

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF THE UNIVERSITY OF
ALABAMA AT BIRMINGHAM
HOSPITAL FOR CALENDAR
YEARS 2009 AND 2010**

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



Lori S. Pilcher
Regional Inspector General

October 2012
A-04-11-00080

Office of Inspector General

<http://oig.hhs.gov>

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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 hospital inpatient 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. 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 (APC).

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

The University of Alabama at Birmingham Hospital (the Hospital) is a 1,017-bed acute care hospital located in Birmingham, Alabama. Medicare paid the Hospital approximately \$380 million for 28,974 inpatient and 174,893 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010, according to CMS's National Claims History data.

Our audit covered \$4,352,532 in Medicare payments to the Hospital for 172 inpatient and 5 outpatient claims that we judgmentally selected as potentially at risk for billing errors. These 177 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 139 of the 177 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 38 claims, resulting in overpayments totaling \$144,423 and potential underpayments totaling \$166,882 for CYs 2009 and 2010. Specifically, 26 inpatient claims had billing errors resulting in overpayments totaling \$132,198, and 2 outpatient claims had billing errors resulting in overpayments totaling \$12,225. Additionally, 10 inpatient claims had billing errors resulting in potential underpayments totaling \$166,882.

Overpayments and potential underpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- correct and resubmit to the Medicare contractor 28 incorrectly billed claims resulting in overpayments totaling \$144,423,
- correct and resubmit to the Medicare contractor 10 incorrectly billed claims resulting in potential underpayments totaling \$166,882, and
- strengthen controls to ensure full compliance with Medicare requirements.

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that it would correct and resubmit to Medicare the identified incorrect claims, strengthen controls to ensure full compliance with Medicare requirements, and develop corrective action plans to address our audit findings. The Hospital's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

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

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient 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. For beneficiary stays incurring extraordinarily high costs, section 1886(d)(5)(A) of the Act provides for additional payments (called outlier payments) to Medicare-participating hospitals.

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. 106-113.¹ 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. All services and items within an APC group are comparable clinically and require comparable resources.²

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.

¹ In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. The types of payments identified included payments for claims billed for:

- inpatient claims for short stays,
- inpatient transfer claims,
- inpatient claims with high-severity level DRG codes,
- inpatient claims for blood clotting factor drugs,
- outpatient claims billed prior to and during inpatient stays,
- outpatient claims billed with modifier 59 (indicating that a procedure or service was distinct from other services performed on the same day),
- inpatient and outpatient claims paid in excess of charges, and
- inpatient and outpatient claims involving manufacturer credits for replaced medical devices.

For 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 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.

The University of Alabama at Birmingham Hospital

The University of Alabama at Birmingham Hospital (the Hospital) is a 1,017-bed acute care hospital located in Birmingham, Alabama. Medicare paid the Hospital approximately \$380 million for 28,974 inpatient and 174,893 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 according to 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 \$4,352,532 in Medicare payments to the Hospital for 172 inpatient and 5 outpatient claims that we judgmentally selected as potentially at risk for billing errors. These 177 claims had dates of service in CYs 2009 and 2010.

We focused our review on the risk areas 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 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 select risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We performed fieldwork at the Hospital from September 2011 through June 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's National Claims History file for CYs 2009 and 2010;
- obtained 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 177 claims (172 inpatient and 5 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for 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 adjustment; 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 139 of the 177 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 38 claims, resulting in overpayments totaling \$144,423 and potential underpayments totaling \$166,882 for CYs 2009 and 2010. Specifically, 26 inpatient claims had billing errors resulting in overpayments totaling \$132,198, and 2 outpatient claims had billing errors resulting in overpayments totaling \$12,225. Additionally, 10 inpatient claims had billing errors resulting in potential underpayments totaling \$166,882.

Overpayments and potential underpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 36 of 172 sampled inpatient claims that we reviewed. Billing errors for 26 inpatient claims resulted in overpayments totaling \$132,198. Additionally, billing errors for 10 inpatient claims resulted in potential underpayments totaling \$166,882.

