

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF UPMC PRESBYTERIAN
SHADYSIDE FOR CALENDAR
YEARS 2008 THROUGH 2011**

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**Stephen Virbitsky
Regional Inspector General**

**September 2013
A-03-12-06105**

Office of Inspector General

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EXECUTIVE SUMMARY

UPMC Presbyterian Shadyside did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$796,000 over 4 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) 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 UPMC Presbyterian Shadyside (Presbyterian Shadyside) 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 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.

Presbyterian Shadyside, which is part of the UPMC health system, is a 1,532-bed acute care hospital located at two campuses, UPMC Presbyterian and UPMC Shadyside, in Pittsburgh, Pennsylvania. Medicare paid Presbyterian Shadyside approximately \$1.05 billion for 62,755 inpatient and 398,989 outpatient claims for services provided to beneficiaries during CYs 2008 through 2011 based on CMS's National Claims History data.

Our audit covered \$3,702,396 in Medicare payments to Presbyterian Shadyside for 239 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 156 inpatient and 83 outpatient claims.

WHAT WE FOUND

Presbyterian Shadyside complied with Medicare billing requirements for 125 of the 239 inpatient and outpatient claims we reviewed. However, Presbyterian Shadyside did not fully comply with Medicare billing requirements for 1 claim that did not result in an overpayment and 113 claims that resulted in overpayments of \$796,202 for CYs 2008 through 2011. Specifically, 66 inpatient claims had billing errors resulting in overpayments of \$558,754, and 47 outpatient claims had billing errors resulting in overpayments of \$237,448. These errors occurred primarily because

Presbyterian Shadyside 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 Presbyterian Shadyside:

- refund to the Medicare contractor \$796,202, consisting of \$558,754 in overpayments for 66 incorrectly billed inpatient claims and \$237,448 in overpayments for 47 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

PRESBYTERIAN SHADYSIDE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Presbyterian Shadyside generally agreed with our findings and identified actions taken to address them. Presbyterian Shadyside disagreed that it incorrectly billed one claim for which Medicare was the secondary payer and stated that it had combined the billed charges for three operating procedures on a single billed line at the request of the Medicare contractor. However, Presbyterian Shadyside agreed that the Medicare contractor overpaid the claim by \$24,851.

Before August 1, 2000, providers were instructed to combine the charges for multiple surgical procedures and submit the charges on the one line with the most significant HCPCS code. However, with the implementation of the Medicare outpatient prospective payment system on August 1, 2000, providers were required to bill charges for each procedure separately. As noted in the report, during the audit, Presbyterian Shadyside submitted the claim with the appropriate charges for each of the three procedures and Medicare determined that, as secondary payer, it owed no payment for the claim. Therefore, we maintain that our finding is 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 other data analysis techniques, we identified hospital claims that were 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 (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether UPMC Presbyterian Shadyside (Presbyterian Shadyside) 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.

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

Hospital Claims at Risk for Incorrect Billing

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

- inpatient claims billed with high severity level DRG codes,
- inpatient short stays,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed during inpatient stays,
- outpatient dental services,
- outpatient claims billed for Lupron injections, and
- outpatient claims billed with modifier -59.

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)).

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).

Presbyterian Shadyside

Presbyterian Shadyside, which is part of the UPMC health system, is a 1,532-bed acute care hospital located at two campuses, UPMC Presbyterian and UPMC Shadyside, in Pittsburgh, Pennsylvania. Medicare paid Presbyterian Shadyside approximately \$1.05 billion for 62,755 inpatient and 398,989 outpatient claims for services provided to beneficiaries during CYs 2008 through 2011 based on CMS’s National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$3,702,396 in Medicare payments to Presbyterian Shadyside for 239 claims that we judgmentally selected as potentially at risk for billing errors. These 239 claims consisted of 156 inpatient and 83 outpatient claims with dates of service in CYs 2008 through 2011 (audit period). We focused our review on the risk areas that we had identified as a result of previous 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. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Presbyterian Shadyside 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

