

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF MEDSTAR
WASHINGTON HOSPITAL CENTER**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

MedStar Washington Hospital Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of \$1 million over 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether MedStar Washington Hospital Center (Washington Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

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

Washington Hospital is a 926-bed acute care teaching hospital located in the District of Columbia. Washington Hospital is a member of the nonprofit MedStar Health regional healthcare system. Medicare paid Washington Hospital approximately \$546 million for 29,448 inpatient and 247,020 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$3,200,322 in Medicare payments to Washington hospital for 313 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 127 inpatient and 186 outpatient claims.

WHAT WE FOUND

Washington Hospital complied with Medicare billing requirements for 138 of the 313 inpatient and outpatient claims we reviewed. However, Washington Hospital did not fully comply with Medicare billing requirements for the remaining 175 claims, resulting in net overpayments of \$1,062,192 for CY 2010 and 2011. Specifically, 80 inpatient claims had billing errors, resulting in net overpayments of \$411,134, and 95 outpatient claims had billing errors, resulting in overpayments of \$651,058. These errors occurred primarily because Washington Hospital did

not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that Washington Hospital:

- refund to the Medicare contractor \$1,062,192, consisting of \$411,134 in net overpayments for 80 incorrectly billed inpatient claims and \$651,058 in overpayments for 95 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

WASHINGTON HOSPITAL COMMENTS

In written comments to our draft report, Washington Hospital concurred with the majority of our findings and recommendations and described the actions it had taken, or planned to take, to address them. Washington Hospital said that it partially concurred with our finding that outpatient or observational stays were incorrectly billed as inpatient and described the measures used to make the inpatient determination for a representative sample of claims for which it did not concur. Washington Hospital partially concurred with our finding that intensity modulated radiation therapy (IMRT) services were not separately billable and said that it did not concur for one service because a Local Coverage Determination (L27515) allowed providers to bill the service separately. Washington Hospital did not concur with our finding that observation services were incorrectly billed and said that CMS had not clearly defined active monitoring procedures.

OFFICE OF INSPECTOR GENERAL RESPONSE

The information noted by Washington Hospital in its examples was included in the medical records we submitted for independent medical review. The independent medical reviewer noted the information in its considerations but determined that the claims for observational stays billed as inpatient stays did not meet Medicare criteria for inpatient status. The Local Coverage Determination cited by Washington Hospital does not specify whether or not the service may be billed separately when it is part of planning the IMRT; however, the Medicare Claims Processing Manual does not allow this service to be billed separately when it is performed for planning the IMRT. Also, the Manual states that observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure. Therefore, we maintain that our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether MedStar Washington Hospital Center (Washington Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services

within each APC group.¹ All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient and outpatient claims paid in excess of charges,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims paid in excess of \$150,000,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims paid in excess of \$25,000,
- outpatient claims for dental services,
- outpatient intensity modulated radiation therapy (IMRT) planning services,
- outpatient claims billed during inpatient stays,
- outpatient claims with observation outliers,
- outpatient claims for surgeries greater than one,
- outpatient claims billed with evaluation and management (E&M) services, and
- outpatient claims billed with modifiers.

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 the provider (the Act, § 1833(e)).

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

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. 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).

MedStar Washington Hospital Center

Washington Hospital is a 926-bed acute care teaching hospital located in the District of Columbia. Washington Hospital is a member of the nonprofit MedStar Health regional healthcare system. Medicare paid Washington Hospital approximately \$546 million for 29,448 inpatient and 247,020 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$3,200,322 in Medicare payments to Washington Hospital for 313 claims that we judgmentally selected as potentially at risk for billing errors with dates of service during 2010 and 2011 (audit period). These 313 claims consisted of 127 inpatient and 186 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 subjected 90 claims to focused medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Washington 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 the Appendix A for the details of our scope and methodology.

