



Office of Audit Services, Region I
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June 2, 2011

Report Number: A-01-10-00527

Jennifer Parks
Chief Integrity and Compliance Officer
Fletcher Allen Health Care, Inc.
1 South Prospect Street
Burlington, VT 05401

Dear Ms. Parks:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Fletcher Allen Health Care for Calendar Years 2008 and 2009*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to call me, or contact Kimberly Rapoza, Audit Manager, at (617) 565-2695 or through email at Kimberly.Rapoza@oig.hhs.gov. Please refer to report number A-01-10-00527 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
FLETCHER ALLEN HEALTH CARE
FOR CALENDAR YEARS
2008 AND 2009**



Daniel R. Levinson
Inspector General

June 2011
A-01-10-00527

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

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 prospective payment system for inpatient hospital services (IPPS). 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.

Fletcher Allen Health Care, Inc. (the Hospital) is a 419-bed teaching hospital located in Burlington, Vermont. Medicare paid the Hospital approximately \$307 million for 15,919 inpatient and 398,178 outpatient claims for services provided to beneficiaries during calendar years (CYs) 2008 and 2009 based on CMS's National Claims History data.

Our audit covered \$3,363,543 in Medicare payments to the Hospital for 80 inpatient and 122 outpatient claims that we identified as potentially at risk for billing errors. These 202 claims had dates of service in CYs 2008 and 2009.

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 162 of the 202 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for

selected inpatient and outpatient claims in other areas. Specifically, of the 202 sampled claims, 40 claims had errors in overpayments totaling \$234,022 for CYs 2008 and 2009. 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.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$234,022, consisting of \$163,063 in overpayments for 10 incorrectly billed inpatient claims and \$70,959 in overpayments for 30 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

FLETCHER ALLEN HEALTH CARE COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that it has refunded overpayments to the Medicare contractor. In addition, the Hospital stated that it has strengthened controls to comply with Medicare requirements. 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.¹

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the prospective payment system for inpatient hospital services (IPPS). 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.

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. 106-113.² 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.³ All services and items within an APC group are comparable clinically and require comparable resources.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, requires CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

² In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

³ 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 techniques. The types of payments to hospitals reviewed by this and related audits included payments for claims billed for:

- inpatient claims with same-day discharge and readmissions,
- inpatient claims for 1-day stays,
- inpatient claims with payments greater than \$150,000,
- inpatient claims for blood clotting factor drugs,
- outpatient claims billed with modifier -59,
- outpatient claims for evaluation and management services billed with surgical services,
- outpatient claims billed during DRG payment windows,
- inpatient and outpatient claims paid in excess of charges, and
- inpatient and outpatient claims involving manufacturer credits for medical devices.

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 diagnosing or treating illness or injury or for improving 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.

Fletcher Allen Health Care, Inc.

Fletcher Allen Health Care, Inc. (the Hospital) is a 419-bed teaching hospital located in Burlington, Vermont. Medicare paid the Hospital approximately \$307 million for 15,919 inpatient and 398,178 outpatient claims for services provided to beneficiaries during calendar years (CYs) 2008 and 2009 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 \$3,363,543 in Medicare payments to the Hospital for 80 inpatient and 122 outpatient claims that we identified as potentially at risk for billing errors. These 202 claims had dates of service in CYs 2008 and 2009.

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 based our review on selected billing requirements and did not include a 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 October and November 2010.

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 2008 and 2009;
- 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 202 claims (80 inpatient and 122 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 the sampled claims to determine whether the services were billed correctly;
- 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;
- 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 162 of the 202 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims. Specifically, of 202 sampled claims, 40 claims had billing errors that resulted in overpayments totaling \$234,022 for CYs 2008 and 2009.

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.

Of 80 sampled inpatient claims, 10 claims had billing errors resulting in overpayments totaling \$163,063 (1 claim had 2 types of errors).

- For claims with inpatient 1-day stays, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services (four errors); the Hospital also billed for an inpatient stay that lacked a physician's signature to admit the patient (one error) (five errors totaling \$21,837 in overpayments).
- For inpatient claims with payments greater than \$150,000, the Hospital billed Medicare with an incorrect revenue code (one error) and incorrect units of service (one error) (two errors totaling \$98,239 in overpayments).
- For inpatient claims for blood clotting factor drugs, the Hospital billed Medicare with an incorrect revenue code and incorrect units of service (one error resulting in a \$38,187 overpayment).
- For inpatient claims paid in excess of charges, the Hospital billed Medicare with an incorrect DRG (one error resulting in a \$19,903 overpayment).⁴
- For claims involving inpatient manufacturer credits for medical devices, the Hospital incorrectly billed Medicare for a medical device after receiving a manufacturer's credit (one error resulting in a \$4,800 overpayment).

