



**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**OFFICE OF AUDIT SERVICES**  
**233 NORTH MICHIGAN AVENUE**  
**CHICAGO, ILLINOIS 60601**

**REGION V**  
**OFFICE OF**  
**INSPECTOR GENERAL**

July 31, 2003

Report Number: A-05-03-00033

Ms. Catherine Jacobson  
Chief Financial Officer  
Rush-Presbyterian-St. Luke's Medical Center  
1700 West Van Buren, Suite 265  
Chicago, Illinois 60612

Dear Ms. Jacobson:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General Report entitled "Review of Medicare Outpatient Prospective Payment System Outlier Payments made to Rush-Presbyterian-St. Luke's Medical Center (Rush)." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Our audit objective was to determine whether Rush was reimbursed properly for outlier payments made during the initial implementation of the Outpatient Prospective Payment System (OPPS). The Centers for Medicare & Medicaid Services (CMS) implemented OPPS with an effective date of August 1, 2000.

For services rendered during the period of August 1, 2000 through June 30, 2001, we judgmentally sampled 50 outpatient claims with outlier payments of \$83,805. We determined that Rush received improper Medicare reimbursements on 38 of these claims (35 overpayments totaling \$7,726 and 3 underpayments totaling \$7,752).

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5).

To facilitate identification please refer to Report Number A-05-03-00033 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink that reads "Paul Swanson". The signature is written in a cursive style with a prominent initial "P".

Paul Swanson  
Regional Inspector General  
for Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**

Jacqueline Garner – Regional Administrator  
Centers for Medicare & Medicaid Services (CMS) – Region V  
233 North Michigan Avenue, Suite 600  
Chicago, IL 60601

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE OUTPATIENT  
PROSPECTIVE PAYMENT SYSTEM  
OUTLIER PAYMENTS**

**RUSH-PRESBYTERIAN-ST. LUKE'S  
MEDICAL CENTER  
CHICAGO, ILLINOIS**



July 2003 A-05-03-00033

# *Office of Inspector General*

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In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

## **OAS FINDINGS AND OPINIONS**

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



## **EXECUTIVE SUMMARY**

### **OBJECTIVE**

Our objective was to determine whether Rush-Presbyterian-St. Luke's Medical Center (Rush) was reimbursed properly for outlier payments made during the initial implementation of the Outpatient Prospective Payment System (OPPS).

### **SUMMARY OF FINDINGS**

The OPPS was mandated by the Balanced Budget Act of 1997 (BBA) and became effective August 1, 2000. Our review was limited to Medicare outpatient claims with significant outlier payments of at least 85 percent of the total claim reimbursement. For services rendered during the period of August 1, 2000 through June 30, 2001, we judgmentally sampled 50 outpatient claims, totaling \$86,491, with outlier payments of \$83,805. We determined that Rush received improper Medicare reimbursements on 38 of these claims (35 overpayments and 3 underpayments.)

The 35 overpayment errors, totaling \$7,726, were attributable to an outlier pricing issue within the Fiscal Intermediary's (FI) claim processing system. Although Rush billed the claims properly, the FI's claim processing system generated outlier overpayments by including non-covered charges from the claims in the calculation of the outlier reimbursements.

The three claims with underpayments of \$7,752 were the result of Rush improperly coding and billing Medicare for implantable devices. Rush omitted a Health Care Financing Administration Common Procedure Coding System (HCPCS) code relating to these implantable devices that would have resulted in a higher claim reimbursement with no outlier payment. Rush was aware of this billing problem and initiated an analysis in calendar year 2002 to identify other claims with implantable devices that were not coded and billed correctly. Although Rush has taken corrective action on this billing condition, these three claims were isolated instances that were excluded from their adjustment analysis.

### **RECOMMENDATIONS**

We recommend that Rush:

- Refund outlier overpayments of \$7,726 and
- Resubmit claims for the improperly billed implantable devices in order to recover the identified underpayments of \$7,752.

