

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
UNIVERSITY OF UTAH HOSPITAL  
FOR CALENDAR YEARS  
2009 AND 2010**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Patrick J. Cogley  
Regional Inspector General

November 2013  
A-07-12-01107

# *Office of Inspector General*

<https://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 <https://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 permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

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.

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

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 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 outpatient and inpatient services.

The University of Utah Hospital (the Hospital) has 535 beds and is located in Salt Lake City, Utah. Medicare paid the Hospital approximately \$259 million for 294,944 outpatient and 13,985 inpatient claims for services provided to Medicare beneficiaries during calendar years (CYs) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$5,437,897 in Medicare payments to the Hospital for 243 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 164 outpatient and 79 inpatient claims with dates of service in CYs 2009 or 2010.

### **OBJECTIVE**

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

## **SUMMARY OF FINDINGS**

The Hospital complied with Medicare billing requirements for 165 of the 243 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 78 claims for CYs 2009 and 2010. For 76 of the 78 claims, the hospital received net overpayments of \$256,259. Specifically, 65 outpatient claims had billing errors that resulted in net overpayments of \$134,586, and 11 inpatient claims had billing errors that resulted in overpayments of \$121,673.

For the remaining two claims with billing errors, we were unable to determine the amount of overpayment, either during our fieldwork or through extensive coordination with the Hospital since then. These outpatient claims, for which the Hospital received \$71,248 in Medicare payments, had multiple billing errors. However, we were not able to determine the amount of overpayment for the portions of the claims that were incorrectly billed. The Hospital informed us that it was working with the Medicare contractor to reprocess the claims.

These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and/or did not fully understand the Medicare billing requirements within the selected risk areas that contained errors.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$256,259, consisting of \$134,586 in net overpayments for the 65 incorrectly billed outpatient claims and \$121,673 in overpayments for the 11 incorrectly billed inpatient claims,
- continue to work with the Medicare contractor to determine the amount of overpayment for the remaining two outpatient claims of \$71,248 and refund the overpayment amount, 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 agreed with our recommendations to refund overpayments to Medicare and to resubmit claims for which we were not able to determine the amount of overpayment. Regarding our third recommendation, the Hospital described corrective actions that it had taken to ensure compliance with Medicare requirements.

After providing its comments, the Hospital advised us of its efforts to work with the Medicare contractor to determine the amount of overpayment for the remaining two outpatient claims and refund that amount. We acknowledge the steps that the Hospital has taken to resubmit these claims in accordance with Medicare billing requirements.

# TABLE OF CONTENTS

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Hospital Outpatient Prospective Payment System .....	1
Hospital Inpatient Prospective Payment System .....	1
Hospital Claims at Risk for Incorrect Billing .....	2
Medicare Requirements for Hospital Claims and Payments .....	2
University of Utah Hospital .....	3
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	3
Objective .....	3
Scope .....	3
Methodology .....	4
<b>FINDINGS AND RECOMMENDATIONS</b> .....	5
<b>BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS</b> .....	5
Incorrect Healthcare Common Procedure Coding System Codes and/or Number of Units .....	5
Manufacturer Credits for Replaced Medical Devices Not Reported .....	7
Incorrect Coding on Outpatient Claim to Identify Beneficiary Status Change .....	7
Incorrect Number of Units for Doxorubicin Hydrochloride .....	7
Incorrect Healthcare Common Procedure Coding System Code for Lupron Injections .....	8
Incorrect Billing for Inpatient-Only Service Under Outpatient Prospective Payment System .....	9
<b>BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS</b> .....	9
Incorrect Diagnosis-Related Groups .....	9
Incorrect Discharge Status .....	10
Incorrect Number of Units .....	10
Incorrect Source of Admission .....	10
<b>RECOMMENDATIONS</b> .....	11
<b>AUDITEE COMMENTS</b> .....	11
<b>OFFICE OF INSPECTOR GENERAL RESPONSE</b> .....	11
<b>OTHER MATTER</b> .....	12

## **APPENDIXES**

A: RESULTS OF REVIEW BY RISK AREA

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

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

#### **Hospital 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.<sup>1</sup> The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.<sup>2</sup> All services and items within an APC group are comparable clinically and require comparable resources.

