

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
UNIVERSITY OF WISCONSIN HOSPITAL
AND CLINICS FOR CALENDAR YEARS
2008 THROUGH 2010**

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**September 2013
A-05-12-00030**

Office of Inspector General

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EXECUTIVE SUMMARY

University of Wisconsin Hospital and Clinics did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of approximately \$316,000 over 3 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represented 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 University of Wisconsin Hospital and Clinics (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned 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.

The Hospital is a nonprofit 566-bed academic medical center located in Madison, Wisconsin, with 117 outpatient clinics located throughout Wisconsin. Medicare paid the Hospital approximately \$573 million for 28,525 inpatient and 584,270 outpatient claims for services provided to beneficiaries during CYs 2008 through 2010 based on CMS's National Claims History data.

Our audit covered \$3,086,985 in Medicare payments to the Hospital for 186 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 85 inpatient and 101 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 87 of the 186 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 99 claims, resulting in net overpayments of \$316,172 for CYs 2008 through 2010. Specifically, 51 inpatient claims had billing errors, resulting in net

overpayments of \$179,056, and 48 outpatient claims had billing errors, resulting in net overpayments of \$137,116. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$316,172, consisting of \$179,056 in net overpayments for 51 incorrectly billed inpatient claims and \$137,116 in net overpayments for 48 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital partially agreed with our first recommendation and described actions that it has taken to address our second recommendation. Specifically, the Hospital disagreed with our findings for 10 inpatient claims in which we stated that the Hospital should have billed the claims as outpatient or outpatient with observation services. In addition, for five outpatient claims billed with manufacturer credits for replaced medical devices, the Hospital corrected the claims using modifier “FC” which is contrary to our finding that modifier “FB” should be reported. The Hospital agreed with our findings and recommendations for the remaining claims. After reviewing the Hospital’s comments, we maintain that our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represented 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 University of Wisconsin Hospital and Clinics (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Medicare Program

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

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

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

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

Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.¹ All services and items within an APC group are comparable clinically and require comparable resources. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient transfers,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims with payments greater than \$150,000,
- inpatient psychiatric facility (IPF) emergency department adjustments,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient and outpatient claims paid in excess of charges,
- outpatient claims billed for Lupron injections,
- outpatient claims billed with modifiers,
- outpatient claims billed with observation services that resulted in outlier payments,
- outpatient claims billed with evaluation and management (E&M) services, and
- outpatient claims with payments greater than \$25,000.

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.

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

Medicare Requirements for Hospital Claims and Payments

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 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).

University of Wisconsin Hospital and Clinics

The Hospital is a nonprofit 566-bed academic medical center located in Madison, Wisconsin, with 117 outpatient clinics located throughout Wisconsin. Medicare paid the Hospital approximately \$573 million for 28,525 inpatient and 584,270 outpatient claims for services provided to beneficiaries during CYs 2008 through 2010 based on CMS’s National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$3,086,985 in Medicare payments to the Hospital for 186 claims that we judgmentally selected as potentially at risk for billing errors. These 186 claims consisted of 85 inpatient and 101 outpatient claims with dates of service in CYs 2008 through 2010 (audit period). We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 20 claims to focused medical review to determine whether the services were medically necessary for 15 claims and billed correctly for 5 claims. 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 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

The Hospital complied with Medicare billing requirements for 87 of the 186 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 99 claims, resulting in net overpayments of \$316,172 for the audit period. Specifically, 51 inpatient claims had billing errors, resulting in net overpayments of \$179,056, and 48 outpatient claims had billing errors, resulting in net overpayments of \$137,116. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. Appendix B contains the results of our review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 51 of 85 selected inpatient claims, which resulted in net overpayments of \$179,056.

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 20 of the 85 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Hospital officials listed human error and the need for additional education as to why key controls did not prevent these types of errors. As a result of these errors, the Hospital received overpayments of \$140,471.²

Incorrect Discharge Status

Hospitals must bill inpatient discharges as transfers when (1) the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge or (2) the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to home under a home health agency’s written plan of care for home health services that begin within 3 days after the date of discharge (42 CFR §§ 412.4 (b) and (c)). 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)).

