



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



May 17, 2012

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

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

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

SUBJECT: Medicare Compliance Review of New York Downtown Hospital for the Period July 1, 2008, Through December 31, 2010 (A-02-11-01022) and Medicare Compliance Review of the University of Colorado Hospital for Calendar Years 2008 and 2009 (A-07-11-05009)

Attached, for your information are advance copies of two of our final reports for hospital compliance reviews. We will issue these reports to New York Downtown Hospital and University of Colorado Hospital within 5 business days.

These reports are 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 the respective Regional Inspectors General for Audit Services:

New York Downtown Hospital

James P. Edert, Regional Inspector General for Audit Services, Region II
(212) 264-4620, email – James.Edert@oig.hhs.gov

University of Colorado Hospital

Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII
(816) 426-3591, email – Patrick.Cogley@oig.hhs.gov

Attachment

cc:

Daniel Converse

Office of Strategic Operations and Regulatory Affairs,
Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION VII
601 EAST 12TH STREET, ROOM 0429
KANSAS CITY, MO 64106

May 22, 2012

Report Number: A-07-11-05009

Ms. Christine Hogan-Newgren
Chief Compliance Officer
University of Colorado Hospital
12401 East 17th Avenue, Mail Stop F 481
Aurora, CO 80045

Dear Ms. Hogan-Newgren:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of the University of Colorado Hospital for Calendar Years 2008 and 2009*. 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 at (816) 426-3591, or contact Scott Englund, Audit Manager, at (573) 893-8338, extension 27, or through email at scott.englund@oig.hhs.gov. Please refer to report number A-07-11-05009 in all correspondence.

Sincerely,

/Patrick J. Cogley/
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
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 THE
UNIVERSITY OF COLORADO HOSPITAL
FOR CALENDAR YEARS
2008 AND 2009**



Daniel R. Levinson
Inspector General

May 2012
A-07-11-05009

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:

Office of Audit Services

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.

Office of Evaluation and Inspections

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.

Office of Investigations

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.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

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.

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 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.

The University of Colorado Hospital (the Hospital) has over 400 beds and is located in Aurora, Colorado. Medicare paid the Hospital approximately \$262 million for 11,866 inpatient and 327,353 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2008 and 2009 based on CMS's National Claims History data.

Our audit covered \$7,519,204 in Medicare payments to the Hospital for 137 inpatient and 27 outpatient claims that we identified as potentially at risk for billing errors for CYs 2008 and 2009. (Of these 164 claims, 158 had dates of service in CYs 2008 and 2009 and the remaining 6 claims, involving replacement medical devices, had dates of service in CY 2010.)

OBJECTIVE

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

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 136 of the 164 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 28 claims, resulting in overpayments totaling \$308,927 for CYs 2008 through 2010. Specifically, 21 inpatient claims had billing errors, resulting in overpayments totaling \$165,760, and 7 outpatient claims had billing errors, resulting in overpayments totaling \$143,167. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$308,927, consisting of \$165,760 in overpayments for the 21 incorrectly billed inpatient claims and \$143,167 in overpayments for the 7 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations for 28 inpatient and outpatient claims. The Hospital stated that claims found to be in error would be re-billed to the Medicare contractor. However, the Hospital strongly disagreed with our statement that the errors occurred because the hospital did not have adequate controls to prevent incorrect billing of Medicare claims. The Hospital said that additional internal controls cannot catch all errors.

We agree that an effective internal control system will not prevent or detect all errors. An effective hospital internal control system provides reasonable, but not absolute, assurance that claims billed to Medicare will comply with Medicare laws and regulations. We note that in its comments on our draft report, the Hospital outlined several areas in which it planned to improve its internal controls, including the billing of blood factors, system requirements for physician orders, vendor device credits, edits for outpatient claims in excess of charges, and edits for duplicate codes. We believe that these actions will enhance the Hospital's compliance with Medicare laws and regulations.