For beneficiaries who receive repetitive or chemotherapy services in a hospital outpatient setting, the hospitals may submit consolidated claims on a monthly basis or at the conclusion of treatment. For beneficiary stays incurring extraordinarily high costs, § 1833(t)(5) of the Act requires that CMS make additional payments (called outlier payments) to Medicare-participating hospitals.

#### **Hospital Inpatient Prospective Payment System**

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

---

<sup>1</sup> In 2009, SCHIP was formally redesignated as the Children's Health Insurance Program.

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

## **Hospital Claims at Risk for Incorrect Billing**

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis techniques. Examples of these types of claims at risk for noncompliance included the following:

- outpatient claims with payments greater than \$25,000,
- outpatient and inpatient claims paid in excess of charges,
- outpatient claims billed with observation services that resulted in outlier payments,
- outpatient claims billed for Doxorubicin Hydrochloride,
- outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed for Lupron injections,
- outpatient claims billed for surgeries with units greater than one,
- outpatient claims billed for intensity modulated radiation therapy planning services,
- outpatient claims billed with modifiers,
- inpatient claims billed with high severity level DRG codes,
- inpatient transfers,
- inpatient claims with payments greater than \$150,000, and
- inpatient psychiatric facility (IPF) emergency department adjustments.

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 outpatient and inpatient 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 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, §§ 1815(a) and 1833(e) of the Act preclude 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, § 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, § 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

## **University of Utah Hospital**

The University of Utah Hospital (the Hospital) has 535 beds and is located in Salt Lake City, Utah. Medicare paid the Hospital approximately \$259 million for 294,944 outpatient and 13,985 inpatient claims for services provided to Medicare beneficiaries during calendar years (CYs) 2009 and 2010 based on CMS's National Claims History data.

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

### **Objective**

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

### **Scope**

Our audit covered \$5,437,897 in Medicare payments to the Hospital for 243 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 164 outpatient and 79 inpatient claims with dates of service in CYs 2009 or 2010.

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 did not use medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the outpatient and inpatient claims selected for 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 outpatient and inpatient claims and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital during February and March 2012.

## Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with CMS and Medicare contractor officials to gain an understanding of Medicare requirements for billing outpatient and inpatient claims;
- extracted the Hospital's outpatient and inpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010 (audit period);
- obtained information on known credits for replaced medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 243 claims (164 outpatient and 79 inpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected 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 selected claims;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- 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 on September 7, 2012.

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.

## FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 165 of the 243 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 78 claims for the audit period. For 76 of the 78 claims, the hospital received net overpayments of \$256,259. Specifically, 65 outpatient claims had billing errors that resulted in net overpayments of \$134,586, and 11 inpatient claims had billing errors that resulted in overpayments of \$121,673.

For the remaining two claims with billing errors, we were unable to determine the amount of overpayment, either during our fieldwork or through extensive coordination with the Hospital since then. These outpatient claims, for which the Hospital received \$71,248 in Medicare payments, had multiple billing errors. However, we were not able to determine the amount of overpayment for the portions of the claims that were incorrectly billed. The Hospital informed us that it was working with the Medicare contractor to reprocess the claims.

These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and/or did not fully understand the Medicare billing requirements within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix A.

### **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 67 of the 164 selected outpatient claims that we reviewed.<sup>3</sup> These errors resulted in net overpayments of at least \$134,586.

#### **Incorrect Healthcare Common Procedure Coding System Codes and/or Number of Units**

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, § 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, § 20.4, of the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed.”

For 34 of 164 selected outpatient claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes and/or incorrect number of units of services provided, and/or submitted claims without required modifiers (10 claims had multiple errors):

---

<sup>3</sup> As explained below, we were unable to determine the amount of overpayment for 2 of the 67 incorrectly billed outpatient claims.