Inpatient Claims With High-Severity Level Diagnosis-Related Group Codes

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.” The *Manual*, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 1 of 48 sampled claims, the Hospital billed Medicare using an incorrect DRG. The Hospital stated that the incorrect coding occurred because of human error. As a result, the Hospital received an overpayment of \$2,908.

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.” The *Manual*, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 17 of 107 sampled claims, the Hospital billed Medicare Part A for inpatient stays that it should have billed as outpatient or outpatient with observation services. In addition, for 1 of the 107 sampled claims, the Hospital billed Medicare using an incorrect DRG code. The Hospital attributed the incorrect billings and coding to human error.

As a result, the Hospital incorrectly billed 18 inpatient claims and received overpayments totaling \$97,169.

Inpatient Claims With Payments Greater Than \$150,000

The *Manual*, chapter 3, section 10, states that a hospital may bill only for services provided. The *Manual*, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

Of the 172 inpatient claims in our sample, the Hospital billed either overstated or understated charges on 17 claims as described below.³

³ Under the IPPS, Medicare makes outlier payments to hospitals when exceptionally costly cases exceed established thresholds. Overstating or understating charges on IPPS claims reduces or increases the cost outlier.

Overstated Charges

For 7 of the 17 sampled claims, the Hospital billed overstated charges to Medicare that resulted in overpayments totaling \$32,121. The Hospital attributed the overpayments to a lack of documentation in the patient's medical records supporting medications administered. The pharmacy department kept an accurate log of medication prepared; however, nursing staff did not always document in the patient's medical record that they had administered the medication.

As a result, the Hospital incorrectly billed 7 claims and received overpayments totaling \$32,121.

Understated Charges

For 10 of the 17 sampled claims, the Hospital billed understated charges to Medicare that resulted in potential underpayments totaling \$166,882. The Hospital attributed the underpayments to insufficient controls for billing untitrated dialysis solution and to a reliance on a manual process for generating charges for blood-clotting factor. The Hospital billed understated charges to Medicare for:

- nine claims for dialysis solutions that resulted in potential underpayments totaling \$11,382 and
- one claim for blood-clotting factor that resulted in a potential underpayment of \$155,500.

Insufficient Controls: Before administering a bag of untitrated dialysis solution, the nursing staff was required to charge for the solution; however, the nursing staff did not always charge for the solution as required.

Reliance on a Manual Process: The maximum charge for blood-clotting factor is 99,999 units; therefore, if more than 99,999 units were administered, the billing department had to manually add a second line to the claim to account for units above the 99,999 limit. This manual process was not completed for one claim.

As a result, the Hospital incorrectly billed 10 claims that resulted in potential underpayments totaling \$166,882.

Total Incorrectly Billed Inpatient Claims

In aggregate, the Hospital incorrectly billed 26 inpatient claims and received overpayments totaling \$132,198. Furthermore, the Hospital incorrectly billed understated charges to Medicare for 10 inpatient claims, which resulted in potential underpayments totaling \$166,882.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for two of five sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$12,225.

Outpatient Claims With Manufacturer Credits for Replaced Medical Devices

Federal regulations (42 CFR § 419.45) 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.

Under 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services....” CMS’s *Provider Reimbursement Manual*, part 1, section 2102.1, 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.

Section 2103 of the *Provider Reimbursement Manual* 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.

For two of the five sampled outpatient claims, the Hospital did not properly bill the claims. For one claim the Hospital did not obtain a credit for a replaced device that was available under the terms of the manufacturer’s warranty. Additionally, for one claim the Hospital did not report a credit received from the manufacturer. The Hospital stated the incorrect billing occurred because it did not have a process in place to request credits from manufacturers and because of human error. As a result, the Hospital received overpayments totaling \$12,225.

RECOMMENDATIONS

We recommend that the Hospital:

- correct and resubmit to the Medicare contractor 28 incorrectly billed claims resulting in overpayments totaling \$144,423,
- correct and resubmit to the Medicare contractor 10 incorrectly billed claims resulting in potential underpayments totaling \$166,882, and
- strengthen controls to ensure full compliance with Medicare requirements.