Presbyterian Shadyside complied with Medicare billing requirements for 125 of the 239 inpatient and outpatient claims we reviewed. However, Presbyterian Shadyside did not fully comply with Medicare billing requirements for 1 claim that did not result in an overpayment² and 113 claims that resulted in overpayments of \$796,202 for the audit period. Specifically, 66 inpatient claims had billing errors resulting in overpayments of \$558,754, and 47 outpatient claims had billing errors resulting in overpayments of \$237,448. These errors occurred primarily because Presbyterian Shadyside did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Presbyterian Shadyside incorrectly billed Medicare for 66 of 156 selected inpatient claims, which resulted in overpayments of \$558,754.

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 39 of the 156 selected claims, Presbyterian Shadyside incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Presbyterian Shadyside officials stated that Case Management staff either made

² This claim did not result in an overpayment because the incorrectly billed service was paid at the same rate as the correct service.

inappropriate decisions when reviewing patient admission status or failed to review the status due to time constraints. As a result of these errors, Presbyterian Shadyside received overpayments of \$419,260.³

Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

Federal regulations require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 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).⁴

For 25 of the 156 selected claims, Presbyterian Shadyside made errors related to manufacturer credits for replaced medical devices. Specifically, for 21 claims, Presbyterian Shadyside received reportable credits from manufacturers for replaced medical devices but did not adjust its inpatient claims with the proper condition or value codes to reduce payment as required. For three claims, Presbyterian Shadyside did not obtain credits for replaced medical devices for which credits were available under the terms of the manufacturers’ warranties. The remaining claim included two replaced medical devices, one for which Presbyterian Shadyside received a reportable credit from the manufacturer but did not adjust its inpatient claim with the proper value code, and one for which Presbyterian Shadyside did not obtain a credit that was available under the terms of the manufacturer’s warranty. Presbyterian Shadyside officials stated that the errors occurred because Presbyterian Shadyside had inadequate controls to identify, obtain, and properly report credits from medical device manufacturers. As a result of these errors, Presbyterian Shadyside received overpayments of \$105,843.

³ Presbyterian Shadyside 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.

⁴ 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.”

Incorrectly Billed Diagnosis-Related Group Codes

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)). 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 2 of the 156 selected claims, Presbyterian Shadyside billed Medicare for incorrect DRG codes. Presbyterian Shadyside officials attributed this to human error in the manual coding process. As a result of these errors, Presbyterian Shadyside received overpayments of \$33,651.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Presbyterian Shadyside incorrectly billed Medicare for 47 of 83 selected outpatient claims, which resulted in overpayments of \$237,448.

Manufacturer Credits for Replaced Medical Devices Not Reported or 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). 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.⁵ Federal regulations also require that all payments to providers of services must be based on the reasonable cost of services (42 CFR §413.9). As described on page 4 of this report, the PRM, part 1, chapter 21, reinforces these requirements in additional detail.

For 13 of the 83 selected claims, Presbyterian Shadyside made errors related to manufacturer credits for replaced medical devices. Specifically, for 11 claims, Presbyterian Shadyside received reportable credits from manufacturers for replaced medical devices but did not properly report the “FB” modifier or reduced charges on its claims. For the remaining two claims, Presbyterian Shadyside did not obtain credits for replaced medical devices for which credits were available under the terms of the manufacturers’ warranties. Presbyterian Shadyside officials stated that the errors occurred because Presbyterian Shadyside had inadequate controls to identify, obtain, and properly report credits from medical device manufacturers. As a result of these errors, Presbyterian Shadyside received overpayments of \$165,303.