- For 23 claims, the Hospital billed Medicare using incorrect HCPCS codes. For these claims, the Hospital billed for 1,487 services,<sup>4</sup> of which we found 179 that were in error:
  - In 112 billed services, the Hospital did not have documentation supporting the HCPCS codes billed.
  - In 35 billed services, the Hospital billed for a service under a HCPCS code that packaged reimbursement for this service together with reimbursement for other services. Contrary to Federal requirements, the Hospital billed for this service again under a separate HCPCS code to claim reimbursement specifically for the service. Accordingly, the additional bill to claim reimbursement specifically for the service was not allowable for Medicare reimbursement.
  - In 32 billed services, the Hospital billed for incorrect HCPCS codes.
- For 15 claims, the Hospital billed Medicare for an incorrect number of units of service. For example, for 1 claim, rather than billing 10 units for HCPCS code J2562 (injection, Plerixafor), the Hospital billed 24 units.
- For five claims, the Hospital billed an incorrect number of units for observation, which resulted in incorrect outlier payments. For example, the Hospital billed for 34 hours of observation instead of 25 hours. Due to the incorrect number of units billed, charges were overstated, resulting in a higher outlier payment than was warranted.
- For two claims, the Hospital billed Medicare without the required modifier reflecting the work performed for bilateral procedures.

The Hospital stated that the majority of these errors occurred due to human error. For four claims with incorrect units of service, the Hospital stated that an incorrect design of an edit caused an incorrect number of units to be billed.

As a result of the errors discussed above, the Hospital received overpayments of \$62,813 for 32 of the 34 claims. For the remaining two claims of \$71,248, we were unable to determine the amount of overpayment.<sup>5</sup> Specifically, both claims were incorrectly billed for a service separately instead of billing the service under a HCPCS code that packaged reimbursement with other services. For this reason, we could not determine the associated charges that should have been used to calculate the associated outlier payments. In addition, one of these claims was billed for an incorrect number of units of drugs, and we could not determine the correct payment that Medicare should make to the Hospital.

---

<sup>4</sup> We refer to “services” within the context of “claims” because, as stated in the Background, the OPSS permits the Hospital to submit consolidated claims for repetitive or chemotherapy services on a monthly basis or at the conclusion of treatment.

<sup>5</sup> As of September 10, 2013, the Hospital had not identified or refunded the related overpayments.

## **Manufacturer Credits for Replaced Medical Devices Not Reported**

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

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPPS. 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.

For 2 of 164 selected outpatient claims, the Hospital received manufacturer credits for replaced medical devices but did not report the modifier “FB” or reduced charges on its claims. For one claim, the Hospital stated that these errors occurred due to human error. For the other claim, the Hospital stated that the error occurred due to a lack of controls to ensure that claims were properly billed when a manufacturer credit was received. As a result of these errors, the Hospital received overpayments of \$28,350.

## **Incorrect Coding on Outpatient Claim to Identify Beneficiary Status Change**

The Manual, chapter 1, § 50.3.2, states that a hospital may change the beneficiary’s status from inpatient to outpatient and submit an outpatient claim under certain conditions. When the hospital submits an outpatient bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report condition code 44 on the outpatient claim. In addition, if the conditions for use of condition code 44 are not met, the hospital may submit a claim for covered “Part B Only” services that were furnished to the inpatient.

For 1 of 164 selected outpatient claims, the beneficiary’s status changed from inpatient to outpatient, but the Hospital did not report condition code 44 in accordance with the Manual’s requirements.

The Hospital stated that this error occurred due to human error and a misunderstanding regarding the use of condition code 44. As a result of this error, the Hospital received an overpayment of \$15,543.

## **Incorrect Number of Units for Doxorubicin Hydrochloride**

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, § 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” The Manual, chapter 17, § 90.2.A, states: “It is ... of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported

HCPCS code are consistent with the quantity of a drug ... that was used in the care of the patient.” If the provider is billing for a drug, according to chapter 17, § 70, of the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 ....”

For 25 of 164 selected outpatient claims, the Hospital incorrectly submitted claims to Medicare with incorrect number of units for Doxorubicin Hydrochloride.<sup>6</sup> For example, for one claim, rather than billing five units of Doxorubicin Hydrochloride, the Hospital billed six units.

The Hospital stated that these errors occurred due to a misunderstanding of the requirements for the documentation of the amount of the drug that was not used. As a result of these errors, the Hospital received overpayments of \$11,114.

