



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**

WASHINGTON, DC 20201



April 3, 2012

**TO:** Peter Budetti  
Deputy Administrator and Director  
Center for Program Integrity  
Centers for Medicare & Medicaid Services

Deborah Taylor  
Director and Chief Financial Officer  
Office of Financial Management  
Centers for Medicare & Medicaid Services

**FROM:** /Brian P. Ritchie/  
Assistant Inspector General for the  
Centers for Medicare & Medicaid Audits

**SUBJECT:** Medicare Compliance Review of Georgetown University Hospital for Calendar Years 2009 and 2010 (A-03-11-00010)

Attached, for your information is an advance copy of our final report on our most recent hospital compliance review. We will issue this report to Georgetown University Hospital within 5 business days.

This report is part of a series of the Office of Inspector General's hospital compliance initiative, designed to review multiple issues concurrently at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at [Brian.Ritchie@oig.hhs.gov](mailto:Brian.Ritchie@oig.hhs.gov), or your staff may contact Stephen Virbitsky, Regional Inspector General for Audit Services, at (215) 861-4470 or through email at [Stephen.Virbitsky@oig.hhs.gov](mailto:Stephen.Virbitsky@oig.hhs.gov).

Attachment

cc: Daniel Converse  
Office of Strategic Operations and Regulatory Affairs,  
Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL



APRIL 9, 2012

OFFICE OF AUDIT SERVICES, REGION III  
PUBLIC LEDGER BUILDING, SUITE 316  
150 S. INDEPENDENCE MALL WEST  
PHILADELPHIA, PA 19106

Report Number: A-03-11-00010

S. Jnatel Simmons, J.D.  
Vice President and Compliance Officer  
MedStar Health, Inc.  
5565 Sterrett Place  
Columbia, MD 21044

Dear Ms. Simmons:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Georgetown University Hospital for Calendar Years 2009 and 2010*. 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Leonard Piccari, Audit Manager, at (215) 861-4493 or through email at [Leonard.Piccari@oig.hhs.gov](mailto:Leonard.Piccari@oig.hhs.gov). Please refer to report number A-03-11-00010 in all correspondence.

Sincerely,

/Stephen Virbitsky/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 East 12<sup>th</sup> Street, Room 235  
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF  
GEORGETOWN UNIVERSITY HOSPITAL  
FOR CALENDAR YEARS  
2009 AND 2010**



Daniel R. Levinson  
Inspector General

April 2012  
A-03-11-00010

# ***Office of Inspector General***

<http://oig.hhs.gov>

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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*

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

Section 8L 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**

### **BACKGROUND**

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

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

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 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.

Georgetown University Hospital (the Hospital) is a 609-bed acute care teaching hospital located in the District of Columbia. The Hospital is a member of the nonprofit MedStar Health regional healthcare system. Medicare paid the Hospital approximately \$204 million for 9,316 inpatient and 81,387 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$1,353,748 in Medicare payments to the Hospital for 140 inpatient and 125 outpatient claims that we identified as potentially at risk for billing errors. These 265 claims had dates of service in CYs 2009 and 2010.

### **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 131 of the 265 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 134 claims, resulting in overpayments totaling \$659,371 for CYs 2009 and 2010. Specifically, 94 inpatient claims had billing errors, resulting in overpayments totaling \$634,653, and 40 outpatient claims had billing errors, resulting in overpayments totaling \$24,718. These overpayments occurred primarily because the Hospital did not have adequate controls over some areas to prevent incorrect billing and coding of Medicare claims or did not fully understand the Medicare billing requirements in these areas.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$659,371, consisting of \$634,653 in overpayments for 94 incorrectly billed inpatient claims and \$24,718 in overpayments for 40 incorrectly billed outpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

## **GEORGETOWN UNIVERSITY HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital concurred that all 134 claims identified in the findings were billed incorrectly. The Hospital also concurred with the overpayment amount for the outpatient claims, but did not concur with the overpayment amount for inpatient claims. The Hospital stated that it anticipates making adjustments for reimbursement under Medicare Part B for services under the 91 short stay inpatient claims and for corrected DRG codes on the remaining 3 inpatient claims. In addition, the Hospital stated that it would continue with an education campaign on billing accuracy with coding and billing staff, attending physicians, and residents.

The Hospital's comments are included in their entirety as the Appendix.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

We agree that, as noted in the report, the Hospital may be able to bill Medicare Part B for some services provided under the 91 short stay inpatient claims billed incorrectly. However, for the three claims billed under the incorrect DRG, we calculated the overpayment based on the correct DRG and that amount should not change.