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

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System.....	1
Hospital Payments at Risk for Incorrect Billing.....	2
Medicare Requirements for Hospital Claims and Payments	2
University of Colorado Hospital.....	3
OBJECTIVE, SCOPE, AND METHODOLOGY	3
Objective.....	3
Scope.....	3
Methodology.....	4
FINDINGS AND RECOMMENDATIONS	4
BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS	5
Inpatient Claims Paid in Excess of Charges	5
Inpatient Claims With Payments Greater Than \$150,000	5
Inpatient Claims for Blood Clotting Factor Drugs	6
Inpatient Short Stays.....	6
Inpatient Manufacturer Credits for Medical Devices	7
BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS	7
Outpatient Manufacturer Credits for Medical Devices.....	7
Outpatient Claims With Payments Greater Than \$25,000.....	8
Outpatient Claims Paid in Excess of Charges.....	8
RECOMMENDATIONS	8
AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	9
Internal Controls	9
Audit Process	9
OTHER MATTERS	10
APPENDIX	
AUDITEE COMMENTS	

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 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 and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. For beneficiary stays incurring extraordinarily high costs, section 1886(d)(5)(A) of the Act provides for additional payments (called outlier payments) to Medicare-participating hospitals.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, P.L. No. 106-113.² 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

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) 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.

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.

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. Examples of the types of claims at risk for noncompliance included the following:

- inpatient and outpatient claims paid in excess of charges,
- inpatient claims with payments greater than \$150,000,
- inpatient claims for organ acquisition charges and blood clotting factor,
- inpatient zero and 1 day stays (short stays),
- inpatient and outpatient manufacturer credits for medical devices, and
- outpatient claims with payments greater than \$25,000.

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

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

Medicare Requirements for Hospital Claims and Payments

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

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the 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 3, section 10, of the Manual states that the hospital

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

may bill only for services provided. In addition, chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

University of Colorado Hospital

The University of Colorado Hospital (the Hospital) has over 400 beds and is located in Aurora, Colorado. Medicare paid the Hospital approximately \$262 million for 11,866 inpatient and 327,353 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2008 and 2009 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 \$7,519,204 in Medicare payments to the Hospital for 137 inpatient and 27 outpatient claims that we judgmentally selected as potentially at risk for billing errors. Of these 164 claims, 158 had dates of service in CYs 2008 and 2009. Six of the 164 claims (involving replacement medical devices) had dates of service in CY 2010.

We focused our review on the risk areas that we had 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, except in the cases of three claims, to determine whether the services were medically necessary.⁴

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 allowed 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 from May to November 2011.

⁴ In response to the Hospital's written comments on our draft report, we used medical review to verify our findings in the case of three claims; these are discussed later in the report.

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 and 2009;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for CYs 2008, 2009, and 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 164 claims (137 inpatient and 27 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- discussed the incorrectly billed and/or coded claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- submitted three claims for medical review to the Medicare contractor;
- calculated the correct payments for those claims requiring adjustments; and
- shared 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 136 of the 164 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare

billing requirements for the remaining 28 claims, resulting in overpayments totaling \$308,927 for CYs 2008 through 2010. Specifically, 21 inpatient claims had billing errors, resulting in overpayments totaling \$165,760, and 7 outpatient claims had billing errors, resulting in overpayments totaling \$143,167. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 21 of 137 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$165,760.

Inpatient Claims Paid in Excess of Charges

Section 1862(a)(1)(A) of the Act states that no Medicare payment may 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." In addition, the Manual, chapter 3, section 10, states that the hospital may bill only for services provided, and chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

For 3 out of 40 sampled claims, the Hospital billed Medicare for incorrect DRG codes (2 errors) or billed Medicare Part A for a beneficiary stay that should have been billed as outpatient (1 error). The Hospital stated that the overpayments occurred due to human error. As a result of these errors, the Hospital received overpayments totaling \$64,189.

Inpatient Claims With Payments Greater Than \$150,000

The Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately." In addition, chapter 3, section 10, states that a hospital may bill only for services provided.

Pursuant to 42 CFR § 412.80, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary.

For 8 out of 17 sampled claims, the Hospital submitted claims to Medicare with incorrect charges that resulted in incorrect outlier payments. For six claims, the Hospital billed for medical services that were not supported by the medical records. For the other two claims, the Hospital billed for off-label use of medication not covered by Medicare.⁵ The Hospital attributed these overpayments to human error. As a result of these errors, the Hospital received overpayments totaling \$40,330.