### **Incorrect Healthcare Common Procedure Coding System Code for Lupron Injections**

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, § 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” The Manual, chapter 17, § 90.2.A, states: “It is ... of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug ... that was used in the care of the patient.” If the provider is billing for a drug, according to chapter 17, § 70, of the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 ....”

The Food and Drug Administration (FDA) identifies and reports drug products with a universally used unique, three-segment number called the national drug code (NDC). Each quarter, CMS provides Medicare contractors with an updated listing that cross-references the NDC to the drug name, billing units, and HCPCS code.

Lupron is a drug commonly used to treat hormone-dependent cancers. The FDA approved Lupron for the treatment of disorders relating to the uterus and for the treatment of prostatic cancer. According to the NDCs in effect during our audit period, Lupron was available for the treatment of: (1) disorders relating to the uterus, in doses of 3.75 mg once a month or 11.5 mg once every 3 months, and was linked to HCPCS code J1950; and (2) prostatic cancer, in doses of 7.5 mg once a month, 22.5 mg once every 3 months, or 30 mg once every 4 months; and was linked to HCPCS code J9217.

For 4 of 164 selected outpatient claims, the Hospital incorrectly billed Medicare for Lupron injections. For three of the four claims that were in error, the Hospital billed Medicare using HCPCS code J1950 when its documentation showed that according to administered dosage, the Hospital should have billed Medicare using HCPCS code J9217. For the remaining claim, the

---

<sup>6</sup> This drug is used in the chemotherapy treatment of a wide range of cancers.

Hospital did not have documentation supporting the claim for Lupron. The Hospital stated that these errors occurred due to an error in the chargemaster that did not differentiate between HCPCS J1950 and J9217.<sup>7</sup> As a result of these errors, the Hospital received overpayments of \$10,404.

### **Incorrect Billing for Inpatient-Only Service Under Outpatient Prospective Payment System**

The Manual, chapter 4, § 180.7, states that no payment is made under the OPSS for services that CMS designates to be “inpatient-only” services. In addition, CMS does not pay for all other services under the OPSS on the same day as the “inpatient-only” procedure.

For 1 of 164 selected outpatient claims, the Hospital incorrectly billed services to the OPSS that occurred on the same day as an inpatient-only procedure. Because the Hospital billed these services under the OPSS, Medicare payment is not allowable.

The Hospital stated that this error occurred due to human error. As a result of this error, the Hospital received an overpayment of \$6,362.

### **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 11 of the 79 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$121,673.

#### **Incorrect Diagnosis-Related Groups**

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.” Chapter 1, § 80.3.2.2, of the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For 4 of 79 selected inpatient claims, the Hospital submitted claims to Medicare with incorrect DRGs. For example, the Hospital used the DRG for acute leukemia without a major operating procedure *with* major complication/comorbidity rather than using the DRG for acute leukemia without a major operating procedure *without* major complication/comorbidity. The Hospital stated that the four errors occurred due to human error in coding diagnosis codes that were not supported by medical records, resulting in incorrect DRGs. As a result of these errors, the Hospital received overpayments of \$88,058.

---

<sup>7</sup> A hospital’s (or other provider’s) chargemaster contains data on every chargeable item or procedure that the provider offers.

## **Incorrect Discharge Status**

Federal regulations (42 CFR § 412.4(b)) state that a discharge of a hospital inpatient is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge. A discharge of a hospital inpatient is also considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to a home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(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)).

For 1 of 79 selected inpatient claims, the Hospital incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. Specifically, the Hospital coded the discharge status as "patient discharged to home" instead of "patient discharged to home under a written plan of care for the provision of home health services." Thus, the Hospital received the full DRG payment instead of the graduated per diem payment it would have received if it had correctly coded the patient's discharge status. The Hospital stated that this error occurred due to human error and conflicting documentation between the physician's and the case manager's notes. As a result of this error, the Hospital received an overpayment of \$21,258.

## **Incorrect Number of Units**

Section 1815(a) of the Act precludes payment to any provider of services without information necessary to determine the amount due the provider. Chapter 1, § 80.3.2.2, of the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately." In addition, chapter 3, § 20.7.3.A, of the Manual states that hospitals receive an add-on payment for the costs of furnishing blood-clotting factors to certain Medicare beneficiaries: "The clotting factor add-on payment is calculated using the number of units ... billed by the provider under special instructions for units of service."

