



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



June 21, 2012

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

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

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

SUBJECT: Medicare Compliance Review of Tampa General Hospital for Calendar Years
2008 Through 2010 (A-04-11-06138)

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

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

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov, or your staff may contact Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750, or through email at Lori.Pilcher@oig.hhs.gov. Please refer to report number A-04-11-06138.

Attachment

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



Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

June 26, 2012

Report Number: A-04-11-06138

Mr. Steve L. Short
Chief Financial Officer
Tampa General Hospital
P.O. Box 1289
Tampa, FL 33601-1289

Dear Mr. Short:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Tampa General Hospital for Calendar Years 2008 Through 2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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

If you have any questions or comments about this report, please do not hesitate to call me, or contact Andrew A. Funtal, Audit Manager, at (404) 562-7762 or through email at Andrew.Funtal@oig.hhs.gov. Please refer to report number A-04-11-06138 in all correspondence.

Sincerely,

/Lori S. Pilcher/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations (CFMFFSO)
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 355
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
TAMPA GENERAL HOSPITAL FOR
CALENDAR YEARS 2008 THROUGH
2010**



Daniel R. Levinson
Inspector General

June 2012
A-04-11-06138

Office of Inspector General

<http://oig.hhs.gov>

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

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

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

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

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Notices

THIS REPORT CONTAINS RESTRICTED INFORMATION

This report should not be reproduced or released to any other party without specific written approval from OAS.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

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

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

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these 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.

Tampa General Hospital (the Hospital) is a 1,004-bed teaching hospital located in Tampa, Florida. Medicare paid the Hospital approximately \$563 million for 36,176 inpatient and 85,321 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 through 2010 based on CMS's National Claims History data.

Our audit covered \$15,026,935 in Medicare payments to the Hospital for 136 claims that we judgmentally selected as potentially at risk for billing errors. These 136 claims had dates of service in CYs 2008 through 2010 and consisted of 92 inpatient and 44 outpatient claims.

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 101 of the 136 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 35 claims, resulting in net overpayments totaling \$82,516 for CYs 2008 through 2010. Specifically, 2 inpatient claims had billing errors, resulting in a net underpayment totaling \$3,428, and 33 outpatient claims had billing errors, resulting in net overpayments totaling \$85,944. Overpayments and underpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$82,516, consisting of \$3,428 in underpayments for two incorrectly billed inpatient claims and \$85,944 in overpayments for 33 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

TAMPA GENERAL HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations. Regarding our recommendations, the Hospital stated that it refunded the full amount of the overpayments and provided information on actions that it had taken or planned to take to strengthen controls to ensure full compliance with Medicare billing requirements.

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.¹

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.

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. 106-113.² 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.³ All services and items within an APC group are comparable clinically and require comparable resources.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC). This transition occurred between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

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

³ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Hospital Payments at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. The types of payments to hospitals reviewed by this and related audits included payments for claims billed for:

- inpatient transfers,
- inpatient hospital-acquired conditions and present on admission indicator reporting,
- inpatient claims with payments greater than \$150,000,
- outpatient claims with payments greater than \$25,000,
- outpatient claims billed with modifier -59,
- outpatient surgeries billed with units greater than one,
- inpatient and outpatient claims paid in excess of charges, and
- inpatient and outpatient manufacturer credits for replaced medical devices.

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

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

Medicare Requirements for Hospital Claims and Payments

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

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

Tampa General Hospital

Tampa General Hospital (the Hospital) is a 1,004-bed teaching hospital located in Tampa, Florida. Medicare paid the Hospital approximately \$563 million for 36,176 inpatient and 85,321 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 through 2010 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit covered \$15,026,935 in Medicare payments to the Hospital for 136 claims that we judgmentally selected as potentially at risk for billing errors. These 136 claims had dates of service in CYs 2008 through 2010 and consisted of 92 inpatient and 44 outpatient claims.

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. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital during April 2011 through March 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2008 through 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 136 claims (92 inpatient and 44 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 the Hospital to conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with the Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- requested that the Medicare contractor make the appropriate adjustments; and
- discussed the results of our review with Hospital officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 101 of the 136 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 35 claims, resulting in net overpayments totaling \$82,516 for CYs 2008 through 2010. Specifically, 2 inpatient claims had billing errors, resulting in a net underpayment totaling \$3,428 and 33 outpatient claims had billing errors, resulting in net overpayments totaling \$85,944. Overpayments and underpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 2 of 92 sampled inpatient claims, which resulted in a net underpayment of \$3,428.

Incorrect Discharge Status

Federal Regulations (42 CFR § 412.4(c)) state that a discharge of a hospital inpatient is considered a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to a home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge. A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 1 of 92 sampled inpatient claims, the Hospital incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. For this claim, the Hospital should have coded the discharge status to a home under a written plan of care for the provision of home health services, instead of as a discharge to home. Accordingly, the Hospital should have received the per-diem payment instead of the full DRG payment. The Hospital stated that this error occurred because of conflicting documentation and inappropriate oversight. As a result of this error, the Hospital received an overpayment of \$2,265.

