

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF HACKENSACK
UNIVERSITY MEDICAL CENTER
FOR THE PERIOD APRIL 1, 2011,
THROUGH SEPTEMBER 30, 2012**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Brian P. Ritchie
Assistant Inspector General
for Audit Services

October 2014
A-02-13-01017

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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

Hackensack University Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated overpayments of at least \$1.7 million over 1½ years.

WHY WE DID THIS REVIEW

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

The objective of this review was to determine whether Hackensack University Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is a 775-bed acute care teaching hospital located in Hackensack, New Jersey. Medicare paid the Hospital approximately \$376 million for 22,385 inpatient and 159,420 outpatient claims for services provided to beneficiaries during the period April 1, 2011, through September 30, 2012 (audit period), based on CMS's National Claims History data.

Our audit covered \$7,570,827 in Medicare payments to the Hospital for 1,553 claims that were potentially at risk for billing errors. We selected a stratified random sample of 200 claims with payments totaling \$1,498,349 for review. These 200 claims had dates of service during the audit period and consisted of 45 inpatient and 155 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 138 of the 200 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 62 claims, resulting in overpayments of \$351,580 for the audit period. Specifically, 26 inpatient claims had billing errors, resulting in overpayments of

\$248,179, and 36 outpatient claims had billing errors, resulting in overpayments of \$103,401. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,719,632 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$1,719,632 (of which \$351,580 were overpayments identified in our sample) in estimated overpayments for claims it incorrectly billed during the audit period, and
- strengthen controls to ensure full compliance with Medicare requirements.

HACKENSACK UNIVERSITY MEDICAL CENTER COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations and described corrective actions that it had taken or planned to take to address them.

The Hospital disagreed with our determinations for 4 of the 62 sampled items that we found not to be in compliance with Medicare billing requirements. Specifically, the Hospital indicated that three inpatient claims met the medical necessity criteria for inpatient admission, and that one outpatient claim did not require a physician's order for observation services to be provided. The Hospital also stated that the error rate of our sample of inpatient short stays is not representative of the Hospital's overall compliance for these stays. In addition, the Hospital disagreed with the statement in our draft report that it did not have a case worker onsite to oversee final patient discharge procedures, and stated that the lack of oversight was specific to the Hospital's operating room and post anesthesia care unit.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We used an independent medical contractor to determine whether the three inpatient and one outpatient claims met medical necessity and coding requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the claims in compliance with Medicare requirements. On the basis of the contractor's conclusions, we determined that the Hospital should have billed the three inpatient claims as outpatient or outpatient with observation services, and that, for the one outpatient claim, an order written by a physician was required in order to receive observation services.

We use computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance. The results from our stratified random sample were

projected to all risk area claims from which they were drawn and were representative of the selected population. Finally, we agree that a lack of case management for overseeing final patient discharge procedures was specific to the Hospital's operating room and post anesthesia care unit, and have revised our report accordingly.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review.....	1
Objective.....	1
Background.....	1
The Medicare Program	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System.....	1
Hospital Claims at Risk for Incorrect Billing	2
Medicare Requirements for Hospital Claims and Payments	2
Hackensack University Medical Center.....	3
How We Conducted This Review.....	3
FINDINGS	3
Billing Errors Associated With Inpatient Claims	4
Incorrectly Billed as Inpatient.....	4
Manufacturer Credits for Replaced Medical Devices Not Obtained	4
Billing Errors Associated With Outpatient Claims.....	5
Manufacturer Credits for Replaced Medical Devices Not Obtained	5
Incorrectly Billed Observation Services	5
Noncovered Dental Services.....	6
Incorrectly Billed Outpatient Services with Modifier -59	6
Overall Estimate of Overpayments.....	6
RECOMMENDATIONS	7
HACKENSACK UNIVERSITY MEDICAL CENTER COMMENTS AND OUR RESPONSE	7
APPENDIXES	8
A: Audit Scope and Methodology	8
B: Statistical Sampling Methodology	10
C: Sample Results and Estimates.....	12