Rush agreed with our findings and will work with their fiscal intermediary (FI) in addressing our recommendations. Rush's response is appended to this report in its entirety (See **APPENDIX 2**).

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## **Glossary of Abbreviations and Acronyms**

APC	Ambulatory Payment Classification
BBA	Balanced Budget Act of 1997
CMS	Centers for Medicare and Medicaid Services
FI	Fiscal Intermediary
HCPCS	Health Care Financing Administration Common Procedure Coding System
NCH	National Claims History
OIG	Office of Inspector General
OPPS	Outpatient Prospective Payment System
Rush	Rush-Presbyterian-St. Luke's Medical Center

## **INTRODUCTION**

### **BACKGROUND**

The Balanced Budget Act of 1997 (BBA) mandated that the Centers for Medicare & Medicaid Services (CMS) implement a Medicare prospective payment system for hospital outpatient services. As such, CMS implemented the outpatient prospective payment system (OPPS), which did not become effective until August 1, 2000. With the exception of certain services, which will continue to use existing fee schedules, payments under OPPS are calculated by grouping services into ambulatory payment classification (APC) groups. Services within an APC are clinically similar and require similar resources. In this respect, some services; such as, anesthesia, supplies, certain drugs and use of recovery and observation rooms; are packaged in APCs and are not paid separately. To ensure “equitable payments,” the BBA also allowed outlier adjustments to be made in an overall budget neutral manner.

The Balanced Budget Refinement Act of 1999 further delineated the requirements for hospital outlier payments to cover some of the additional cost of care beyond thresholds established by the Secretary. The payments in total cannot exceed 2.5 percent of total program payments for outpatient hospital services for each year before 2004. Outlier payments are determined by: (1) calculating the cost of services on OPPS claims (multiplying the total charges for covered OPPS services by an outpatient cost-to-charge ratio); (2) determining whether these costs exceed 2.5 times the OPPS payments; and (3) allowing 75 percent of the amount by which the costs exceeds the OPPS payments.

Since any new billing methodology for providers, such as OPPS, presents the possibility for billing errors and potentially significant underpayments or overpayments, we focused our review on claims having significant outlier payment amounts. We considered the larger outlier payments to have more potential for billing errors.

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

The objective of our review was to determine whether Rush-Presbyterian-St. Luke’s Medical Center (Rush) was properly reimbursed for outlier payments made during the initial implementation of OPPS.

### **SCOPE**

Since OPPS became effective for services rendered on or after August 1, 2000, our review was limited to OPPS outlier payments made to Rush for services rendered from August 1, 2000 through June 30, 2001. We further limited our review to claims having significant outlier amounts, which we defined as payments that were at least 85 percent of the total claim reimbursement. Since our audit objective focused on Medicare outpatient claims with outliers that were paid under OPPS, we did not perform a complete review of Rush’s overall internal control structure. Instead, we limited our internal control testing to understanding Rush’s

controls over the accumulation of Medicare charges, creation of outpatient bills, and submission of Medicare outpatient claims.

## **METHODOLOGY**

To accomplish our objective, we:

- Obtained CMS's National Claims History (NCH) file and identified 2,166 Medicare outpatient claims with outlier payments, totaling \$757,155, for services rendered during the period August 1, 2000 through June 30, 2001.
- Identified high-risk outlier claims, defined as claims having an outlier payment of at least 85 percent of the total claim payment.
- Selected a judgmental sample of 50 claims with outlier payments totaling \$83,805.
- Discussed and obtained an understanding of Rush's billing procedures for accumulating charges, creating outpatient bills, and submitting Medicare claims.
- Reviewed the medical files and discussed the medical necessity and reasonableness of the charges billed for the selected claims.

The 50 claims sampled represent approximately 2 percent of the hospital's OPPS outlier claims and approximately 11 percent of the total outlier payments received by Rush during this audit period. Our review was conducted in accordance with generally accepted government auditing standards. Our fieldwork was performed at Rush's offices in Chicago, Illinois, and the Office of Inspector General's (OIG) offices in Chicago, Illinois, and St. Paul, Minnesota, during the period January through February 2003.