⁵ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPSS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

Incorrectly Billed as Outpatient

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 24 of the 83 selected claims, Presbyterian Shadyside incorrectly billed Medicare Part B for outpatient services provided during inpatient stays. For 19 claims, Presbyterian Shadyside provided services, such as cardiac catheterization and gastrointestinal procedures, to inpatients of other UPMC hospitals. Those services should have been included on the other hospitals' inpatient (Part A) claims to Medicare. For the remaining five claims, the services should have been included on Presbyterian Shadyside's inpatient claims to Medicare. Presbyterian Shadyside officials stated that the errors occurred either because it did not have an alert to notify the registrar that the patient was an inpatient of another UPMC hospital, or the registrar bypassed an alert when the patient was an inpatient of Presbyterian Shadyside. As a result of these errors, Presbyterian Shadyside received overpayments of \$33,714.

Incorrectly Billed Medicare Secondary Payer Claim

When an insurer pays primary benefits, Medicare (as secondary payer) may supplement those payments, provided the insurer's payment is less than the provider's charges and less than Medicare's allowed payment amount, and the provider is not obligated to accept the insurer's amount as payment in full.⁶ The MSP Manual states: "The provider completes the bill in the usual manner and determines the charges including those covered by the primary payer's payment. The amount paid by the primary payer for Medicare covered services is reported in the appropriate value code and amount" (chapter 3, § 40.1.2). Medicare calculates its payment for Secondary Payer claims by apportioning the primary payer's claim payment using the billed charge amount for each covered service (MSP Manual, chapter 5, § 50.2.1).

For 1 of the 83 selected claims, Presbyterian Shadyside incorrectly billed Medicare for three operating room procedures. Specifically, Presbyterian Shadyside charged the primary payer \$17,407 for each of the three services as separate line items, but charged Medicare \$52,221 (the aggregate amount of the three services) for just one of the services and included no charge on the lines for the other two services. Because the charge for two of the services was zero, Medicare did not allocate any of the primary payer's payment to those lines and paid Presbyterian Shadyside the full allowed amount for those two services (\$24,851).⁷

Presbyterian Shadyside officials did not provide a cause because it did not agree with this billing error. As a result of this error, Presbyterian Shadyside received an overpayment of \$24,851.

⁶ Pub. No. 100-05, *Medicare Secondary Payer Manual* (MSP Manual), chapter 3, section 30.3.

⁷ During the audit, Presbyterian Shadyside submitted the claim with the appropriate charges for each of the three services and Medicare determined that, as secondary payer, it had overpaid Presbyterian Shadyside \$24,851.

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 6 of the 83 selected claims, Presbyterian Shadyside incorrectly billed Medicare for the treatment or removal of teeth. Presbyterian Shadyside officials attributed this to human error in reviewing dental claims for noncovered services. As a result of these errors, Presbyterian Shadyside received overpayments of \$10,574.

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)). 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 1 of the 83 selected claims, Presbyterian Shadyside billed Medicare for an incorrect HCPCS code for the drug Lupron. Lupron is packaged in two separate dosage levels, each of which had its own HCPCS code. Presbyterian Shadyside administered the dose for one HCPCS code but billed for the other. Presbyterian Shadyside officials attributed this to human error by clinical department staff when responding to a system edit for the drug. As a result of this error, Presbyterian Shadyside received an overpayment of \$1,700.

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, 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 2 of the 83 selected claims, Presbyterian Shadyside 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. Presbyterian Shadyside officials attributed this to errors made by the department performing the services when reviewing claims billed with HCPCS code pairs for the appropriate modifier. As a result of these errors, Presbyterian Shadyside received overpayments of \$1,306.

RECOMMENDATIONS

We recommend that Presbyterian Shadyside:

- refund to the Medicare contractor \$796,202, consisting of \$558,754 in overpayments for 66 incorrectly billed inpatient claims and \$237,448 in overpayments for 47 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

PRESBYTERIAN SHADYSIDE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Presbyterian Shadyside generally agreed with our findings and identified actions taken to address them. Presbyterian Shadyside disagreed that it incorrectly billed one claim for which Medicare was the secondary payer and stated that it had combined the billed charges for three operating procedures on a single billed line at the request of the Medicare contractor. However, Presbyterian Shadyside agreed that the Medicare contractor overpaid the claim by \$24,851.