D: Results of Review by Risk Area13

E: Hackensack University Medical Center Comments.....14

INTRODUCTION

WHY WE DID THIS REVIEW

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

OBJECTIVE

Our objective was to determine whether Hackensack University Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of 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 descriptions 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. In addition to the basic payments, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Claims at Risk for Incorrect Billing

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- inpatient short stays,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed with observation services that resulted in outlier payments,
- outpatient claims billed with modifier -59,
- outpatient claims billed with Doxorubicin Hydrochloride,
- outpatient claims billed with Herceptin, and
- outpatient dental 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), § 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 to the provider (§ 1833(e)).

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

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No.

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

100-04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Hackensack University Medical Center

The Hospital, which is part of the Hackensack University Health Network, is a 775-bed acute care teaching hospital located in Hackensack, New Jersey. Medicare paid the Hospital approximately \$376 million for 22,385 inpatient and 159,420 outpatient claims for services provided to beneficiaries from April 1, 2011, through September 30, 2012, (audit period) based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$7,570,827 in Medicare payments to the Hospital for 1,553 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 200 claims with payments totaling \$1,498,349. These 200 claims had dates of service during the audit period and consisted of 45 inpatient and 155 outpatient claims.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 68 claims to focused medical review to determine whether the services met medical necessity and coding requirements. 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 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.

See Appendix A for the details of our scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 138 of the 200 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 62 claims, resulting in overpayments of \$351,580 for the audit period. Specifically, 26 inpatient claims had billing errors resulting in overpayments of \$248,179, and 36 outpatient claims had billing errors resulting in overpayments of \$103,401. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,719,632 for the audit period.

See Appendix B for our statistical sampling methodology, Appendix C for our sample results and estimates, and Appendix D for the results of our review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 26 of 45 sampled inpatient claims, which resulted in overpayments of \$248,179.

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, § 1862 (a)(1)(A)).

For 24 of the 45 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services. The Hospital stated that these errors occurred because there was no process in place for monitoring procedures ordered on the outpatient surgery list in its Emergency Department, and that patients were discharged prior to the Hospital’s initiating a request to change patients’ statuses from inpatient admission to outpatient status. In addition, the Hospital did not always have a case manager onsite to oversee final patient discharge procedures. As a result of these errors, the Hospital received overpayments of \$207,569.²

Manufacturer Credits for Replaced Medical Devices Not Obtained

Federal regulations require reductions in the IPPS payment 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 cost of the device (42 CFR § 412.89). Federal regulations state, “All payments to providers of services must be based on the reasonable cost of services” (42 CFR § 413.9). 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, § 100.8). The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements in additional detail (Pub. No. 15-1).³

² The Hospital 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.

³ The PRM 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” (part I, § 2102.1). Section 2103 further defines prudent buyer principles and 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

For 2 of the 45 inpatient claims, the Hospital did not obtain a credit for a replaced medical device for which a credit was available under the terms of the manufacturer's warranty. The Hospital stated that these errors occurred because it did not have a formal process in place for identifying the devices subject to manufacturer credits. As a result of these errors, the Hospital received overpayments of \$40,610.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 36 of 155 sampled outpatient claims, which resulted in overpayments of \$103,401.

Manufacturer Credits for Replaced Medical Devices Not Obtained

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 § 419.45). As described in footnote 3 of this report, the PRM reinforces these requirements in additional detail.

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

For 5 of the 155 sampled claims, the Hospital did not obtain a credit for a replaced device that was available under the terms of the manufacturer's warranty. The Hospital stated that these errors occurred because it did not have a formal process in place to identify the implantable medical devices that were subject to warranty or recall. As a result of these errors, the Hospital received overpayments of \$62,303.