FINDINGS

Washington Hospital complied with Medicare billing requirements for 138 of the 313 inpatient and outpatient claims we reviewed. However, Washington Hospital did not fully comply with Medicare billing requirements for the remaining 175 claims, resulting in net overpayments of \$1,062,192 for the audit period. Specifically, 80 inpatient claims had billing errors, resulting in net overpayments of \$411,134, and 95 outpatient claims had billing errors, resulting in overpayments of \$651,058. These errors occurred primarily because Washington Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

Appendix B summarizes, by risk areas reviewed, the overpayments identified in this report.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Washington Hospital incorrectly billed Medicare for 80 of 127 selected inpatient claims, which resulted in net overpayments of \$411,134.

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 77 of the 127 selected claims, Washington Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient services or outpatient with observation. Washington Hospital officials did not provide a cause for these billing errors, but indicated that it identified an opportunity for education and improvement. As a result of these errors, Washington Hospital received overpayments of \$415,904.²

Incorrectly Billed Diagnosis Related Group Codes

The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 3 of the 127 selected claims, Washington Hospital billed Medicare for an incorrect DRG code. Washington Hospital officials attributed this primarily to a lack of a centralized billing function and to human error. As a result of these errors, Washington Hospital received an overpayment for one claim and was underpaid for two claims, for a net underpayment of \$4,770.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Washington Hospital incorrectly billed Medicare for 95 of 186 selected outpatient claims, which resulted in overpayments of \$651,058. One claim contained more than one type of error.

Incorrectly Billed Units of Service

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 definition of service units ... is the number of times the service or procedure being reported was performed” (chapter 4, § 20.4). For 17 of the 186 selected claims, Washington Hospital billed for more units of service than it performed. Washington Hospital billed for excess units for cardiac catheterizations, the implant

² Washington 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 or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

and removal of medical devices, other surgeries, and drugs. Washington Hospital officials attributed some of these errors to its automated billing system and some to disruptions due to relocation of the billing function. As a result of these errors, Washington Hospital received overpayments of \$616,705.

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 (the Act, § 1862(a)(12)).

For 14 of 186 selected claims, Washington Hospital billed Medicare for dental services that were not covered under Medicare. Washington Hospital officials attributed this to insufficient awareness of the Medicare requirements related to dental services. As a result of these errors, Washington Hospital received overpayments of \$16,796.

Incorrectly Billed Intensity Modulated Radiation Therapy Planning Services

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 that certain services should not be billed when they are performed as part of developing an IMRT plan (chapter 4, § 200.3.2).

For 43 of the 186 selected claims, Washington Hospital incorrectly billed Medicare for services that were already included in the payment for IMRT planning services billed on the same claim. These services were performed as part of developing an IMRT plan and should not have been billed in addition to the HCPCS code for IMRT planning. Washington Hospital officials stated that some of these claims were correct because the services were part of planning delivery of the treatment specified in the IMRT plan and not part of developing the plan. However, planning the treatment is included in the HCPCS for IMRT planning. For other claims, Washington Hospital officials stated that the errors occurred primarily because clinicians were not always aware of the IMRT billing requirements. As a result of these errors, Washington Hospital received overpayments of \$8,521.

Manufacturer Credit for Replaced Medical Device Not Obtained

Federal regulations require a reduction in the OPPS 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).

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.³ For 1 of the 186 selected claims, Washington Hospital did not obtain a credit for a replaced device for which credits were available under the terms of the manufacturer’s warranty. Washington Hospital officials indicated that this error occurred because of confusion over the applicability of a warranty credit for this device. As a result of this error, Washington Hospital received an overpayment of \$3,540.

Outpatient Services Incorrectly Billed During Inpatient Stays

Certain items and nonphysician services furnished to inpatients are covered under Part A and consequently are covered by the inpatient prospective payment rate (the Manual, chapter 3, § 10.4).

For 6 of the 186 selected claims, Washington Hospital incorrectly billed Medicare Part B for outpatient services provided during an inpatient stay that should have been included on its inpatient (Part A) bills to Medicare. Washington Hospital officials did not explain these billing errors. As a result of these errors, Washington Hospital received overpayments of \$2,437.