Before August 1, 2000, providers were instructed to combine the charges for multiple surgical procedures and submit the charges on the one line with the most significant HCPCS code. However, with the implementation of the Medicare outpatient prospective payment system on August 1, 2000, providers were required to bill charges for each procedure separately. As noted in the report, during the audit, Presbyterian Shadyside submitted the claim with the appropriate charges for each of the three procedures and Medicare determined that, as secondary payer, it owed no payment for the claim. Therefore, we maintain that our finding is valid.

Presbyterian Shadyside's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$3,702,396 in Medicare payments to Presbyterian Shadyside for 239 claims that we judgmentally selected as potentially at risk for billing errors. These 239 claims consisted of 156 inpatient and 83 outpatient claims with dates of service in CYs 2008 through 2011 (audit period).

We focused our review on the risk areas that we had identified as a result of previous 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 Presbyterian Shadyside'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 Presbyterian Shadyside for Medicare reimbursement.

Our audit included contacting Presbyterian Shadyside in Pittsburgh, Pennsylvania, during June 2012 through July 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Presbyterian Shadyside'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 other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 239 claims (156 inpatient and 83 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 medical record documentation provided by Presbyterian Shadyside to support the selected claims;

- requested that Presbyterian Shadyside conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed Presbyterian Shadyside's procedures for submitting Medicare claims;
- discussed the incorrectly billed claims with Presbyterian Shadyside 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 Presbyterian Shadyside 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 Overpayments	Value of Overpayments
Inpatient				
Claims Billed With High Severity Level Diagnosis-Related Group Codes	33	\$699,761	16	\$299,468
Short Stays	58	390,650	25	153,443
Manufacturer Credits for Replaced Medical Devices	65	2,031,647	25	105,843
Inpatient Totals	156	\$3,122,058	66	\$558,754
Outpatient				
Manufacturer Credits for Replaced Medical Devices	24	398,991	14	190,154
Claims Billed During Inpatient Stays	24	33,714	24	33,714
Dental Services	10	26,214	6	10,574
Claims Billed for Lupron Injections	1	3,347	1	1,700
Claims Billed With Modifier -59	24	118,072	2	1,306
Outpatient Totals	83	\$580,338	47	\$237,448
Inpatient and Outpatient Totals	239	\$3,702,396	113	\$796,202

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 Presbyterian Shadyside. 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: PRESBYTERIAN SHADYSIDE COMMENTS



August 12, 2013

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

Re: Report Number A-03-12-06105 Medicare Compliance Review of UPMC Presbyterian Shadyside for Calendar Years 2008 Through 2011

Dear Mr. Virbitsky-

I am writing on behalf of UPMC Presbyterian Shadyside, which is in receipt of the above referenced draft audit report. Presbyterian Shadyside strives to maintain our culture which supports and promotes compliance with applicable federal, state and local laws and regulations. This includes implementation of operational procedures and controls to minimize the risk of billing errors and a strong compliance monitoring program. An effective program provides reasonable assurance that claims billed to Medicare will comply with Medicare laws and regulations, but the complexity and ambiguity of the regulations, the systems required to process thousands of transactions and the required human intervention can result in overpayments and underpayments.

We have reviewed the draft report in detail and in general agree that the claims identified contain some form of error that affected reimbursement. We have reprocessed all claims identified by your audit for corrected reimbursement.

UPMC has a compliance program that continually monitors our internal billing controls and makes recommendations as needed based on both internal findings and external input to strengthen controls.

Presbyterian Shadyside has reviewed the recommendation in the report and specifically responds as follows:

Incorrectly Billed as Inpatient

According to CMS Manual, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain in the hospital at least overnight

and occupy a bed. Furthermore, the decision to admit is a complex medical judgment in which a physician must take many factors into consideration including past medical history, current medical needs of the patient, types of care available in an inpatient and outpatient setting, and the appropriateness of this care for each individual patient. CMS has recognized as evidenced by its recent inpatient regulatory proposal, the observation/inpatient decision making process is difficult and not always definitive.