Incorrectly Billed Observation Services

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act, § 1862(a)(1)(A)). The Manual 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. A provider 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... observation time ends when all medically necessary services related to

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."

observation care are completed” (chapter 4, § 290.2.2). The Manual also states: “Observation services must also be reasonable and necessary to be covered by Medicare” (chapter 4, § 290.1). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 19 of the 155 sampled claims, the Hospital billed Medicare for incorrect units of service for HCPCS code G0378 (hospital observation services). The Hospital stated that these errors occurred due to a weakness in its workflow process and human error. As a result of these errors, the Hospital received overpayments of \$18,929.

Noncovered Dental Services

The Act precludes payment under Part A or Part B for any expense incurred for items or services where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth (§ 1862 (a)(12)).

For 6 of the 155 sampled claims, the Hospital incorrectly billed Medicare for the removal of teeth. The Hospital stated that these errors were due to human error. Specifically, the Hospital stated that scheduling personnel did not evaluate dental procedures to assure that the services were covered by Medicare. As a result of these errors, the Hospital received overpayments of \$16,397.

Incorrectly Billed Outpatient Services With Modifier -59

The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, §80.3.2.2). It also states: “The ‘-59’ modifier is used to indicate a distinct procedural service This may represent a different session or patient encounter, a different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)” (chapter 23, § 20.9.1.1).

For 6 of the 155 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes with modifier -59 for services that were already included in the payments for other services billed on the same claim. The Hospital stated that these errors occurred due to unclear guidance on billing issues and discrepancies in educational materials. As a result of these errors, the Hospital received overpayments of \$5,772.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,719,632 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$1,719,632 (of which \$351,580 were overpayments identified in our sample) in estimated overpayments for claims it incorrectly billed during the audit period, and
- strengthen controls to ensure full compliance with Medicare requirements.

HACKENSACK UNIVERSITY MEDICAL CENTER COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations and described corrective actions that it had taken or planned to take to address them.

The Hospital disagreed with our determinations for 4 of the 62 sampled items that we found not to be in compliance with Medicare billing requirements. Specifically, the Hospital indicated that three inpatient claims met the medical necessity criteria for inpatient admission, and one outpatient claim did not need a physician order for observation services to be provided. The Hospital also stated that the error rate of our sample of inpatient short stays is not representative of the Hospital's overall compliance for these stays. In addition, the Hospital disagreed with the statement in our draft report that it did not have a case worker onsite to oversee final patient discharge procedures, and stated that the lack of oversight was specific to the Hospital's operating room and post anesthesia care unit. The Hospital's comments are included in their entirety as Appendix E.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We used an independent medical contractor to determine whether the three inpatient and one outpatient claims met medical necessity and coding requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the claims in compliance with Medicare requirements. On the basis of the contractor's conclusions, we determined that the Hospital should have billed the three inpatient claims as outpatient or outpatient with observation services, and that, for the one outpatient claim, an order written by a physician was required in order to receive observation services.

We use computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance. The results from our stratified random sample were projected to all risk area claims from which they were drawn and were representative of the selected population. Finally, we agree that a lack of case management for overseeing final patient discharge procedures was specific to the Hospital's operating room and post anesthesia care unit, and have revised our report accordingly.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$7,570,827 in Medicare payment to the Hospital for 1,553 claims that were potentially at risk for billing errors. We selected a stratified random sample of 200 claims with payments totaling \$1,498,349 for review. These 200 claims had dates of service during the audit period and consisted of 45 inpatient and 155 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 68 claims to focused medical review to determine whether the services met medical necessity and coding requirements.

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. 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 the Hospital for Medicare reimbursement.

We conducted our fieldwork from May 2013 through November 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's National Claims History file for the audit period;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 200 claims (45 inpatient and 155 outpatient) totaling \$1,498,349 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;
- obtained information on known credits for replaced cardiac medical devices from device manufacturers for the audit period;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for submitting Medicare claims;
- used CMS's Medicare administrative contractor medical review staff and an independent contractor to determine whether 68 sampled claims met medical necessity and coding 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;
- used the results of the sample to estimate the Medicare overpayments to the Hospital (Appendix C); and
- discussed the results of the 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 objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population contained inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during the audit period.