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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.<sup>1</sup>

#### **Hospital Inpatient Prospective Payment System**

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

#### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>2</sup> 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.<sup>3</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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<sup>1</sup> Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required 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.

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

<sup>3</sup> 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 short stays,
- inpatient same-day discharges and readmissions,
- inpatient and outpatient claims involving manufacturer credits for replaced medical devices,
- outpatient claims billed with modifier -59,
- outpatient claims billed during an inpatient stay,
- outpatient claims for evaluation and management services billed with other services,
- outpatient surgeries with greater than one unit,
- inpatient and outpatient claims paid in excess of charges, and
- outpatient claims paid in excess of \$25,000.

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

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

## **Medicare Requirements for Hospital Claims and Payments**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may

process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

## **Georgetown University Hospital**

Georgetown University Hospital (the Hospital) is a 609-bed acute care teaching hospital located in the District of Columbia. The Hospital is a member of the nonprofit MedStar Health regional healthcare system. Medicare paid the Hospital approximately \$204 million for 9,316 inpatient and 81,387 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

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

### **Scope**

Our audit covered \$1,353,748 in Medicare payments to the Hospital for 265 claims that we judgmentally selected as potentially at risk for billing errors. These 265 claims had dates of service in CYs 2009 and 2010 and consisted of 140 inpatient and 125 outpatient claims.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not use 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 claims selected for 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 inpatient and outpatient claims 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 August and September 2011.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;
- requested information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2009 and 2010;
- 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 265 claims (140 inpatient and 125 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 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 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 131 of the 265 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 134 claims, resulting in overpayments totaling \$659,371 for CYs 2009 and 2010. Specifically, 94 inpatient claims had billing errors, resulting in overpayments totaling \$634,653, and 40 outpatient claims had billing errors, resulting in overpayments totaling \$24,718. These overpayments occurred primarily because the Hospital

did not have adequate controls over some areas to prevent incorrect billing and coding of Medicare claims or did not fully understand the Medicare billing requirements in these areas.

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 94 of the 140 selected inpatient claims, which resulted in overpayments totaling \$634,653.

### **Inpatient Short Stays**

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

For 91 of the 140 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Hospital officials attributed these errors to physicians in the residency and fellows training programs misunderstanding the criteria for inpatient admission and observation status. As a result, the Hospital received overpayments totaling \$576,927.<sup>4</sup>

### **Inpatient Claims Paid in Excess of Charges**

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

For 3 of the 140 selected claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that these errors occurred because of human error. As a result, the Hospital received overpayments totaling \$57,726.

## **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 40 of 125 selected outpatient claims, which resulted in overpayments totaling \$24,718.

### **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. Chapter 4, section 20.4 of the Manual states that “The definition of service units ... is the number of times the service or procedure being reported was performed.” Additionally, the Manual, chapter 1, section 80.3.2.2,

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<sup>4</sup> The Hospital may bill Medicare Part B for a limited range of services related to some of these 91 incorrect Medicare Part A short-stay claims. 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 or adjudicated by the MAC during our review.

requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 3 of the 125 selected claims, the Hospital submitted claims to Medicare with incorrect units of service (2 claims) or missing medical record documentation to support the procedure performed (1 claim). Hospital officials stated these overpayments occurred because of human error. As a result, the Hospital received overpayments totaling \$15,889.

### **Outpatient Claims Billed During an Inpatient Stay**

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.

For 15 of the 125 selected 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) bill to Medicare. Hospital officials stated these errors occurred because of human error. As a result, the Hospital received overpayments totaling \$4,469.

### **Outpatient Multiple Surgeries**

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 of the Manual states that "The definition of service units ... is the number of times the service or procedure being reported was performed."

For 1 of the 125 selected claims, the Hospital incorrectly billed Medicare for overstated surgical service units performed. Hospital officials stated this error occurred because of human error. As a result, the Hospital received overpayments totaling \$3,150.

### **Outpatient Evaluation and Management Services Billed With Other 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, requires that claims be completed accurately to be processed correctly and promptly.

