for a replaced device that was available under the terms of the manufacturer’s warranty (1 claim), or UMMC used an incorrect HCPCS code (1 claim). UMMC officials stated that the errors occurred because UMMC did not have appropriate internal control procedures for coordinating functions among various departments to ensure that it submitted claims correctly. As a result of these errors, UMMC received overpayments of \$124,693.

Incorrectly Billed Number of Units

The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, section 80.3.2.2). In addition, the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed” (chapter 4, section 20.4).

For 6 of 49 selected outpatient claims, UMMC submitted claims to Medicare with an incorrect number of units. UMMC officials stated that these errors occurred because of human error. As a result of these errors, UMMC received overpayments of \$7,112.

Incorrectly Billed Evaluation and Management Services

The Manual 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 (chapter 12, section 30.6.6(B)).

For 7 of the 49 selected claims, UMMC incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. These services were primarily associated with joint

⁴ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPSS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

injections. UMMC officials stated that these errors occurred because coding staff did not always understand the billing requirements for E&M services. As a result of these errors, UMMC received overpayments of \$447.

RECOMMENDATIONS

We recommend that UMMC:

- refund to the Medicare contractor \$1,646,664, consisting of \$1,514,412 in overpayments for 137 incorrectly billed inpatient claims and \$132,252 in overpayments for 21 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

UMASS MEMORIAL MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, UMMC concurred with most of our findings and recommendations with the following exceptions:

- UMMC concurred that in five selected claims the final discharge disposition code it reported did not accurately describe the services it provided to Medicare beneficiaries. However, UMMC stated that it disagreed with our description that for one claim a patient was discharged to a hospice because the patient was discharged to an inpatient rehabilitation facility. UMMC also stated that it disagreed with some of our descriptions of the errors associated with these five claims.
- UMMC stated that for one claim it incurred the cost of a medical device because it did not pursue a warranty or receive a manufacturer credit. UMMC expressed concern that submitting a claim with either modifier FC or FB would be inaccurate and stated that it will work with its Medicare contractor to determine the resolution of this claim.

UMMC stated that it would process the necessary adjustments through its Medicare contractor and that it would continue to monitor and strengthen existing internal controls, educate staff, and update existing policies and procedures to minimize the risk of errors. UMMC's comments are included in their entirety as Appendix C.

We have updated the final report to make a technical correction that UMMC discharged a patient to an inpatient rehabilitation facility and not to a hospice. Otherwise, we maintain that for five claims UMMC incorrectly billed Medicare for patient discharges that should have been billed as transfers to other facilities. We also maintain that for one claim UMMC did not obtain a credit for a replaced medical device that was available under the manufacturer's warranty but acknowledge UMMC will work with its Medicare contractor to resolve this claim. However, we maintain UMMC should have appended the claim with the FB modifier and reduced charges. We acknowledge UMMC's efforts to strengthen its compliance with Medicare requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$2,996,292 in Medicare payments to UMMC for 232 claims that we judgmentally selected as potentially at risk for billing errors. These 232 claims consisted of 183 inpatient and 49 outpatient claims. Of these 232 claims, 227 had dates of service in CYs 2010 or 2011, and 5 claims (involving inpatient manufacturer credits for replaced medical devices) had dates of service in CYs 2009 or 2012. (See footnote 2.)

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.

We limited our review of UMMC'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 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 UMMC for Medicare reimbursement.

We conducted our fieldwork during February through March 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted UMMC's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2010 and 2011, and for CYs 2009 and 2012 (5 claims);
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2009 through 2012;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 232 claims (183 inpatient and 49 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by UMMC to support the selected claims;
- requested that UMMC conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed UMMC's procedures for submitting Medicare claims;
- discussed the incorrectly billed claims with UMMC 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 UMMC officials.

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

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Short Stays	151	\$2,023,808	125	\$1,468,748
Manufacturer Credits for Replaced Medical Devices	11	297,157	4	18,796
Transfers	5	67,229	5	11,419
Claims Billed With High Severity Level Diagnosis-Related Group Codes	12	116,549	2	8,271
Same-Day Discharges and Readmissions	4	98,983	1	7,177
Inpatient Totals	183	\$2,603,726	137	\$1,514,412
Outpatient				
Manufacturer Credits for Replaced Medical Devices	14	\$249,046	8	\$124,693
Drugs	10	141,823	6	7,112
Claims Billed With Evaluation and Management Services	25	1,697	7	447
Outpatient Totals	49	\$392,566	21	\$132,252
Inpatient and Outpatient Totals	232	\$2,996,292	158	\$1,646,664