SAMPLING FRAME

Medicare paid the Hospital \$208,813,780 for 9,059 inpatient and 31,173 outpatient claims in 34 risk areas for services provided to beneficiaries during the audit period based on CMS's National Claims History data.

From these 34 risk areas, we selected 9 consisting of 18,141 claims totaling \$136,867,096 for further review. We then removed the following:

- all \$0 paid claims,
- all claims under review by the Recovery Audit Contractor, and
- all duplicated claims within individual high risk categories.

We assigned each claim that appeared in multiple risk areas to just one area. We then further revised our sampling frame based on refinements within each category, resulting in a sampling frame of 1,553 unique Medicare claims in 9 risk areas totaling \$7,570,827.

Risk Area	Number of Claims	Amount of Payments
1. Inpatient Short Stays	244	\$2,225,67
2. Inpatient Manufacturer Credits for Replaced Medical	10	\$442,396
3. Inpatient Claims Billed with High-Severity-Level DRG	5	\$33,400
4. Outpatient Observation with Outliers	1090	\$3,867,15
5. Outpatient Claims Billed with Modifier -59	109	\$434,976
6. Outpatient Claims Billed for Doxorubicin Hydrochloride	65	\$262,427
7. Outpatient Claims Billed for Herceptin	13	\$83,529
8. Outpatient Manufacturer Credits for Replaced Medical	10	\$202,777
9. Outpatient Billing for Dental Services	7	\$18,491
Total	1,553	\$7,570,82

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into nine strata based on risk area.

SAMPLE SIZE

We selected 200 claims for review as follows:

Stratum	Medicare Issue	Claims in Sample
1	Inpatient Short Stays	30
2	Inpatient Manufacturer Credits for Replaced Medical Devices	10
3	Inpatient Claims Billed with High-Severity-Level DRG Codes	5
4	Outpatient Observation with Outliers	30
5	Outpatient Claims Billed with Modifier -59	30
6	Outpatient Claims Billed for Doxorubicin Hydrochloride	65
7	Outpatient Claims Billed for Herceptin	13
8	Outpatient Manufacturer Credits for Replaced Medical Devices	10
9	Outpatient Billing for Dental Services	7
	Total Sampled Claims	200

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General/Office of Audit Services (OIG/OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata 1, 4, and 5. After generating the random numbers for strata 1, 4, and 5, we selected the corresponding claims in each stratum. We selected all claims in strata 2, 3, 6, 7, 8, and 9.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate our estimates. We used the lower-limit of the 90-percent confidence interval to estimate the amount of improper Medicare payments in our sampling frame during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	244	\$2,225,674	30	\$245,681	20	\$179,441
2*	10	442,396	10	442,396	2	40,610
3*	5	33,400	5	33,400	4	28,128
4	1090	3,867,157	30	99,786	19	18,929
5	109	434,976	30	109,862	6	5,772
6*	65	262,427	65	262,427	0	0
7*	13	83,529	13	83,529	0	0
8*	10	202,777	10	202,777	5	62,303
9*	7	18,491	7	18,491	6	16,397
Total	1,553	\$7,570,827	200	\$1,498,349	62	\$351,580

* We reviewed all claims in this stratum.