## **FINDINGS AND RECOMMENDATIONS**

We determined that Rush received improper Medicare reimbursements on 38 of the 50 outpatient claims reviewed (35 overpayments and 3 underpayments). The overpayments were attributable to a problem in the Fiscal Intermediary's (FI) claim processing system and totaled \$7,726. The three underpayments of \$7,752 pertained to improperly billing Medicare for implantable devices. Rush should have billed for the implantable devices using a specific HCPCS code, which would have resulted in a higher claim reimbursement with no outlier payment.

### **Overpayments Due to FI Pricing Problem**

The outlier overpayments on 35 claims, totaling \$7,726, were caused by an edit problem within the FI's pricer program, which inappropriately included non-covered charges in the calculation of outlier payments. Because the calculation of an outlier payment for OPPS claims is contingent, in part, on Medicare covered charges that are packaged in APCs, overstating charges could result in excessive or unwarranted outlier payments. When the FI pricer included non-

covered charges in the calculation of the outlier payment; overpayments were generated. We determined that Rush had properly identified non-covered charges on the claims submitted to the FI for payment. These errors only occurred on claims having lines of service with both covered and non-covered charges. The FI was unable to provide a definitive technical explanation for this system problem and indicated that this problem would not be addressed internally any earlier than April 1, 2003. See **APPENDIX 1** for an example of the effect these overstated charges have on the outlier reimbursement.

### **Improper Coding for Implantable Devices**

We identified three improperly billed claims that were underpaid by \$7,752. When Rush prepared its Medicare billing for implantable devices on the three claims, it omitted the appropriate HCPCS “C” codes. If these codes had been used, no outlier payment would have been paid on these claims. Instead, the total claim reimbursement would have been higher than the reimbursement as an outlier claim. We determined that Rush was entitled to an additional reimbursement of \$7,752, when the proper “C” codes were applied.

Before we began our review, Rush was aware that charges related to implantable devices had been billed and coded improperly and began a two-phase initiative to review these claims and to submit adjustments for those that were improperly billed and coded. The first phase of Rush’s initiative began in August 2002 and covered claims with dates of services from April 2001 through August 2002. The second phase was performed in December 2002 and covered claims with dates of services from July 2001 through December 2002.

It appears that our identified claims with improper coding for implantable devices were inadvertently excluded from Rush’s review. Rush confirmed that these claims were not included in either of their initiatives. Since Rush’s corrective action should address the internal billing concern, no additional procedural recommendations are in order.

### **RECOMMENDATIONS**

We recommend that Rush:

- Refund the overstated outlier overpayments of \$7,726 and
- Resubmit claims for improperly billed implantable devices in order to recover the identified underpayments of \$7,752.

### **AUDITEE RESPONSE**

Rush agreed with our findings and will work with their fiscal intermediary (FI) in refunding the the \$7,726 in identified overpayments and refilling claims for the underpayments identified of \$7,752. Rush’s response is appended to this report in its entirety (See **APPENDIX 2**).

# **APPENDIX**

**APPENDIX 1**

**Effect of Pricer Problem**

Within our sample of 50 claims, we had identified 35 claims where the FI's pricer program generated an outlier overpayment. Because the outpatient outlier payment calculation under OPSS is contingent, in part, on Medicare covered charges for APC group, overstated covered charges result in excessive or unwarranted outlier payments. The following example illustrates the effect that this pricer problem had in generating outlier overpayments.