Incorrectly Billed Healthcare Common Procedure Coding System Code

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 1 of the 186 selected claims, Washington Hospital submitted a claim to Medicare with an incorrect HCPCS code. Washington Hospital officials did not explain this billing error. As a result of this error, Washington Hospital received an overpayment of \$1,355.

Incorrectly Billed Observation Services

The Manual states: “Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services” (chapter 4, § 290.1). The Manual

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.” “If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.” (part 1, § 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 full or partial credits or payments 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 supplied.”

also states: “[o]bservation time begins at the clock time documented in the patient’s medical record, which coincides with the time that observation care is initiated in accordance with a physician’s order Hospitals should not report, as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services” (chapter 4, § 290.2.2).

For 8 of the 186 selected claims, Washington Hospital officials did not properly bill observation stays. For one claim, hospital personnel did not intend to place the patient into observation. Washington Hospital officials indicated that this occurred because of human error. For the remaining seven claims, Washington Hospital incorrectly billed the amount of observation time: four claims billed more observation time than provided and three claims billed less observation time than provided. Washington Hospital officials did not explain these billing errors but stated that properly determining observation time is “not well defined” in the CMS requirements. As a result of these eight errors, Washington Hospital received a net overpayment of \$1,224.

Insufficiently Documented Services

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)).

For 4 of the 186 selected claims, Washington Hospital incorrectly billed Medicare for services that were not supported in the medical record or for a service that the medical record indicated was not performed. Washington Hospital officials did not provide a cause for these billing errors, but indicated that it identified an opportunity for education and improvement. As a result of these errors, Washington Hospital received overpayments of \$339.

Incorrectly Billed Evaluation and Management Services

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). 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). The Manual also states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure (chapter 12, § 30.6.6(B)).

For 2 of the 186 selected claims, Washington Hospital incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. Washington Hospital officials did not explain these billing errors, but indicated that it identified an opportunity for education and improvement. As a result of these errors, Washington Hospital received overpayments of \$141.

RECOMMENDATIONS

We recommend that Washington Hospital:

- refund to the Medicare contractor \$1,062,192, consisting of \$411,134 in net overpayments for 80 incorrectly billed inpatient claims and \$651,058 in overpayments for 95 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

WASHINGTON HOSPITAL COMMENTS

In written comments to our draft report, Washington Hospital concurred with the majority of our findings and recommendations and described the actions it had taken, or planned to take, to address them. Washington Hospital said that it partially concurred with our finding that outpatient or observational stays were incorrectly billed as inpatient and described the measures used to make the inpatient determination for a representative sample of claims for which it did not concur. Washington Hospital partially concurred with our finding that IMRT services were not separately billable and said that it did not concur for one service because a Local Coverage Determination (L27515) allowed providers to bill the service separately. Washington Hospital did not concur with our finding that observation services were incorrectly billed and said that CMS had not clearly defined active monitoring procedures.

Washington Hospital's comments are included as Appendix C. We did not include the attachments because they were too voluminous.

OFFICE OF INSPECTOR GENERAL RESPONSE

The information noted by Washington Hospital in its examples was included in the medical records we submitted for independent medical review. The independent medical reviewer noted the information in its considerations but determined that the claims for observational stays billed as inpatient stays did not meet Medicare criteria for inpatient status. The Local Coverage Determination cited by Washington Hospital does not specify whether or not the service may be billed separately when it is part of planning the IMRT; however, the Manual does not allow this service to be billed separately when it is performed for planning the IMRT (chapter 4, § 200.3.2). Also, The Manual states that observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (Chapter 4, § 290.2.2). Therefore, we maintain that our findings and recommendations are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$3,200,322 in Medicare payments to Washington Hospital for 313 claims that we judgmentally selected as potentially at risk for billing errors with dates of service during the audit period. These 313 claims consisted of 127 inpatient and 186 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 subjected 90 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of the hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. 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 Washington Hospital for Medicare reimbursement.