Incorrect Diagnosis-Related Groups

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."

For 1 of 92 sampled inpatient claims, the Hospital submitted the claim to Medicare with an incorrect diagnosis code, which resulted in an incorrect DRG. Specifically, the incorrectly coded claim generated DRG code 314 (Other Circulatory System Diagnoses with MCC) based on the principal diagnosis code of 999.31 (Infection Central Venous Catheter). However, the medical records supported a more severe diagnosis code as the cause of admission. The appropriate coding would have resulted in DRG code 870 (Septicemia or Severe Sepsis w/ Mechanical Ventilation 96+ hours) based on the secondary diagnosis of code 038.8 (Septicemia).

The Hospital stated that the coding error occurred because the coder did not correctly identify the principal diagnosis supported by the documentation. As a result of this error, the Hospital received an underpayment of \$5,693.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 33 of 44 sampled outpatient claims, which resulted in overpayments totaling \$85,944.

No-Cost Replacement of Medical Devices Billed to Medicare

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.

Billing Requirements for Medical Device Credits

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual explain how a provider should report no-cost and reduced-cost devices under the OPPTS. For services furnished on or after January 1, 2007, CMS requires the provider to use the modifier “FB” and reduce 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.

For 3 of 44 sampled outpatient claims, the Hospital received full manufacturer credits for replaced devices but did not use the “FB” modifier or reduce charges on its claims. These overpayments occurred because the Hospital’s controls to identify and report credits from the device manufacturers were ineffective. As a result of these errors, the Hospital received overpayments totaling \$59,220.

Inaccurately Reported Healthcare Common Procedure Coding System Codes and Incorrect Number of Units

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

The Manual, chapter 23, section 20.9.1.1, 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).” In addition, chapter 4, section 20.4, states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For 29 of 44 sampled outpatient claims, the Hospital incorrectly billed Medicare for HCPC codes that were included in payments for other services billed on the same claim (27 errors), that were insufficiently documented in the medical records (1 error), or that contained an incorrect number of units (1 claim). For most of these claims, the Hospital billed separately for an electrocardiogram (EKG) and attached modifier -59 to indicate a distinct procedural service. However, in these instances, the payment for the EKG was already included in the payment for the insertion of a cardiac medical device. The Hospital stated that these errors occurred either because its staff misunderstood the billing requirements for modifier -59 or because of human error. The Hospital attributed the incorrect units to a combination of system error and insufficient oversight. As a result of these errors, the Hospital received overpayments totaling \$1,141.

Noncovered Implantable Automatic Cardiac Defibrillator

CMS's National Coverage Determination Manual, chapter 1, section 20.4, outlines the covered indications for implantable automatic defibrillators and states that patients must not have had a percutaneous transluminal coronary angioplasty (PTCA) within the past 3 months.

For 1 of 44 sampled outpatient claims, the Hospital incorrectly billed Medicare for an implantable automatic cardiac defibrillator (ICD) that did not meet Medicare coverage requirements. Specifically, the ICD was not covered because the beneficiary had a PTCA within 3 months of the ICD implantation. The Hospital stated that this error occurred because its staff was not aware that the ICD was not covered. As a result of this error, the Hospital received an overpayment of \$25,583.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$82,516, consisting of \$3,428 in underpayments for two incorrectly billed inpatient claims and \$85,944 in overpayments for 33 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

TAMPA GENERAL HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our findings and recommendations. Regarding our recommendations, the Hospital stated that it refunded the full amount of the overpayments and provided information on actions that it had taken or planned to take to strengthen controls to ensure full compliance with Medicare billing requirements.

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

APPENDIX

APPENDIX: TAMPA GENERAL HOSPITAL COMMENTS



Steve L. Short
Executive Vice President, Finance and Administration

April 20, 2012

Ms. Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

RE: OIG Report Number: A-04-11-06138

Dear Ms. Pilcher:

Tampa General Hospital (TGH) is in receipt of the April 4, 2012 draft report provided by the Department of Health & Human Services, Office of Inspector General (OIG) entitled, "Medicare Compliance Review of Tampa General Hospital for Calendar Years 2008 through 2010". TGH has had an opportunity to review the OIG audit report, and we generally agree with the findings outlined therein.

TGH continually strives to eliminate billing errors. While TGH would have preferred that no errors were identified, we note that our error rate is very low for the types of complex cases prevalent at the region's leading safety-net hospital provider and trauma center.

We concur with the two report recommendations and note the following with regard to those recommendations:

- 1) We agree that TGH was overpaid in the amount of \$82,516. All of the amounts identified as errors in the report have been corrected and resubmitted to our fiscal intermediary, First Coast Service Options, Inc.
- 2) We agree to the recommendation to strengthen controls to ensure full compliance with Medicare requirements. TGH devotes a significant amount of time and resources on continuing education for its certified coders, patient accounts staff, and other personnel. In addition, TGH regularly conducts internal audits focused on DRG coding and the appropriate submission of claims.