⁵ "Off-label" use refers to the use of approved drugs for clinical indications that the Food and Drug Administration has not approved.

Inpatient Claims for Blood Clotting Factor Drugs

Pursuant to 42 CFR § 412.80, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary. In addition, the Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For 1 out of 18 sampled claims, the Hospital submitted a claim to Medicare with incorrect charges, that resulted in an incorrect outlier payment. Specifically, the Hospital billed for off-label use of medication that was not covered by Medicare. The Hospital stated that all claims with blood factor HCPCS codes should have been routed to specific employees within the patient billing department for review and added that in this case it did not follow its procedure for this type of claim review because of personnel turnover in that department. As a result of this error, the hospital received an overpayment of \$11,208.

Inpatient Short Stays

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” Section 1814(a)(3) of the Act states that payment for services furnished an individual may be made only to providers of services that are eligible and only if “... with respect to inpatient hospital services, which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual’s medical treatment ...”

For 5 out of 51 sampled claims, the Hospital incorrectly billed Medicare for inpatient short stays. Specifically:

- One claim had no inpatient order. Hospital officials stated that in the case of this claim, the admission order was missing the paper form that should have accompanied it.
- The Hospital identified another claim that, according to Hospital officials, qualified only as an admission for observation rather than as an inpatient admission. These officials said that in this case the inpatient criteria used by the nurse was not appropriate to the patient’s course of stay.
- According to the Hospital, a third claim should have been changed back to observation status from inpatient status before discharge. Hospital officials stated that in this case, the attending physician had written a “change to observation” order prior to the patient’s discharge, but the change was not communicated to the admissions department to update the claim.
- For the remaining two claims, the language in the physicians’ admission orders was ambiguous. Hospital officials said that the Hospital did not have documentation of the physicians’ intent for the type of admission for these two patients.

The Hospital stated that although it attempted to review every short-stay case prior to discharge, there were human errors. As a result of these errors, the Hospital received overpayments totaling \$28,370.

Inpatient Manufacturer Credits for Medical Devices

Federal regulations (42 CFR § 412.89) 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 cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device. The Manual, chapter 3, section 100.8, states that to correctly bill for a replacement device that was provided with a credit, the hospital must code its Medicare claims with a combination of condition code 49 or 50 along with value code “FD.”

For four out of five sampled claims, the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claim with the appropriate value and condition codes to reduce payment as required. These overpayments occurred because the Hospital did not have adequate controls to report the appropriate value and condition codes in order to accurately reflect credits it had received from manufacturers. As a result of these errors, the Hospital received overpayments totaling \$21,663.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 7 of 27 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$143,167.

Outpatient Manufacturer Credits for Medical Devices

Federal regulations (42 CFR § 419.45) require a reduction in the OPSS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device.

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

Additionally, CMS guidance in Transmittal 1383, dated November 23, 2007, explains that for services furnished on or after January 1, 2008, CMS requires the provider to report the modifier “FC” on a claim that includes a procedure code for the insertion of a replacement device if the provider receives a credit from the manufacturer of 50 percent or more of the cost of the replacement device. Partial credits for less than 50 percent of the cost of a replacement device need not be reported with any modifier.

For five out of six sampled claims, the Hospital received a full credit for a replaced medical device but did not report the “FB” modifier or reduced charges on its claim.⁶ These overpayments occurred because the Hospital did not have adequate controls to report the appropriate modifiers and charges to reflect credits received from manufacturers. As a result of these five errors, the Hospital received overpayments totaling \$113,171.

Outpatient Claims With Payments Greater Than \$25,000

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, states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For one out of five sampled claims, the Hospital incorrectly billed Medicare for services performed once but billed twice on the same claim. The Hospital stated that this overpayment occurred because there was not an edit in the billing system to catch this type of error. As a result of this error, the Hospital received an overpayment totaling \$15,264.