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

APPENDIX C: UMASS MEMORIAL MEDICAL CENTER COMMENTS



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December 12, 2013

Mr. David Lamir
Regional Inspector General for Audit Services,
Office of the Inspector General, Audit Services, Region 1
John F. Kennedy Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Re: Draft Report Number A-01-13-00503

Dear Mr. Lamir,

Thank you for the opportunity to review the draft *Medicare Compliance Review of UMass Memorial Medical Center for Calendar Years 2010 and 2011*, prepared by the Office of the Inspector General (OIG) based on a review of eight identified Medicare Hospital billing risk areas. In accordance with your letter, I am responding to your request for written comments related to the validity of facts contained in the draft report, the reasonableness of the recommendations offered by the OIG and the nature of corrective actions taken or planned. Overall, we are in general agreement with the majority of information contained in this draft report; however, there are a few exceptions as noted below.

UMass Memorial Medical Center (UMMMC) is committed to compliance with regulations surrounding federal health care programs, and has a long-standing compliance program dedicated to assisting our health care system navigate the complexities of billing regulations for services we provide to Medicare beneficiaries.

UMMMC is processing the necessary adjustments with the Medicare Administrative Contractor, NGS, with the exception of the inpatient short stay cases. We will work with NGS to determine the best way of adjusting those claims to allow for the billing of Medicare Part B for services that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient.

In response to the audit findings we offer the following.

Medical Necessity of Inpatient Admission

We concur with the OIG's finding that in 125 of the 183 selected inpatient claims, the medically necessary services provided to the Medicare beneficiaries reviewed could have been provided in an outpatient "status." In performing our internal assessment, we reviewed each case according to Interqual guidance for the admission date of service.

Prior to this review, UMMMC had implemented a software program to assist our Care-Coordination department in assessing clinical documentation against nationally recognized guidelines to further assist physicians in appropriately determining the setting into which the patient is placed for care. Since this review began, UMMMC has undertaken a comprehensive physician re-education program championed by the Chief Medical Officer, the Compliance Office and our Care-Coordination department, as well as other executive leaders. We have also increased care-coordination staff in our emergency department with the goal of having 24/7 coverage in this area. We are committed to remain diligent in complying with CMS regulation surrounding medical necessity of inpatient admissions.

To the extent applicable, and as noted by the OIG in the Report, UMMMC intends to bill Medicare Part B for all services that would have been reasonable and necessary had the beneficiary been originally designated as an outpatient rather than admitted as an inpatient.

Inpatient Manufacturer Device Credits

We concur with the OIG's finding related to 4 of the 183 inpatient claims where UMMMC received a manufacturer device credit and did not report the correct value code and condition code in an adjusted inpatient claim. UMMMC had implemented significant internal controls in 2009 addressing the Medicare regulation for reporting credits received for replacement devices in both the inpatient and outpatient setting. These controls consist of requiring manufacturer monthly reporting of credits for devices replaced under warranty, recall or free of charge. Additionally, an internal intranet communication tool was implemented which allowed clinical, purchasing and billing staff to record information necessary to determine when a manufacturer credit received triggered the claim adjustment requirement. However, in researching the claims identified in this review, we identified further opportunities to strengthen existing internal controls which have been implemented. We will continue to monitor and review Medicare billing related to this regulation.

Inpatient Discharge Status

We concur with the OIG's finding that in 5 of the 183 selected claims; the final discharge disposition code reported on the claim did not accurately describe the services provided to the Medicare beneficiary once they had left our facility. However, we wish to clarify certain findings of the OIG as noted below.

- We disagree with the OIG statement that a sampled discharge disposition code indicated the patient had been discharged to hospice. In this particular case, the patient discharge disposition code reported the patient had been discharged to an inpatient rehabilitation facility.
- We also disagree with the OIG's statement that in some of these five cases, the claims should have been coded to reflect a discharge to either home under a written plan of care for the provision of home health services or to a psychiatric unit of a hospital. All five of these patients received post-acute care at an acute care facility.

- In two of the five cases, the patient's discharge was not assigned to one of the qualifying DRGs affected by the Post Acute Care Transfer (PACT) policy and no overpayment was received.
- One of the five cases was not a coding error as the patient was discharged to home. However, after discharge from our facility, the patient was seen by their Primary Care Physician (PCP) and admitted to an acute-care facility on the same day of discharge.

UMMMC is committed to correctly reporting discharge disposition status and has taken steps to strengthen our process of documenting discharge status. The results of this review have been shared with individuals responsible for the documentation of discharge status and for the coding of discharge status reported on claims submitted to payors.