We conducted our fieldwork from July through October 2012 at Washington Hospital in the District of Columbia.

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 the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers 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;
- judgmentally selected 313 claims (127 inpatient and 186 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 Washington Hospital to support the selected claims;

- requested that Washington 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 contractor medical review staff and an independent contractor to determine whether 90 selected claims met medical necessity requirements;
- discussed the incorrectly billed claims with Washington 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 Washington 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: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over/Under-Payments	Value of Net Over - Payments
Inpatient				
Short Stays	90	\$492,705	80	\$411,134
Inpatient Claims Paid in Excess of Charges	7	277,072	0	0
Claims Billed with High Severity Level DRG Codes	14	155,825	0	0
Claims Paid in Excess of \$150,000	1	201,326	0	0
Manufacturers Credits for Replaced Medical Devices	15	683,517	0	0
Inpatient Totals	127	\$1,810,445	80	\$411,134
Outpatient				
Claims Paid in Excess of Charges	22	\$579,590	15	\$524,086
Claims Paid in Excess of \$25,000	3	158,043	3	95,110
Dental Claims	14	16,467	12	13,964
Intensity Modulated Radiation Therapy Planning Services	51	248,626	43	8,521
Manufacturer Credits for Replaced Medical Devices	16	317,966	1	3,540
Claims Billed During an Inpatient Stay	16	3,673	6	2,437
Claims With Observation Outliers	9	28,554	8	1,268
Claims for Surgeries Greater Than One	11	21,270	2	1,696
Claims Billed with Evaluation Management Services	39	12,074	5	436
Claims Billed With Modifiers (Modifier 59)	5	3,614	0	0
Outpatient Totals	186	\$1,389,877	95	\$651,058
Inpatient and Outpatient Totals	313	\$3,200,322	175	\$1,062,192

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

APPENDIX C: WASHINGTON HOSPITAL COMMENTS

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John Sullivan
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July 12, 2013

Mr. Stephen Virbitsky
Department of Health and Human Services
Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services, Region III
150 S. Independence Mall West
Philadelphia, PA 19106

RE: Report Number A-03-12-06103

Dear Mr. Virbitsky:

This letter shall serve as response to the Office of Inspector General (OIG) DRAFT report titled "MedStar Washington Hospital Center Did Not Fully Comply with Medicare Requirements for Billing Inpatient and Outpatient Services," dated June 12, 2013. Per your instructions, we are providing written comments on the report as well as supporting documentation to rebut some of the findings contained therein.

Following are MedStar Washington Hospital Center's (MWHC) comments on the eleven areas that OIG examined during the audit and which the OIG report states resulted in net overpayments and underpayments.

Area 1: Incorrectly Billed as Inpatient

MWHC believes that we correctly billed \$240,711 as inpatient admissions. Many of the patients were critically ill or had critical test results that warranted an inpatient admission rather than outpatient observation. Some of the clearest examples follow.

Sample 04: Chest pain, hypotension. EKG with possible acute MI (showed lateral ST elevation)

Sample 76: Blood pressure of 230/150 and potassium of 6.8

Sample 77: Potassium of 8.8 with EKG changes

The above cases represent a subset of the claims of which we are in disagreement. In fact, the test results in these cases were more severe than nationally recognized and published standards for inpatient admission – that is, the Milliman Care Guidelines and InterQual Level of Care Criteria. Specifically, please note the relevant admission criteria for EKG, blood pressure, and potassium levels contained in these standards. The relevant portions of these publications are highlighted and included an attachment to this letter. As noted previously, the cases cited are only a subset of the cases for which we disagree with the OIG outcome. We can provide additional examples upon request to further substantiate our disagreement with the findings in this area.