Of 122 sampled outpatient claims, 30 claims had billing errors, resulting in overpayments totaling \$70,959.

- For outpatient evaluation and management services billed with surgical services, the Hospital submitted claims to Medicare with insufficient medical record documentation to support billing the evaluation and management services (15 errors), and the Hospital submitted a claim with an incorrect HCPCS code (1 error) (16 errors totaling \$1,191 in overpayments).
- For outpatient claims paid in excess of charges, the Hospital submitted claims to Medicare with incorrect HCPCS codes (three errors), incorrect units of service (three errors), and missing medical record documentation (one error) (seven errors totaling \$69,529 in overpayments).

⁴ Prior to the start of our audit, CMS's Recovery Audit Contractor (RAC) requested the medical records for this claim as part of its ongoing DRG validation reviews. The RAC also determined the claim to be in error, and the hospital has refunded the overpayment. As a result, we did not include this claim in the calculation of overpayments for this review.

- For outpatient claims billed during DRG payment windows, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays that should have been included on the Hospital's inpatient (Part A) bills to Medicare (seven errors totaling \$239 in overpayments).⁵

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 10 of the 80 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$163,063 (one claim had two types of errors).

Inpatient 1-Day 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 diagnosing or treating illness or injury or for improving the functioning of a malformed body member.” Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if, “with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual’s medical treatment”

For 5 of the 37 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services (4 errors), and the Hospital billed for an inpatient stay that lacked a physician’s signature to admit a patient to inpatient care (1 error). The hospital attributed the patient admission errors to inadequate communication between the utilization review staff and admitting physicians due to the short nature of the patient stays. The Hospital stated that human error caused the missing signature on the physician order to admit the beneficiary for inpatient care. As a result, the Hospital received overpayments totaling \$21,837.

Inpatient Claims With Payments Greater Than \$150,000

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately” Additionally, chapter 3, section 20.7.3.A, states that hospitals receive an add-on payment for the costs of furnishing blood clotting factor to certain Medicare beneficiaries and that providers must use revenue code 636 (drugs requiring detail coding) so that the clotting factor charges are not included in the Medicare claim’s cost outlier computations.⁶

⁵ The DRG payment window includes the date of a beneficiary’s inpatient admission and the 3 calendar days immediately preceding that inpatient admission.

⁶ Under the IPPS, Medicare makes outlier payments to hospitals when exceptionally costly cases exceed established thresholds.

For the two sampled claims, the Hospital billed Medicare with an incorrect revenue code (one error) and incorrect units of service (one error). Specifically, the Hospital used revenue code 250 (Pharmacy) instead of revenue code 636, which caused the clotting factor charges to be included in the cost outlier computations. The Hospital stated that these overpayments occurred because its computer software was programmed incorrectly and because of human error. As a result, the Hospital received overpayments totaling \$98,239.

Inpatient Claims for Blood Clotting Factor Drugs

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 3, section 20.7.3.A, states that hospitals receive an add-on payment for the costs of furnishing blood clotting factors to certain Medicare beneficiaries and that the provider must use revenue code 636 so that the clotting factor charges are not included in the cost outlier computations. In addition, 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 one of the two sampled claims, the Hospital billed Medicare with an incorrect revenue code and incorrect units of service. Specifically, the Hospital used revenue code 250 instead of revenue code 636, which caused the clotting factor charges to be included in the cost outlier computations. The Hospital stated that this overpayment occurred because its computer software was programmed incorrectly and because of human error. As a result, the Hospital received an overpayment of \$38,187.

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 diagnosing or treating illness or injury or for improving 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 30 sampled claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that the incorrect coding occurred because of human error. As a result, the Hospital received an overpayment of \$19,903.⁷

Inpatient Manufacturer Credits for 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

⁷ Prior to the start of our audit, CMS’s Recovery Audit Contractor (RAC) requested the medical records for this claim as part of its ongoing DRG validation reviews. The RAC also determined the claim to be in error, and the hospital has refunded the overpayment. As a result, we did not include this claim in the calculation of overpayments for this review.

to correctly bill 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 one of the seven sampled claims, the Hospital incorrectly billed Medicare for a medical device after receiving a credit from the manufacturer. Specifically, the Hospital did not report the required condition code, value code, and charge on the Medicare claim to reflect the credit received. The Hospital stated that this overpayment occurred because of a clerical error. As a result, the Hospital received an overpayment of \$4,800.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 30 of 122 sampled outpatient claims, which resulted in overpayments totaling \$70,959.