Incorrect Diagnosis-Related Groups

We concur with the OIG's findings that for 2 of the 183 selected claims, UMMMC billed Medicare for an incorrect DRG code resulting from human error. The results of this review have been discussed with coding staff and re-education provided. Additionally, UMMMC will continue to monitor this risk area through our DRG Coding Audit program.

Incorrectly Billed as Separate Inpatient Stay

We agree that for 1 of the 183 selected inpatient claims, the patient was readmitted to UMMMC on the day of discharge for the same medical condition. UMMMC has a review process which includes a medical record review to determine if the readmission was related to the discharge, and communication to billing staff to combine admission. This one case was due to human error in communication of the need to combine the two claims. All parties involved in this process have been made aware of this audit finding and re-educated around the Medicare regulations regarding this risk area.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

We generally concur with the OIG statement with one exception; UMMMC received a warranty credit for a replaced device in only 7 of the 49 selected outpatient claims. All of these cases have been resubmitted to Medicare for recoupment of overpayments.

For the eighth case, UMMMC did not obtain a credit for the replaced device available under the terms of the manufacturer's warranty. The OIG's recommended claim correction is to reprocess the claim by appending a modifier, either FC or FB. The Medicare Claims Processing Manual, Chapter 4, section 20.6.4, contains the following definitions of these modifiers.

- Modifier FB - “Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)”
- Modifier FC - “Partial credit received for replaced device.”

In addition, the OIG has also based its recommendation on instruction found in the Medicare Provider Reimbursement Manual, which contains instruction for cost reporting purposes. Section 2103 of this manual states the following:

B. Application of Prudent Buyer Principle.--Intermediaries may employ various means for detecting and investigating situations in which costs seem excessive. Included may be such techniques as comparing the prices paid by providers to the prices paid for similar items or services by comparable purchasers, spotchecking, and querying providers about indirect, as well as direct, discounts. In addition, where a group of institutions has a joint purchasing arrangement which seems to result in participating members getting lower prices because of the advantages gained from bulk purchasing, any potentially eligible providers in the area which do not participate in the group may be called upon to justify any higher prices paid. Also, when most of the costs of a service are reimbursed by Medicare (for example, for a home health agency which treats only Medicare beneficiaries), examine the costs with particular care. In those cases where an intermediary notes that a provider pays more than the going price for a supply or service or does not try to realize savings available under warranties for medical devices or other items, in the absence of clear justification for the premium, the intermediary excludes excess costs in determining allowable costs under Medicare.

UMMMC recognizes, in this one instance, the hospital did not pursue a warranty credit. However, UMMMC neither received the device with-out cost nor was a credit received. As a result, UMMMC is concerned that submitting the claim with either Modifier FC or FB would be inaccurate. We will work with the MAC to determine resolution of this claim.

UMMMC has shared the results of this review with clinical, finance and billing staffs and re-education has been provided to UMMMC departments involved in the documentation, communication and billing of these claims. Existing policies and procedures were reviewed, updated and new procedures created to strengthen our internal control system around this very complex Medicare Billing Regulation.

Number of Units

We concur that for 5 of 49 selected outpatient claims, UMMMC submitted Medicare claims with an incorrect number of units. For the sixth claim noted in the OIG’s report, UMMMC reported the correct number of units. The MAC (NHIC) incorrectly paid providers for the CPT code submitted and notified hospitals of this error and instructed hospitals not to reprocess claims as NHIC would be reprocessing these claims once the FISS error had been corrected. However, upon this review, we discovered that NHIC had not corrected the claim.

For the 5 claims UMMMC submitted in error, we determined that the medication billed was a single-dose vial. Medicare policy allows for billing the unit content of a single dose vial, however, hospitals must show documentation of the waste. Procedures have been enhanced and education provided to clinical staff to prevent future errors resulting from billing a single-dose vial when the full amount of the vial has not been administered to the patient.

Evaluation and Management Services

We agree that for 7 of the 49 selected claims, UMMMC incorrectly billed Medicare for Evaluation and Management (E&M) services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. However, the majority of the services incorrectly billed were primarily associated with the application of a paste boot, not joint injections. The Hospital has re-educated physician staff regarding the coding rules, regulations and guidelines relating to when an E&M code is appropriately billed in addition to the application of a paste boot on the same day of service. We will continue to include these services in our auditing and monitoring of E&M services.

We appreciate the support, cooperation and professionalism exhibited by the OIG audit team who performed this review. Please feel free to contact me if you have any questions.

Sincerely,

Marjorie A. Beal

/Marjorie A. Beal/

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