ESTIMATES

Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	\$2,315,603
Lower Limit	\$1,719,632
Upper Limit	\$2,911,574

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Overpayments	Value of Overpayments
Inpatient				
Short Stays	30	\$245,681	20	\$179,441
Manufacturer Credits for Replaced Medical Devices	10	442,396	2	40,610
Claims Billed With High-Severity-Level DRG Codes	5	33,400	4	28,128
Inpatient Totals	45	\$721,477	26	\$248,179
Outpatient				
Manufacturer Credits for Replaced Medical Devices	10	\$202,777	5	\$62,303
Observation Claims With Outliers	30	99,786	19	18,929
Dental Services	7	18,491	6	16,397
Claims Billed With Modifier -59	30	109,862	6	5,772
Claims Billed for Doxorubicin Hydrochloride	65	262,427	0	0
Claims Billed for Herceptin	13	83,529	0	0
Outpatient Totals	155	\$776,872	36	\$103,401
Inpatient and Outpatient Totals	200	\$1,498,349	62	\$351,580

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at Hackensack University Medical Center. 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 E: HACKENSACK UNIVERSITY MEDICAL CENTER COMMENTS



September 8, 2014

Mr. James P. Edert
Regional Inspector General, Audit Services
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Re: Draft Report Number A-02-13-01017

Dear Mr. Edert,

Hackensack University Medical Center (HackensackUMC) appreciates the opportunity to review and provide comment on the draft report entitled Medicare Compliance Review of Hackensack University Medical Center for the Period April 1, 2011, through September 30, 2012, (Report Number A-02-13-01017). As requested in your letter, I am providing written comments related to the validity of the facts and reasonableness of the recommendations in this report and the nature of corrective action taken or planned.

HackensackUMC is committed to compliance with all federal regulations and standards governing its participation in federal health care programs and has a well-established compliance program dedicated to assuring that HackensackUMC, its employees and staff understand and comply with applicable laws and regulations. As indicated in this letter, HackensackUMC has enhanced its internal controls and plans to work with the Medicare Administrative Contractor to appeal where noted, recalculate extrapolated errors where appropriate and process any necessary adjustments.

In response to the OIG's review findings, HackensackUMC provides the following comments:

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Incorrectly Billed as Inpatient

HackensackUMC generally concurs with the OIG's findings for 21 of the 24 incorrectly billed claims in the 45 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services. However, we believe that the error rate of this sample is not representative of our overall compliance for inpatient short stays. HackensackUMC has devoted significant resources to improving our case management processes. The claims reviewed comprise a small percentage of our short stay volume, and my belief is the provider community would be better served if OIG shared these risk areas prospectively so we may further improve our processes. In performing our internal assessment of this sample, a HackensackUMC Physician Advisor

1

Hackensack University Medical Center | 30 Prospect Avenue | Hackensack, NJ 07601 | 551-996-2000 | www.HackensackUMC.org

reviewed each record using Interqual criteria as well as their medical judgment to evaluate the medical necessity of the admission.

- We disagree with the OIG statement that the Hospital did not have a case manager onsite to oversee final patient discharge procedures. We did have case management on site and in the emergency room 15 hours a day and on weekends. The oversight that was lacking was specific to the OR and PACU, and a weakness in the system allowed the cases to be discharged prior to the review by case management.
- We are appealing 3 of the 24 claims in the review as we believe the cases met the medical necessity criteria for inpatient admission. As indicated in the Report, HackensackUMC 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.

During the review period, HackensackUMC had a full-time physician advisor available to the emergency department during daytime hours to assist in evaluating the medical necessity of patient stay and appropriate patient status. Since the review began, HackensackUMC has provided physician re-education on evaluating the medical necessity of patient stays and appropriate patient status. We have also increased case management accessibility in the emergency department with the goal of proactive interaction with the emergency physicians to enhance care-coordination when establishing patient status. Lastly, case management has worked with our Revenue Cycle Team to improve the registration process for patients going from the emergency setting directly to the operating room.

Manufacturer Credits for Replaced Medical Devices Not Obtained

We concur with the OIG's findings related to 2 of the 45 inpatient claims, HackensackUMC did not obtain a credit for a replaced medical device for which a credit was available under the terms of the manufacturer warranty. In late 2012, we performed an internal review to determine what the medical center's processes were for identifying and billing patients for implantable devices replaced under warranty or recalled for credit. In early 2013, prior to the OIG notice of review, a policy and procedure was drafted, and we began piloting this new process.