Outpatient Evaluation and Management Services Billed With Surgical Services

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. 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 16 of the 45 sampled claims, the Hospital submitted claims to Medicare with insufficient medical record documentation to support billing the evaluation and management services (15 errors), and the Hospital submitted a claim that had an incorrect HCPCS code (1 error). The Hospital attributed the errors with insufficient documentation primarily to a single Hospital department that did not fully understand the Medicare billing requirements for evaluation and management services. The Hospital stated that the incorrect HCPCS code was due to human error. As a result, the Hospital received overpayments totaling \$1,191.

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. 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 20.4, states: “The definition of service units ... is the number of times the service or procedure being reported was performed”

For 7 of the 30 sampled claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes (3 errors), incorrect units of service (3 errors), and missing medical record documentation (1 error). The Hospital stated that these overpayments occurred because its computer software was programmed incorrectly and because of human error. As a result, the Hospital received overpayments totaling \$69,529.

Outpatient Claims Billed During Diagnosis-Related Group Payment Windows

The Manual, chapter 3, section 10.4, states that Part A covers certain items and nonphysician services furnished to inpatients, and consequently the inpatient prospective payment rate covers these services. These services include laboratory and pathology services.

For 7 of the 15 sampled claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays that should have been included on the Hospital's inpatient (Part A) bills to Medicare. Most of the claims billed in error were for laboratory or pathology services. The Hospital stated that these overpayments occurred because its computer software edit was not designed to identify outpatient charges posted after the Hospital submitted the inpatient claims to Medicare. As a result, the Hospital received overpayments totaling \$239.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$234,022, consisting of \$163,063 in overpayments for 10 incorrectly billed inpatient claims and \$70,959 in overpayments for 30 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

FLETCHER ALLEN HEALTH CARE COMMENTS

In comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that it has refunded overpayments to the Medicare contractor. In addition, the Hospital stated that it has strengthened controls to comply with Medicare requirements. The Hospital's comments are included in their entirety as the appendix.

APPENDIX

APPENDIX: FLETCHER ALLEN HEALTH CARE COMMENTS



May 23, 2011

Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region 1
John F. Kennedy Federal Building
Room 2425
Boston MA 02203

Re: Report Number A-01-10-00527

Dear Mr. Armstrong:

I am writing to provide comments on behalf of Fletcher Allen Health Care (Fletcher Allen) to the report entitled "Medicare Compliance Review of Fletcher Allen Health Care for Calendar Years 2008 and 2009." Thank you for the opportunity to respond to the draft report.

As noted in the draft report, the Office of Inspector General (OIG) performed this review of nine areas determined to be at risk for non-compliance based on the OIG's prior audits, investigations and inspections of many hospitals. The audit covered 202 claims and \$3,363,543 in Medicare payments to Fletcher Allen.

Fletcher Allen concurs with the Office of Inspector General's (OIG's) findings that of 202 sampled claims, 40 claims had billing errors that resulted in overpayments totaling \$234,022. Fletcher Allen has made necessary refunds and has taken several steps to strengthen its controls to ensure full compliance with Medicare requirements.

Our responses to the OIG's recommendations are set forth below.

1. Refund to the Medicare contractor overpayments of \$234,022.

Fletcher Allen has refunded the full amount of the overpayments to Medicare and secondary payers.

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Michael Armstrong
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2. Strengthen controls to ensure full compliance with Medicare requirements.

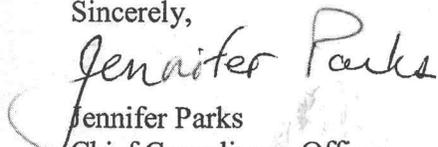
Fletcher Allen regularly conducts coding and compliance education, monitoring and auditing. To strengthen those efforts and address the issues raised by the OIG's findings, we have implemented several measures, including the following:

- Modified edits in the billing system for outpatient services that should be combined with an inpatient stay;
- Corrected assigned revenue codes in areas where errors occurred;
- Conducted additional coding education and auditing; and
- The case management process to determine whether a patient is an inpatient or not has been streamlined to occur "real time" and is more efficient.

Fletcher Allen takes these obligations very seriously and will continue to monitor and audit claims and institute additional controls as necessary.

Please contact me if you need any additional information.

Sincerely,


Jennifer Parks
Chief Compliance Officer
Fletcher Allen Health Care
Jennifer.Parks@vtmednet.org