Per the instructions in your letter, provided below are the TGH corrective action taken or planned for the following five (5) areas cited in the audit report:

- Inpatient Incorrect Discharge Status
- Inpatient Miscoded DRG
- Outpatient No-Cost Replacement of Medical Devices Billed to Medicare

APPENDIX: TAMPA GENERAL HOSPITAL COMMENTS

- Outpatient Claims Billed with Modifier 59
- Outpatient Non-Covered Implantable Automatic Cardiac Defibrillator

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The audit report concluded that TGH incorrectly billed Medicare for 2 of 92 sampled inpatient claims, which resulted in a net underpayment of \$3,428.

Inpatient Incorrect Discharge Status: One inpatient billing error identified an incorrect discharge status as a result of human oversight. The current process TGH has in place to safeguard against this type of error is for the coder to perform a validation of discharge disposition at final coding. In this instance, the physician's discharge order was hand written and contained approximately eight orders. The first order read "discharge to home", while the final order read "order home health". The latter was, unfortunately, overlooked. Since the OIG audit, TGH has implemented a certified electronic medical record which will help strengthen controls to ensure compliance with Medicare requirements.

Inpatient Miscoded DRG: The other inpatient billing error identified an incorrect diagnosis code, and thus an incorrect DRG was assigned and billed which resulted in an underpayment to TGH. While we do not believe this isolated coder error is indicative of a systemic problem requiring corrective action, TGH remains committed to providing continuing and ongoing training to all its certified coders.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The audit report concluded that TGH incorrectly billed Medicare for 33 of 44 sampled outpatient claims, which resulted in overpayments of \$85,944.

Outpatient No-Cost Replacement of Medical Devices Billed to Medicare: Three outpatient billing errors were identified relating to manufacturer credits or no-cost replacement of medical devices. TGH has historically relied on medical device vendors to determine appropriate warranty payments due to the hospital. This process has been deemed insufficient as the vendor-dependent process resulted in extended notification periods which conflicted with timely billing guidelines. In response to the OIG audit and as a corrective action, TGH has implemented a new policy to ensure that all explanted devices that are returned to vendors for a credit or rebate are tracked and that the appropriate billing adjustments are made to comply with current Medicare guidelines. The policy includes the following action steps:

- Explanted devices are returned to the vendor based on vendor specifications.
- An electronic requisition is created that denotes both the patient and the serial number of the returned device.
- Information from the electronic requisition is input into a tracking log for quarterly follow-up with vendors. Vendors represented on the log are required to provide TGH with an itemized list of devices that were provided at no charge or given partial credit.
- Devices on the tracking log are compared to quarterly information provided by vendors. If the criteria for a rebate or credit are not met, it is denoted on the tracking log and no further action is required. If the device did meet criteria, TGH will confirm receipt of credit.
- Once the credit or rebate is confirmed, the claim is adjusted to remove the charge for the newly implanted device.
- TGH submits a revised claim to the payer.

APPENDIX: TAMPA GENERAL HOSPITAL COMMENTS

TGH is confident that this new policy and procedure will reduce, if not eliminate, the number of billing errors related to manufacturer credits or no-cost replacement of medical devices.

Outpatient Non-Covered Implantable Automatic Cardiac Defibrillator: One outpatient billing error was identified relating to an outpatient non-covered implantable automatic cardiac defibrillator (ICD). In response to the OIG audit and as a corrective action, TGH has implemented a continuing education initiative to educate physicians that CMS does not provide coverage for ICDs implanted for primary prevention in patients who have had an acute myocardial infarction within the past 40 days, or a PTCA or CABG within the past three months. In addition, TGH has implemented an automatic second review of all ICD cases prior to billing. Utilizing its newly installed certified electronic medical record, patients who had an ICD insertion based on ICD-9 procedure codes or CPT codes will be identified and sent to an internal medical bill auditor for review of the account prior to billing.

Outpatient Claims Billed with Modifier 59: The OIG review identified billing errors related to the attachment of modifier -59 to a second EKG when one was already included as a component of the procedure the patient received. This resulted in duplicate payments of the EKG. Historically, TGH billers were responsible for deciding when and when not to attach modifier -59. With the implementation of the certified electronic medical record system, TGH will gain efficiencies resulting in a better defined charge structure. This will negate the Biller option to add or remove the 59 modifier.

Finally an outpatient billing error was identified due to an incorrect number of units attached to the revenue code. Again, with the implementation of the certified electronic medical record, TGH now has a system in place that will alert the Biller if the quantity attached to any revenue code exceeds the number allowed in the Medically Unlikely Edit (MUE) table, used in Medicare claims processing.

CONCLUSION:

Tampa General Hospital is committed to full compliance with all laws, regulations, and policies required for its participation in the Medicare program. Accordingly, TGH has complied with the recommendations of the audit report by promptly resubmitting claims cited for overpayment and strengthening its controls in the area of Medicare billing compliance as specified in this responsive letter.

Sincerely,

Steve L. Short
Executive Vice President, CFO