Outpatient Claims Paid in Excess of Charges

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, states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For the only sampled claim, the Hospital incorrectly billed Medicare for services performed once but billed twice on the same claim. Although one line had a charge of zero for the duplicated HCPCS code, the Hospital received two payments for this claim. The Hospital stated that this overpayment occurred because the zero-charge line item was not recognized as a problem. As a result of this error, the Hospital received an overpayment of \$14,732.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$308,927, consisting of \$165,760 in overpayments for the 21 incorrectly billed inpatient claims and \$143,167 in overpayments for the 7 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

⁶ One of the five incorrect claims had both a full credit and a partial credit. The associated dollar amounts for both are included in the total provided at the end of this paragraph.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations for 28 inpatient and outpatient claims. The Hospital stated that claims found to be in error would be re-billed to the Medicare contractor. However, the Hospital strongly disagreed with our statement that the errors occurred because the hospital did not have adequate controls to prevent incorrect billing of Medicare claims. The Hospital said that additional internal controls cannot catch all errors. The Hospital also expressed an opinion concerning our audit process.

A summary of Hospital's comments regarding controls and our audit process, and our response, follows.

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

Internal Controls

Auditee Comments

In response to our statement that the errors identified in this report occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims, the Hospital commented: "We strongly disagree with [the OIG's] assessment. The majority of the errors were non-systemic in nature, without patterns found and caused by human error. Additional internal controls cannot catch all human errors."

Office of Inspector General Response

We agree that an effective internal control system will not prevent or detect all errors. An effective hospital internal control system provides reasonable, but not absolute, assurance that claims billed to Medicare will comply with Medicare laws and regulations. We note that in its comments on our draft report, the Hospital outlined several areas in which it planned to improve its internal controls, including the billing of blood factors, system requirements for physician orders, vendor device credits, edits for outpatient claims in excess of charges, and edits for duplicate codes. We believe that these actions will enhance the Hospital's compliance with Medicare laws and regulations.

Audit Process

Auditee Comments

The Hospital also made several comments concerning various aspects of the audit process. For example, the Hospital stated:

[W]e would appreciate the following:

- more timely notification of the audit, areas of audit, scope and claims selected for audit
- no scope changes once claims have been reviewed and audit commences
- appropriate skill sets in the auditors doing the review, i.e. a CPA [certified public accountant] isn't the best person to review for medical necessity.

Office of Inspector General Response

We provided the Hospital with timely notification of our audit, its scope, and our areas of interest. We notified the Hospital of our intent to conduct our audit in a letter dated February 9, 2011. Through discussions with Hospital officials, we reached a mutually acceptable starting date of May 16, 2011, for the commencement of our onsite visit.

We planned our audit in accordance with GAGAS, which state: "Scope is the boundary of the audit and is directly tied to the audit objective." GAGAS also state that the scope defines the subject matter that the auditors will assess and report on, such as a particular program or aspect of a program and the necessary documents or records.

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services. During our review of the documentation provided by the Hospital, we identified unsupported charges on the itemized billings. The Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately." These unsupported charges were non-compliant with Medicare regulations and directly related to the audit objective. Because the scope of our work directly related to the audit objective and because we did not change the audit objective, we do not believe that the level of detailed auditing was outside the scope of the audit. Additionally, we believe that the level of auditing performed was consistent with the broader interests of those relying on our report, including the public.

As stated in the report, "We evaluated compliance with selected billing requirements but did not use medical review, with the exception of three claims, to determine whether the services were medically necessary." Auditors review documentation to determine compliance with Medicare guidance. If auditors need an opinion on medical necessity, they consult with an expert, such as the Medicare contractor. The medical review for the three claims was performed by medical professionals with the Medicare contractor. We did not use CPAs (that is, OIG auditors) to determine whether the services discussed in our findings were medically necessary.