² The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

For 3 of the 85 selected claims, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers. For these claims, the Hospital should have coded the discharge status either as a transfer to an acute care hospital, or to home under a written plan of care for the provision of home health services. However, the Hospital incorrectly coded the discharge status to home under a written plan of care for the provision of home health services, expired, or to home; therefore, the Hospital should have received the per diem payment instead of the full DRG payment. Hospital officials stated that the incorrect billings occurred because of human error or the patient changed arranged care after discharge without the Hospital's control and knowledge. As a result of these errors, the Hospital received overpayments of \$26,794.

Manufacturer Credits for Replaced Medical Devices Not Reported

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). 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 (which identifies the replacement device) and value code "FD" (which identifies the amount of the credit or cost reduction received by the hospital for the replaced device) (chapter 3, § 100.8).

For 2 of the 85 selected claims, the Hospital received a reportable medical device credit for a replaced medical device from a manufacturer but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required. Hospital officials stated that these errors occurred because the credit memos were not forwarded to the appropriate patient billing department. As a result of these errors, the Hospital received overpayments of \$8,690.

Unsupported Charges Resulting in Incorrect Outlier Payments

The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2). In addition, it states that a hospital may bill only for services provided (chapter 3, § 10). CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary (42 CFR § 412.80).

For 3 of the 85 selected claims, the Hospital incorrectly billed Medicare for unsupported charges. The Hospital incorrectly included charges for services or medications in cost outlier computations, thus creating overpayments. Hospital officials attributed these overpayments to human error. As a result of these errors, the Hospital received overpayments of \$3,129.

Incorrect Source-of-Admission Code

CMS increases the Federal per diem rate for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary used emergency department services; however, the IPF should not receive the additional payment if the beneficiary was discharged from the acute care section of the same hospital (42 CFR § 412.424 and the Manual, chapter 3, § 190.6.4). The Manual also states that IPFs report source-of-admission code "D" to identify patients who have been transferred to the IPF from the same hospital (chapter 3, § 190.6.4.1). An IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 22 of the 85 selected claims, the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to its IPF upon discharge from its acute care section. Hospital officials stated that the errors occurred because the claim scrubber edit was not working properly, and most of the coders misunderstood the admission source code to use when a patient transferred from their acute care unit to the psychiatric unit. As a result of these errors, the Hospital received overpayments of \$1,965.

Incorrectly Billed Diagnosis-Related Group Code

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 1 of the 85 selected claims, the Hospital billed Medicare with an incorrect procedure code, which resulted in an incorrect DRG code. Hospital officials attributed this error to the technical and interpretative nature of coding resulting in differences of opinion as to which procedure code was most appropriate. For this claim, a different procedure code more appropriately specified the procedure performed. As a result of this error, the Hospital was underpaid \$1,993.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 48 of 101 selected outpatient claims, which resulted in net overpayments of \$137,116.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45(a)). For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier "FB" and reduced charges on a claim that includes a procedure code for the

insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device.³

For 5 of the 101 selected claims, the Hospital received full credit for replaced devices but did not report the “FB” modifier and reduced charges on its claims. Hospital officials stated that these errors occurred because the credit memos were not forwarded to the appropriate patient billing department. As a result of these errors, the Hospital received overpayments of \$53,406.

Incorrectly Billed Healthcare Common Procedure Coding System Code

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

For 13 of the 101 selected claims, the Hospital submitted the claims to Medicare with the same incorrect HCPCS code. Hospital officials attributed this to a new system and human error. As a result of these errors, the Hospital received overpayments of \$40,855.

Incorrectly Billed Lupron Injections and an Insufficiently Supported Medication

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

The U.S. Food and Drug Administration (FDA) approved Leuprolide acetate (Lupron) for the treatment of different diagnoses that each have their own national drug code (NDC). CMS provides a quarterly listing that cross-references the NDC to the HCPCS code. HCPCS code J9217 is referenced to the NDC approved to treat prostatic cancer while HCPCS code J1950 is referenced to the NDC approved to treat disorders relating to the uterus.