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that it would correct and resubmit to Medicare the identified incorrect claims, strengthen controls to ensure full compliance with Medicare requirements, and develop corrective action plans to address our audit findings. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: THE UNIVERSITY OF ALABAMA AT BIRMINGHAM HOSPITAL COMMENTS



September 19, 2012

Report Number: A-04-11-00080

Lori S. Pilcher

Regional Inspector General for Audit Services

Office of Audit Services, Region IV

61 Forsyth Street, SW, Suite 3T41

Atlanta, GA 30303

Dear Ms. Pilcher:

The University of Alabama Hospital ("UAB Hospital" or the "Hospital") is in receipt of the U.S. Department of Health and Human Services, Office of the Inspector General (OIG), draft report entitled, *Medicare Compliance Review of the University of Alabama at Birmingham Hospital for Calendar Years 2009 and 2010*. UAB Hospital has reviewed the recommendations contained in the draft report and respectfully submits its response to each section of the report below.

The OIG's audit included 172 inpatient and 5 outpatient claims, with dates of service in calendar years 2009 and 2010 that were *judgmentally* selected as potentially high risk for billing errors. Although the Hospital complied with all Medicare billing requirements for the vast majority (139 of 177) of these "high risk" claims under review, the audit did illustrate some areas for improvement. UAB Hospital takes its compliance responsibilities quite seriously, and continues to invest in financial and human resources to ensure that these responsibilities are met.

Inpatient Claims with High-Severity Level Diagnosis-Related Group Codes. UAB Hospital concurs with the OIG audit team's findings of 1 incorrect claim (out of 48 claims) resulting from human error. UAB Hospital has reviewed and reinforced with staff its policies and procedures with regard to the clinical scenario in question and will correct and resubmit the claim.

Corporate Compliance Office
225 Old Hillman Building
620 20th Street South
205.975.0585
Fax 205.975.9378

The University of
Alabama at Birmingham
Mailing Address:
OHB 225
619 19TH ST S
BIRMINGHAM AL 35249-6543

Inpatient Short Stays. UAB Hospital concurs with the OIG audit team's findings that 1 claim (out of 107) involved the use of an incorrect DRG and 17 cases (out of 107) reflected services that could have potentially been provided in an alternative setting. The Hospital will correct and resubmit claims for these 18 claims. UAB Hospital will continue to review and improve current policies and procedures to further improve controls related to admission status orders, case management review of patient status under the Hospital's Utilization Management Plan and the ongoing use of concurrent review of all Medicare admissions using screening tools and secondary physician review.

Inpatient Claims with Payments Greater Than \$150,000. The Hospital concurs with the OIG audit team's findings related to overstated and understated charges and will correct and resubmit the identified claims. The Hospital notes that the reference to "titrated dialysis solution" in the "Overstated Charges" paragraph of this section should be replaced with "medications", reference to "the nursing staff was required to scan the bag to generate a charge" should be replaced "with charge for the solution" and reference to "the coding department had to manually add a second line to the claim to account for units above the 99,999 limit" should be replaced with "the billing department". The Hospital will continue to furnish staff with training for processes related to high risk claims and perform audits in these areas.

Outpatient Claims With Manufacturer Credits for Replaced Medical Devices. The Hospital concurs with the OIG audit team's findings and will correct and resubmit the identified claims. UAB Hospital has reviewed the policies and procedures to ensure that manufacturer credits are requested and documented as a part of routine clinical processes in this situation to ensure accurate claims processing in future transactions.

We would like to thank the audit team for the time they spent in reviewing our documentation and processes, and engaging in a dialogue with the leadership of UAB Hospital to assist us in improving our performance within these high risk processes. As a result of the audit teams findings and subsequent report, UAB Hospital's Chief Financial Officer and Chief Compliance Officer assumed responsibility for the successful execution of the corrective actions outlined above, as well as, constructing on-going monitoring activities to ensure future compliance with established Medicare billing regulations. Claims will be corrected and resubmitted totaling in overpayments of \$144,423 and underpayments of \$166,882.

Sincerely,



Deborah Grimes, RN, JD, CHC

AVP, Chief Compliance Officer