For 21 of the 125 selected claims, the Hospital incorrectly billed Medicare for services that were not separably payable because they were part of the usual preoperative and postoperative care associated with a procedure and paid as part of that procedure. Hospital officials stated that these errors occurred because billing documents were improperly sorted during the Hospital's transition from paper to electronic medical records. As a result, the Hospital received overpayments totaling \$1,210.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$659,371, consisting of \$634,653 in overpayments for 94 incorrectly billed inpatient claims and \$24,718 in overpayments for 40 incorrectly billed outpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

## **GEORGETOWN UNIVERSITY HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital concurred that all 134 claims identified in the findings were billed incorrectly. The Hospital also concurred with the overpayment amount for the outpatient claims, but did not concur with the overpayment amount for inpatient claims. The Hospital stated that it anticipates making adjustments for reimbursement under Medicare Part B for services under the 91 short stay inpatient claims and for corrected DRG codes on the remaining 3 inpatient claims. In addition, the Hospital stated that it would continue with an education campaign on billing accuracy with coding and billing staff, attending physicians, and residents.

The Hospital's comments are included in their entirety as the Appendix.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

We agree that, as noted in the report, the Hospital may be able to bill Medicare Part B for some services provided under the 91 short stay inpatient claims billed incorrectly and that we were unable to determine the effect this would have on the overpayment amount since it was not completed during our review. However, for the three claims billed under the incorrect DRG, we calculated the overpayment based on the correct DRG and that amount should not change.

# **APPENDIX**

## APPENDIX: GEORGETOWN UNIVERSITY HOSPITAL COMMENTS



Hospital Administration

February 23, 2012

VIA Federal Express

Mr. Stephen Virbitsky  
Regional Inspector General for Audit Services  
Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, PA 19106-3499

Re: Audit No. A-03-11-00010

Dear Mr. Virbitsky:

On behalf of Georgetown University Hospital, I am providing comments to the report entitled: *Medicare Compliance Review of Georgetown University Hospital for Calendar Years 2009 and 2010*. I appreciate the opportunity to respond to the draft report.

As noted in the draft report, the Office of Inspector General (OIG) reviewed 265 claims totaling \$1,353,748 in Medicare payments to the Hospital. These claims were judgmentally selected as potentially at risk for billing errors. The 265 claims had dates of service in CYs 2009 and 2010 and consisted of 140 inpatient and 125 outpatient claims. The Hospital's comments regarding each category of claims covered and reviewed during the OIG's audit are denoted below.

Inpatient Short Stays

The Hospital concurs that 91 claims were billed incorrectly as inpatient short stays. As it concerns the overpayment amount, as stated in footnote number 4 of the draft report, "The Hospital may bill Medicare Part B for a limited range of services related to some of these 91 incorrect Medicare Part A short-stays. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because the services had not been billed or adjudicated by the MAC during our review." For these same reasons, the Hospital is not presently in the position to concur with the OIG regarding the amount of the overpayment. We anticipate that it will be less than \$576,927 after adjustments are made for reimbursement of the Part B services provided.

Inpatient Claims Paid In Excess of Charges

The Hospital concurs that 3 claims were billed with incorrect DRG codes. As it concerns the overpayment amount, the Hospital anticipates that adjustments will be made to the claims at issue based on the correct DRG assignment(s). For this reason, the Hospital is not presently in the position to concur with the OIG regarding the amount of the overpayment. We anticipate that it will be less than \$57,726 after adjustments are made to reimbursement consistent with the correct DRG assignment(s).

Outpatient Claims Paid in Excess of Charges; Outpatient Claims Billed During an Inpatient Stay; Outpatient Multiple Surgeries; Outpatient Evaluation and Management Services Billed With Other Services

The Hospital concurs with the OIG's findings and will refund to the Hospital's Medicare Administrative Contractor \$24,718, representative of 40 outpatient claims reviewed by the OIG and identified as billed in error.

The Hospital's responses to the OIG's recommendations are as follows:

1. We will refund to the Medicare Administrative Contractor \$24,718, representative of 40 outpatient claims reviewed by the OIG and identified as billed in error. Regarding overpayments associated with the 94 inpatient claims reviewed by the OIG and identified as billed in error, the Hospital will process appropriate refunds to the Medicare Administrative Contractor pending adjustment to reimbursement made for the services provided.
2. Prior to the OIG's audit, the Hospital launched an education campaign and conducted audits to monitor billing accuracy. The Hospital will continue to provide documentation, coding and compliance education to coding and billing staff, attending physicians and residents on an ongoing basis. Further, the Hospital will continue to monitor and audit internal controls and remediate identified errors.

Georgetown University Hospital takes its obligation to bill correctly very seriously. Indeed, the Hospital strives at all times to accurately bill for services provided and will continue to do so. Thank you again for the opportunity to respond to the draft report.

Sincerely,



Paul Warda  
Chief Financial Officer  
Georgetown University Hospital