Knowledge and Compassion
Focused on You

We believe that outcome bias resulted in the OIG's claim of overpayments in this area in that these cases were reviewed in hindsight. Outcomes and length of stay cannot be predicted in advance for severely ill patients. These inpatient cases were managed by MWHC in a very efficient and appropriate manner resulting in a one-day length of stay. Critically ill patients are costly to treat and require quick mobilization and redirection of resources. Hospitals should be rewarded and not penalized for providing prompt and efficient care to severely ill patients and minimizing the length of stay.

Also, note that the Centers for Medicare & Medicaid Services (CMS) considers the assignment of patient status to be the attending and treating physician's responsibility. The Medicare Benefit Policy Manual, Chapter 1, Section 10, specifically states that "the severity of the signs and symptoms exhibited by the patient" should determine whether the status should be an inpatient admission or an outpatient observation--not the length of stay.

Concur/Non-Concur-MWHC agrees with the OIG's finding in part. We have outlined above the rationale for our non-concurrence with \$240,711 in overpayments. With respect to corrective actions, an outside consulting firm has been hired to support the determination of patient status--as to whether the patient should be admitted as an inpatient or placed in outpatient observation. Also, when we implement our computerized provider order entry (CPOE) system, planned for later this year, patient status will be a required entry, with plans to include referenced guidelines.

Area 2: Incorrectly Billed Diagnosis Related Group Codes

The OIG concluded that MWHC received a net underpayment of \$4,770 (overpaid on one claim and underpaid two claims).

Concur-MWHC agrees with the OIG finding. With respect to corrective actions, billing has transitioned to a centralized process.

Area 3: Incorrectly Billed Units of Service

Concur-MWHC agrees with the OIG finding. With respect to corrective actions, the relevant software has been corrected to prevent this from occurring in the future.

Area 4: Noncovered Dental Services

Concur-MWHC agrees with the OIG finding. The corrective actions include additional training and education for billing staff.

Area 5: Incorrectly Billed Intensity Modulated Radiation Therapy Planning Services

Concur/Non-Concur-MWHC agrees with the OIG's finding in part. We believe that we correctly billed \$6,148 for the separately allowable code 77290, per local coverage determination (LCD) 127515. We consider the CT scans to be separate from the intensity modulated radiation therapy (IMRT) plan. The corrective action for the area of concurrence (code 77370) includes additional staff training at national radiation oncology conferences and billing meetings.

Area 6: Manufacturer Credit for Replaced Medical Device Not Obtained

Concur – MWHC agrees with the OIG finding. Please note, however, that we did not receive the warranty application approval and subsequent credit for the replaced device until December 17, 2012 (after this audit occurred). With respect to corrective actions, MWHC will continue to request manufacturer credit, as appropriate.

Area 7: Outpatient Services Incorrectly Billed During Inpatient Stays

Concur-MWHC agrees with the OIG finding. The corrective actions are related to the education of billing staff.

Area 8: Incorrectly Billed Healthcare Common Procedure Coding System Code

Concur –MWHC agrees with the OIG finding. The corrective actions are related to additional training and education for our coders.

Area 9: Incorrectly Billed Observation Services

Non-Concur- MWHC disagrees with the OIG finding of \$1,268 in overpayment. The term "actively monitored procedures" is not defined by CMS. As such, carve-out hours will vary by provider and auditor. To refine our process, we have hired new staff and an outside coding compliance audit firm to support our efforts while awaiting additional guidance from CMS.

Area 10: Insufficiently Documented Services

Concur-MWHC agrees with the OIG finding. The error is attributable to human error. The corrective actions include additional training for physicians and billing staff.

Area 11: Incorrectly Billed Evaluation and Management Services

Concur-MWHC agrees with the OIG finding. The corrective actions include additional training for physicians and billing staff.

In summary, our finding reduces the amount of overpayments determined by the OIG from \$1,062,192 to \$814,065. We propose a payment of \$814,065 in full accord and satisfaction for overpayments noted in the OIG Report (A-03-12-06103).

If you have any questions or would like additional information concerning this response, please do not hesitate to call me at 202-877-6101.

Respectfully Submitted,

/John Sullivan/

President
MedStar Washington Hospital Center

Attachments