A multidisciplinary team developed a process for identifying patients and billing Medicare for implantable devices replaced under recall or warranty. A central electronic repository was developed. Accessible to all involved department, the repository contained a device return log, various scanned forms and documents, and is now used to track possible and actual credits and the rebilling to Medicare when credits received were at least 50% of the replacement cost. We continue to monitor and evaluate the efficacy of this process.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Manufacturer Credits for Medical Devices Not Obtained

We concur with the OIG's findings related to 5 of the 155 outpatient claims, HackensackUMC did not obtain a credit for a replaced medical device for which a credit was available under the terms of the manufacturer warranty. In late 2012 we performed an internal review to determine what the medical center's processes were for identifying and billing patients for implantable devices replaced under warranty or recalled for credit. In early 2013, prior to the OIG notice of review, a policy and procedure was drafted, and we began piloting this new process.

A multidisciplinary team developed a process for identifying patients and billing Medicare for implantable devices replaced under recall or warranty. A central electronic repository was developed. Accessible to all involved department, the repository contained a device return log, various scanned forms and documents, and is now used to track possible and actual credits and the rebilling to Medicare when credits received were at least 50% of the replacement cost. We continue to monitor and evaluate the efficacy of this process.

Incorrectly Billed Observation Services

We generally concur with the OIG statement with one exception; the OIG stated that one claim was paid in error because the patient's medical record did not contain a valid order signed by a physician for outpatient observation services. During the period of review (April 1, 2011, through September 30, 2012), a physician order was not a requirement for observation services. According to the Medicare Claims Processing Manual- Chapter 4, Section 290.1 - Outpatient Observation Services:

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.

- HackensackUMC is appealing the above noted claim as observation is an outpatient service and was ordered by an APN practicing within her scope. We believe that a physician order was not a requirement for the observation services provided during the period of review.

Additional errors were attributed to incorrectly calculated units of observation. Prior to this review, an automated process was implemented in August 2013 to calculate observation units and carve outs for separately billable monitored procedures. In addition, Medical Leadership is now implementing an educational initiative to ensure timely communication and patient hand off reports between physicians treating observation cases. This will assure that patients are appropriately discharged when observation is no longer required.

Noncovered Dental Services

We concur with the OIG's findings that for 6 of the 155 sampled claims, the Hospital incorrectly billed Medicare for the removal of teeth. Since this review, a screening process has been employed at the time of scheduling to ensure that the appropriate dental services are performed based on the coverage criteria. In addition, we provided education to the OR Scheduling Team and appropriate physicians regarding Medicare's Regulations as it relates to Dental Services. If services must be performed for clinical reasons; physician/scheduling team must inform Beneficiary that these are non-covered services and statutorily excluded. Beneficiary will be informed of his/her liability and claims will be submitted to Medicare for a denial only. As a secondary control, a coding logic edit was implemented to identify claims that do not meet the established Medicare criteria prior to the bill dropping.

Incorrectly Billed Outpatient Services with Modifier-59

We concur with the OIG's findings that for 6 of the 155 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes with modifier -59 for services that were already included in the payment for other services billed on the same claim. HackensackUMC has a strong coding compliance program in place and as noted in the report, the identified errors were attributed to conflicting guidance.

Since the review, HackensackUMC implemented additional edits to identify code pairs that cannot be unbundled. In addition, the Department of Health Information Management conducts focused reviews on accounts with the use of Modifier-59 and has added all issues identified by this audit to their coding compliance program. The Department will continue to provide staff education on Modifier-59 and has purchased additional reference tools for the APC Auditor and Coders to use for guidance.

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

Sincerely,

Thomas A. Flynn

/Thomas A. Flynn/

Thomas A. Flynn
Vice President, Chief Compliance Officer
Hackensack University Medical Center

c/ Robert C. Garrett, President and CEO, Hackensack University Health Network