For 10 of the 101 selected claims, the Hospital incorrectly billed Lupron injections either billing the incorrect HCPCS code (8 errors), billing it twice (1 error), or billing for Lupron that was not supported in the medical records (1 error). For the eight claims, the Hospital submitted claims using the HCPCS code J1950 instead of the correct HCPCS code J9217 for beneficiaries with prostatic cancer, and billed with either eight or six service units when the correct amount should have been four or three, respectively. In addition, one of the eight claims included payment for a different drug which was not supported in the medical records. Although Hospital officials

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

believed using HCPCS code J1950 instead of HCPCS code J9217 was a technical error, they disagreed it was incorrectly billed and claimed it did not result in a different payment. However, HCPCS code J1950 has a higher Medicare reimbursement than HCPCS code J9217. Hospital officials attributed the remaining incorrect billings to human error. As a result of these errors, the Hospital received overpayments of \$21,285.

Incorrectly Billed Outpatient Services With Modifiers -59, -50, and -73

The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). It 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). It also states: “Modifier -50 is used to report bilateral procedures that are performed at the same operative session as a single line item” (chapter 4, § 20.6.2). The Manual also states: “Modifier -73 is used by the facility to indicate that a procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well-being of the patient after the patient had been prepared for the procedure (including procedural pre-medication when provided), and been taken to the room where the procedure was to be performed, but prior to administration of anesthesia” (chapter 4, § 20.6.4).

For 5 of the 101 selected claims, the Hospital incorrectly billed Medicare for HCPCS codes with modifiers. Specifically, the Hospital billed with modifier -59 for services that were already included in the payments for other services billed on the same claim (3 errors), with modifier -50 for a bilateral procedure when only one procedure was allowed for billing (1 error), or with modifier -73 for a HCPCS code that did not require anesthesia (1 error). Hospital officials attributed this to human error. As a result of these errors, the Hospital received net overpayments of \$20,319.

Unsupported Charges Resulting in Incorrect Outlier Payments

The Manual states: “Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services” (chapter 4, § 290.1). The Manual also states that observation time begins at the time documented in the patient’s medical record, which coincides with the time that observation care is initiated in accordance with a physician’s order. The Manual continues, “Hospitals should not report, as observation care, services that are part of another Part B service...” (chapter 4, § 290.2.2). The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). The Manual also states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 8 of the 101 selected claims, the Hospital incorrectly billed Medicare for unsupported charges that resulted in incorrect outlier payments. On all eight claims, the Hospital overstated the hours of observation because it counted time prior to the order for observation care and/or included observation time for services that were part of another Part B service. For six of these

eight claims, the Hospital also incorrectly billed Medicare for medications that were not supported in the medical records. The Hospital attributed this to human error. As a result of these errors, the Hospital received overpayments of \$844.

Incorrectly Billed Evaluation and Management Services

The Manual states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure (chapter 12, § 30.6.6(B)).

For 7 of the 101 selected claims, the Hospital incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. These services were primarily associated with follow up visits. Hospital officials stated that these incorrect billings occurred due to human error. As a result of these errors, the Hospital received overpayments of \$407.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$316,172, consisting of \$179,056 in net overpayments for 51 incorrectly billed inpatient claims and \$137,116 in net overpayments for 48 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS COMMENTS

In written comments on our draft report, the Hospital partially agreed with our first recommendation. The Hospital disagreed with our findings for 10 inpatient claims in which we stated that the Hospital should have billed the claims as outpatient or outpatient with observation services. For each of these 10 claims, the Hospital provided a claim-by-claim examination contending that inpatient status admission for Part A reimbursement was appropriate.

With regard to five outpatient claims billed with manufacturer credits for replaced medical devices, the Hospital corrected the claims per guidance from NGS, the Medicare contractor for the Hospital. The Hospital received instruction from NGS to file a credit for these medical devices using modifier “FC”, and stated NGS’s guidance was contrary to our finding showing modifier “FB” should be used.

The Hospital agreed with our findings and recommendations for the remaining claims and addressed our second recommendation by stating that it has reviewed and improved its educational, internal audit, and compliance programs to address the issues identified.

The Hospital's comments are included as Appendix C. We excluded the Hospital's claim-by-claim examination from the Hospital's comments because it included personally identifiable information.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid.