OTHER MATTERS

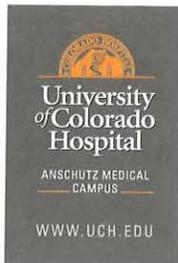
Although our objective was to determine whether the Hospital complied with Medicare billing requirements for the selected inpatient and outpatient claims discussed above, we also identified three claims for which the errors appeared to have taken place during processing by the Medicare

contractor. It would therefore be appropriate for the Hospital to coordinate with the Medicare contractor to resolve these claims. Specifically:

- During our review of inpatient claims paid in excess of charges, we found two claims for which the Medicare contractor overpaid the Hospital by \$31,346 in excess of the allowable amount for the correct DRGs. The Hospital attributed the DRG overpayments to an error on the part of the Medicare contractor. After analyzing these two claims and verifying the correctness of the DRG codes and payment amounts, we agreed with the Hospital's conclusion.
- Additionally, during our review of inpatient claims for organ acquisition charges and blood clotting factor drugs, we found one claim for which the Medicare contractor overpaid the Hospital. As a result of this error, organ acquisition charges were included in the calculation of the Hospital's outlier payment, which in turn resulted in an overpayment to the Hospital of \$19,437. The Hospital stated that removal of organ acquisition charges was the responsibility of the Medicare contractor. After being contacted by us regarding this claim, the Medicare contractor agreed that it had paid the claim incorrectly because organ acquisition charges were already included in the calculation of the outlier payment. The Medicare contractor also stated that it is in the process of identifying other similar claims paid inappropriately, and will take action to adjust those claims.

APPENDIX

APPENDIX: AUDITEE COMMENTS



Office of Compliance/Internal Audit - Board of Directors

Mail Stop F481 • Leprino Building • Room 1027
12401 E. 17th Ave. • Aurora, CO 80045
Phone: 720-848-7825 • Fax: 720-848-5545

April 10, 2012

Patrick H Cogley
Regional Inspector General for Audit Services
DHHS OIG
Office of Audit Services – Region VII
601 E 12th St, Room 0429
Kansas City, MO 64106

Re: Report Number A-07-11-05009
Updated Response

Dear Mr. Cogley:

This letter is provided in response to your correspondence dated January 25, 2012, regarding the audit report noted above of selected Medicare inpatient and outpatient claims submitted by the University of Colorado Hospital.

The lines noted in italics were the original instructions for review provided to the hospital by the OIG. Our comments are listed in the order the issues were addressed in your draft report.

Tab D: IP payments greater than charges

"Please verify the diagnosis and procedure codes and locate the supporting documentation for those diagnosis and procedure codes."

Of the 49 sampled claims, it was ultimately determined (with hospital review and follow-up review by TrailBlazer Health), that three claims had been submitted with a coding error leading to an overpayment of these claims. The amount of overpayment on these three claims is \$41,512.52.

Additionally, at the time of the TrailBlazer coding audit, a medical necessity review was completed for three claims. One of the three claims was determined to not warrant inpatient status resulting in an overpayment of \$22,985.98.

Human error was involved in the miscoding on these encounters. The Health Information Management Department self-audits its' coders on a quarterly basis. In addition, as

Compliance receives feedback on audits with coding errors, this is shared with the appropriate Coding Manager for staff education. This is not a systemic concern.

Tab B: Inpatient Claims greater than \$150,000

"Please verify the diagnosis and procedure codes and locate the supporting documentation for those diagnosis and procedure codes."

All 17 claims were reviewed by the hospital according to the OIG instructions given and the medical record documentation supported the billed diagnosis and procedure codes for all claims. No exceptions were found.

Following this review and more than a week after the auditors' arrival for a two-week audit, the original scope as communicated to us by the OIG was significantly broadened. Following the validation, the OIG auditors expanded the scope to include a line-by-line charge audit on the individual claims.

Of the 17 sampled claims with total billed charges of \$3,377,085, eight were found to have one or more individual items subjectively chosen by the OIG auditors for review. In some cases, the item in question would not be documented in the medical record at this level of detail. For example, the OIG questioned such items as types of room charges, neurosurgical coils, scalpels, surgical packing and specialized staples used in the OR; repeat radiology tests on same day (e.g. repeat CT scan to determine worsening patient condition).

While this level of detailed auditing was outside of the original scope AND was inappropriate, we have removed the charges where the documentation did not support the charge and re-billed the claim. The charges for these removed items represent \$95,057 (0.03%) in overcharges related to individual line item charges not found/substantiated by the medical record.

The errors on six of the eight claims were random in nature, with no pattern established and represented human error in the areas of billing and/or documentation so no additional controls are needed.