UPMC has made significant efforts to ensure our utilization review processes are compliant with established CMS procedures and guidance regarding inpatient admission and billing. In accordance with existing requirements for Utilization Review under the Conditions of Participation for hospitals (located at 42 CFR §482.30), UPMC has implemented the necessary steps to ensure that the level of care is determined in real-time. Care management staff uses a screening tool to determine appropriateness of level of care determination and consults with a physician advisor as appropriate. In addition, Corporate Compliance and Internal Audit periodically monitor the process to assure compliance with established policies and procedures.

UPMC agrees upon retrospective review that 39 of the 156 selected inpatients could have been treated in an outpatient or observation setting.

Manufacturer Credits for Replaced Medical Devices

Presbyterian Shadyside had a process in place to identify recalls and created a "no charge" CDM code to facilitate this. The interdepartmental communication which supported coding the claim with the correct condition code, value code and modifiers was not optimal. The area implanting the medical device did not always know when a device was covered by a warranty. Presbyterian Shadyside immediately developed an interdisciplinary team to refine and strengthen the existing process to communicate that a device has been replaced to all appropriate parties including the party sourcing the device, return the device per manufacturer instructions and have sourcing communicate the percentage and amount of any credits received to billing so that they are able to accurately code the bill. Presbyterian Shadyside acknowledges the noted errors in coding both inpatient and outpatient device replacement claims eligible for credits.

Incorrectly Billed as Outpatient Claims

Presbyterian Shadyside often performs specialty services for patients that are inpatients at other facilities. These services should be billed to the facility in which the patient is an inpatient. An alert is in place to notify the registrar when the patient is registered at any of UPMC's facilities as an inpatient. However, the registrar must take action to address the potential issue. In the fall 2012, a report was created in the billing department to retrospectively correct the claim if a registration issue occurs.

Incorrectly Billed Medicare Secondary Payer (MSP) Claim

Although the claim in question was paid incorrectly, Presbyterian Shadyside respectfully disagrees that the claim was billed incorrectly. The claim was billed in accordance with MSP guidelines. The primary payer payment of \$57,122.03 was correctly indicated on the bill and the Value Code 44, "Obligated to Accept as Payment in Full" (OTAF) amount, was indicated to be \$57,132.03. This indicates that only \$10 payment was being requested. Our Medicare Fiscal intermediary has requested us to roll multiple surgical procedure charges into one line for billing purposes. Of note, we did have another MSP claim in the sample with similarly rolled charges that paid correctly.

Noncovered Dental Services

In the fall 2012, Presbyterian Shadyside automated their previously manual process to move dental services not covered by Medicare to "noncovered services" on the claim.

Incorrectly Billed HCPCS

Lupron is packaged in two dosage levels, 3.75 mg for endometriosis and 7.5 mg for Prostatic Cancer. Each dose has a separate HCPCS code associated with it in the charge description master, but two vials of 3.75 mg associated with one code equal the exact dosage associated with the other code. Presbyterian Shadyside put a patient gender edit in place in September 2011, prior to this audit, to make sure the right HCPCS is associated with the claim.

Presbyterian Shadyside takes its compliance obligations very seriously. The UPMC Office of Ethics, Compliance and Audit Services proactively monitors compliance with all regulations including billing regulations. Control enhancement recommendations and training are provided when areas for improvement are identified.

The leadership of UPMC Presbyterian Shadyside would like to thank the OIG auditors who conducted the review for their professionalism, time and collaboration. Please feel free to contact me if you have any questions about UPMC Presbyterian Shadyside's efforts in this regard.

Sincerely,



Ms. Eileen Simmons
Chief Financial Officer and Compliance Officer
UPMC Presbyterian Shadyside