For the 10 inpatient claims that that Hospital should have billed as outpatient or outpatient with observation services, we used an independent medical review contractor to determine whether the claims met inpatient medical necessity requirements. The contractor examined all of the medical records and documentation the Hospital submitted and carefully considered this information to determine whether it billed the claims according to Medicare requirements. Based on the contractor's conclusions, we determined that the 10 inpatient claims should have been billed as outpatient or outpatient with observation services.

For the five outpatient claims billed with manufacturer credits for replaced medical devices, we maintain that modifier "FB" should have been used. Modifier "FC" is only used in cases of a partial credit. For the five claims, the Hospital received either a full credit for the replaced device or the credit covered the full cost of the new replacement device which are both situations where modifier "FB" is required.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$3,086,985 in Medicare payments to the Hospital for 186 claims that we judgmentally selected as potentially at risk for billing errors. These 186 claims consisted of 85 inpatient and 101 outpatient claims with dates of service in CYs 2008 through 2010 (audit period).

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 20 claims to focused medical review to determine whether the services were medically necessary for 15 claims and billed correctly for 5 claims.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

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

We conducted our fieldwork from January to December 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 the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 186 claims (85 inpatient and 101 outpatient claims) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- used an independent contractor to determine whether 15 selected claims met medical necessity requirements and 5 selected claims met billing requirements;
- 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 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 objectives.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Under / Over-payments	Value of Net Over-payments
Inpatient				
Short Stays	23	\$164,769	20	\$140,471
Transfers	3	70,225	3	26,794
Manufacturer Credits for Replaced Medical Devices	11	270,102	2	8,690
Claims With Payments Greater Than \$150,000	4	693,501	3	3,129
Psychiatric Facility Emergency Department Adjustments	22	234,117	22	1,965
Claims Billed With High-Severity-Level Diagnosis-Related Group Codes	8	358,301	0	0
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	7	194,862	0	0
Claims Paid in Excess of Charges	7	222,599	1	(1,993)
Inpatient Totals	85	\$2,208,476	51	\$179,056
Outpatient				
Manufacturer Credits for Replaced Medical Devices	8	\$108,106	5	\$53,406
Claims Paid in Excess of Charges	21	58,088	13	40,855
Claims Billed for Lupron Injections	10	39,124	10	21,285
Claims Billed With Modifiers	17	76,451	5	20,319
Claims Billed With Observation Services That Resulted in Outlier Payments	10	27,663	8	844
Claims Billed With Evaluation and Management Services	20	7,652	7	407
Claims With Payments Greater Than \$25,000	15	561,425	0	0
Outpatient Totals	101	\$878,509	48	\$137,116
Inpatient and Outpatient Totals	186	\$3,086,985	99	\$316,172

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 the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX C: UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS COMMENTS



September 9, 2013

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, Ill 60601

RE: DRAFT - Medicare Compliance Review of the University of Wisconsin Hospital and Clinics for Calendar Years 2008 through 2010. (A-05-12-00030)

Dear Ms. Fulcher:

This letter responds to the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled *Medicare Compliance Review of University of Wisconsin Hospital and Clinics for Calendar Years 2008 Through 2010, dated 08/06/2013*. The University of Wisconsin Hospital and Clinics (UWHC) appreciates the opportunity to comment on the OIG's draft report. We are committed to complying with all regulations and standards governing Federal health care programs, and embrace opportunities to improve our educational, internal audit and compliance programs to monitor and minimize the risk of non-compliant claims.

UWHC respectfully disagrees with OIG's conclusions regarding ten of the 99 claims which OIG asserts UWHC was not fully compliant. OIG's assertion with regard to each of these ten claims hinges on whether the care provided by UWHC should have been billed as an inpatient admission for which reimbursement under Medicare Part A was claimed by UWHC, or whether the care should have been billed under Medicare Part B as observation or short stay. Attachment A to this letter is a claim-by-claim examination of these ten claims. As Attachment A necessarily contains Protected Health Information (PHI), it is not appropriate for publication.

When one factors in the proper reimbursement amount for these ten claims, the net overpayment amount falls by \$74,454 to \$241,718. This yields a 7.8% error rate by dollars on OIG's judgmental audit of \$3,086,985 in Medicare payments to UWHC. UWHC's total revenue from Medicare during the audit period was more than \$600,000,000.