Two of these eight claims had \$36,480 (0.01%) in overcharges related to billing for a blood factor drug used in a non-covered manner.

We concur with the OIG regarding the billing errors as well as the need for increased control over the billing of blood factors. A process has been put in place for all claims with billed blood factor drugs to be moved to a work queue for additional review for the presence of a hemophilia diagnosis. All claims not meeting these criteria will have the blood factor drug moved to non-covered status on the claim.

Tab F: Hemophilia

"Please verify the Hemophilia diagnosis codes and then determine whether a hemophilia drug was given."

Of the 18 sampled claims, one was found to be in error resulting in an overpayment to the hospital. The blood factor was given in an off-label manner and the charges were not moved to non-covered at the time of original billing.

We concur with the OIG regarding this billing error as well as the need for increased control over the billing of blood factors. A process has been put in place for all claims with billed blood factor drugs to be moved to a work queue for additional review for the presence of a hemophilia diagnosis. All claims not meeting these criteria will have the blood factor drug moved to non-covered status on the claim.

Tabs G and H: 1 and 2 day stays

“Please locate the signed physicians’ orders for admission as an inpatient. Also, please explain and locate in the chart what justified the change in observation status to inpatient status.”

Of the 51 sampled claims, 5 claims were found by the OIG to be in error. All five were related to the physician order for inpatient status.

These 5 claims will be re-billed to their appropriate status. The University of Colorado Hospital has implemented the Epic software package for electronic medical records. The system requires that a physician order for patient status be in place, with an electronic date and time stamp placed on the order to prevent confusion or errors.

Tab J: Medical Device Credits – Inpatient and Outpatient

No OIG instructions for review provided.

We concur with the OIG findings regarding overpayment in this area.

Controls were put in place after this audit in the form of a process to recognize situations where a vendor credit has been received for a device on the Medicare required reporting list. The vendor credit memo will be forward to our Business Services Department to re-bill the claim according to Medicare’s billing guidelines for device credits.

Tab A: Outpatient Claims greater than \$25,000

“Please verify the procedure codes and flag the supporting documentation for those procedure codes.”

We concur that one of the five claims reviewed was billed with a duplicate CPT code resulting in an overpayment.

Tab C: Outpatient Payments greater than charges

“Please verify the procedure codes and locate the supporting documentation for those procedure codes.”

There was only one encounter reviewed by the OIG. We concur that the one claim reviewed was billed with a duplicate CPT code resulting in an overpayment.

Controls in place since July 2010 include a report run weekly to identify any outpatient claims paid in excess of charges. In addition, an edit has been programmed in the Epic software system to flag any claim with a duplicate CPT code being billed in more than one revenue code or more than one line on the UB-04. This system control should prevent any such further issues.

In closing, for future audits we would appreciate the following:

- more timely notification of the audit, areas of audit, scope and claims selected for audit. These claims must be pre-audited which is time consuming and requires much planning and resources. Untimely communication of the audit creates greater challenges in getting the claims reviewed by the scheduled date,
- a scope that is consistent with the time allotted for the on site OIG audit,
- no scope changes once claims have been reviewed and audit commences,
- good use of on site time, i.e. utilizing Hospital staff for review and questions while on site, and
- appropriate skill sets in the auditors doing the review, i.e. a CPA isn't the best person to review for medical necessity.

Regarding the two OIG report recommendations:

- claims found to be in error will be re-billed to the Medicare Administrative Contractor (TrailBlazer Health, Inc.).
- processes have been developed and staff training has occurred in the areas of NovoSeven (blood factor) and medical device credits.

In the Findings and Recommendations section of the OIG report, they write:

“These errors occurred primarily because the hospital did not have adequate controls to prevent incorrect billing of Medicare claims.”

We strongly disagree with their assessment. The majority of the errors were non-systemic in nature, without patterns found and caused by human error. Additional internal controls cannot catch all human errors.

That said, the University of Colorado Hospital will continue to audit claims and institute additional controls as necessary.

Thank you for the opportunity to respond to the draft report.

Sincerely,



Christine H. Newgren, CHC, FHFMA
Vice President of Compliance and Internal Audit
University of Colorado Health