Rush submitted a claim with outpatient charges totaling \$4,275.80, which contained non-covered charges of \$619.35. Medicare covered charges were \$3,656.45. Instead of excluding the total non-covered charges that were billed, the pricer program excluded only \$24.35 in non-covered charges resulting in an outlier overpayment of \$159.50. The following table shows how this outlier overpayment was calculated:

Line #		Calculation of Reimbursement Received	OIG Calculation	Overpayment
	<b>OPPS OUTLIER CALCULATION</b>			
1	Total Charges Billed	4,275.80	4,275.80	
2	Non-covered Charges excluded	24.35	619.35	
3	Medicare covered OPSS charges (Line 1 - Line 2)	4,251.45	3,656.45	
4	Less Fee Schedule Charges (if applicable)	0.00	0.00	
5	Net Charges for Outlier Calc. (Line 3 - Line 4)	4,251.45	3,656.45	
6	OPSS Cost-to-Charge Ratio	0.35743198	0.35743198	
7	Charges Adjusted to Cost (Line 5 x Line 6)	1,519.60	1,306.93	
8	Total APC Payments	93.82	93.82	
9	Outlier Threshold Amount (Line 8 x 2.5)	234.55	234.55	
10	Costs Over Outlier Cost Threshold (Line 7 - Line 9)	1,285.05	1,072.38	
11	Outlier Payment (75% of the Difference)	963.79	804.29	
	<b>PROVIDER REIMBURSEMENT CALCULATION</b>			
12	APC Payment (From Line 8)	93.82	93.82	
13	Less: Coinsurance	33.35	33.35	
14	APC Payment to Provider	60.47	60.47	
15	Fee Schedule Payments to Provider (if applicable)	0.00	0.00	
16	Outlier Payment	963.79	804.29	
17	<b>Total Payment to Provider</b>	<b>1,024.26</b>	<b>864.76</b>	<b>159.50</b>

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COLLEGE OF HEALTH SCIENCES  
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**CATHERINE A. JACOBSON**  
Senior Vice President of Finance  
Chief Financial Officer and Treasurer

June 13, 2003

Paul Swanson  
Regional Inspector General for Audit Services  
Office of Audit Services  
Department of Health and Human Services  
233 North Michigan Avenue  
Chicago, Illinois 60601

Dear Mr. Swanson:

Rush-Presbyterian-St. Luke's Medical Center (Rush) has received and reviewed Report # A-05-03-00033 concerning the Office of Inspector General's (OIG) review of Medicare Outpatient Prospective Payment System Outlier Payments. We are writing to you at this point in order to provide comments on the draft report as requested in your letter of May 13, 2003.

**Overpayments Due to FI Pricing Problem:**

Rush agrees to the facts as stated in the draft report and will proceed to refund \$7,726 in identified overpayments. Since this is a problem that originates with the FI, the standard adjustment process will not work in any attempt that Rush makes to refund the overpayments, thus a direct contact to the Medicare Audit and Reimbursement Unit at AdminaStar Federal will be made to effect this refund. In addition, the audit report indicates that this error remained uncorrected at least as of April 2003 which indicates that there is the potential of additional overpayments as the result of this payment error at the FI. In Rush's discussions with AdminaStar regarding the refunds identified, we will determine from them how they wish to proceed in determining whether other overpayments occurred and the timeframe for correcting the pricing problem.

**Improper Coding for Implantable Devices**

Rush agrees to the facts as stated in the draft report and has been underpaid by \$7,752 due to improper coding. Since the dates of service on these claims are now outside of the filing limits, there may not be an opportunity for Rush to recover this money; a direct contact will be made to the FI to determine if a filing for these claims may be made. As stated in the draft report, Rush has corrected the coding error and did submit adjustments for claims identified as to having this error. These claims were not identified in that process.

Thank you for this opportunity to address the OIG draft report on Rush's OPPS billing practices. We look forward to receiving the final report.

Sincerely,

*Catherine Jacobson /mf*

Catherine Jacobson

Cc: Cynthia Boyd, M.D.  
Janis Anfossi

# ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Swanson, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Stephen Slamar, *Audit Manager*

Scott Nelson, *Senior Auditor*

Rhonda Walker-Byrd, *Auditor*

Yuson Chon, *Auditor*

## Technical Assistance

Tammie Anderson, *Advanced Audit Techniques Audit Manager*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.