OIG ASSERTED NONCOMPLIANCE ASSOCIATED WITH INPATIENT CLAIMS

With regard to ten of these claims, UWHC respectfully disagrees with the OIG's assertion that UWHC's billing was not fully compliant. Please see Attachment A for a claim-by-claim examination of these ten claims. With regard to the balance of the claims in this group, UWHC concurs with OIG findings, has made full repayments to Medicare, and will bill for the appropriate Part B reimbursement (\$8,505 aggregate).

Corrective Action

UWHC has investigated these inpatient claims and has instituted corrective action as described:

1. For the two claims for which UWHC received a full credit for replaced medical devices from a manufacturer but failed to adjust our inpatient claims with the proper condition and value codes to reduce payment as required, the cause of the error was a failure of UWHC staff to forward the credit memos to our billing department. This work-flow failure has been corrected.
2. For the 22 claims for which UWHC incorrectly coded the source-of-admission for beneficiaries who were admitted to UWHC's inpatient psychiatric unit upon discharge from acute care units, the cause of the error was a temporary malfunction of a claims scrubber edit. The malfunction was attendant to a larger system upgrade and was rectified some time ago. Subsequent to our examination of the 22 claims OIG had identified, UWHC undertook a review of all Medicare admissions to UWHC's inpatient psychiatric unit between 04/01/06 and 03/23/2012. We reviewed over 1,300 such admissions, and found that these were correctly billed over 98% of the time. After reviewing each one, UWHC found three additional cases, over and above the 22 found by OIG, with this same error. UWHC has corrected all 25 of these claims.
3. For the balance of the inpatient claims which were not fully compliant, the cause was a combination of human error and the inherently subjective nature of some facets of Medicare reimbursement. UWHC has reviewed and improved its educational, internal audit and compliance programs to address the issues identified by OIG and has corrected all of those claims.

OIG ASSERTED NONCOMPLIANCE ASSOCIATED WITH OUTPATIENT CLAIMS

With regard to the claims in this group, UWHC concurs with OIG findings and has repaid all claims except as noted below.

With regard to the seven claims involving *Inpatient and Outpatient Manufacturer Credits for Replacement of Medical Devices*, UWHC has corrected all seven claims per guidance from NGS. Medicare has recouped the original payment and paid UWHC a lesser amount. The computation of this amount is based on specific instructions provided by NGS in response to UWHC's query regarding how to file a credit for these medical devices. Note that UWHC's practices were based on instruction from NGS to use modifier -FC, not modifier -FB. Contrary to NGS's guidance, OIG asserts UWHC should have used modifier -FB.

With regard to eight of the ten claims involving *Lupron - J1950 Billed with Incorrect Diagnosis*, UWHC has not repaid the difference between the amount billed and the proper amount of reimbursement (\$12,122 aggregate).

Corrective Action

UWHC has investigated our processes in connection with these outpatient claims and has instituted corrective action as described:

1. For the five claims for which UWHC received a full credit for replaced devices but did not report the "FB" modifier and reduce charges on its claims, the cause of the error was a failure of UWHC staff to forward the credit memos to our billing department. This work-flow failure has been corrected.
2. For the balance of the outpatient claims, the cause was a combination of human error and the inherently subjective nature of some facets of Medicare reimbursement. UWHC has reviewed and improved its educational, internal audit and compliance programs to address these issues.

SUMMARY

In summary, UWHC respectfully disagrees with the OIG's findings regarding 10 of the claims. See discussion above and on Attachment A regarding these claims.

Of the remaining 89 identified claims, UWHC proactively corrected 80 claims. The only remaining identified claims are the eight Lupron claims referred to above and one claim (E-01) for which UWHC was underpaid (\$3,045). As a result, factoring in the aggregate Part B reimbursement for the ten claims originally submitted as inpatient, for which UWHC concurred with OIG, the net remaining amount which UWHC will refund to Medicare is \$572.

The integrity and accuracy of our revenue cycle processes is a top priority. UWHC continues to review and improve its ongoing education, internal audit and compliance programs to achieve and maintain a very high rate of compliant claims submission.

Attachment:

- A. Claim-by-Claim Examination of 10 claims. (Not for Publication)

Sincerely,

Daniel J Weissburg, JD, CHC
Director of Compliance

cc: Donna Katen-Bahensky, President and CEO
James Dechene, SVP General Counsel