For 1 of 79 selected inpatient claims, the Hospital billed Medicare with the incorrect number of units for the blood-clotting factor. Specifically, the Hospital did not have documentation supporting 8,800 of 474,000 units billed. The Hospital stated that this error occurred due to a documentation error in the medical record. As a result of this error, the Hospital received an overpayment of \$12,074.

## **Incorrect Source of Admission**

Federal regulations (42 CFR § 412.424(d)(1)(v)) state that CMS will adjust the Federal per diem base rate upward for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department. Chapter 3, § 190.6.4, of the Manual states that CMS makes this additional payment regardless of whether the beneficiary used emergency department services. However, 42 CFR § 412.424(d)(1)(v)(B) states that the IPF would not receive the additional payment if the beneficiary was discharged from the acute

care section of the same hospital. In addition, the Manual, chapter 3, § 190.6.4.1, states that the source-of-admission code “D” is reported by an IPF to identify patients who have been transferred to the IPF from the same hospital.

For 5 of 79 selected inpatient claims, the Hospital incorrectly coded the source of admission for beneficiaries who were admitted to the IPF upon discharge from the Hospital’s acute care section. For each of the five claims, the Hospital should have used the source-of-admission code “transfer to inpatient psychiatric facility from hospital.” Instead, the Hospital incorrectly used the source-of-admission code “admission from a non-healthcare point of origin” on four claims and “admission from the emergency room” on the remaining claim. The Hospital stated that the errors occurred due to human error. As a result of these errors, the Hospital received overpayments of \$283.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$256,259, consisting of \$134,586 in net overpayments for the 65 incorrectly billed outpatient claims and \$121,673 in overpayments for the 11 incorrectly billed inpatient claims,
- continue to work with the Medicare contractor to determine the amount of overpayment for the remaining two outpatient claims of \$71,248 and refund the overpayment amount, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital agreed with our recommendations to refund overpayments to Medicare and to resubmit claims for which we were not able to determine the amount of overpayment. Regarding our third recommendation, the Hospital described corrective actions that it had taken to ensure compliance with Medicare requirements.

In a footnote on its comments, the Hospital stated that we removed an inpatient claim with an underpayment of approximately \$200,000 from the scope of our audit.

The Hospital’s comments appear in their entirety as Appendix B.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

At the time that we issued our draft report, we were unable to determine the amount of overpayment for seven outpatient claims. After providing its comments, the Hospital resubmitted five of these claims for which the overpayments were determined to be a total of \$33,180. We updated this final report for these five claims, which included increasing the amount of total overpayments from \$223,079 to \$256,259.

The Hospital also advised us of its efforts to work with the Medicare contractor to determine the amount of overpayment for the remaining two outpatient claims and refund that amount. As of September 10, 2013, the Hospital had not identified or refunded the related overpayments. We acknowledge the steps that the Hospital has taken to resubmit these claims in accordance with Medicare billing requirements.

Regarding the inpatient claim that the Hospital referred to in the footnote on its comments, we removed this claim and other claims from our scope *after* we learned that CMS had *previously* selected the claims as part of other reviews.

#### **OTHER MATTER**

We identified two outpatient claims for which the Medicare contractor paid the Hospital at an orphan drug rate instead of at the standard rate, which resulted in an overpayment of \$9,016. The term “orphan drugs” is commonly applied to those drugs that treat diseases and conditions that are considered rare. The Hospital stated that it submitted these claims pursuant to Federal requirements and that the overpayments occurred because of errors that transpired when the Medicare contractor processed the claims. Accordingly, we will forward detailed data on these claims to the Medicare contractor for further adjudication.

**APPENDIX A: RESULTS OF REVIEW BY RISK AREA**

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Under / Over-payments</b>	<b>Value of Net Over-payments</b>
<b>Outpatient</b>				
Claims With Payments Greater Than \$25,000	31	\$1,009,849	18	\$39,431
Claims Paid in Excess of Charges	25	177,452	7	35,000
Claims Billed With Observation Services That Resulted in Outlier Payments	8	78,787	8	22,980
Claims Billed for Doxorubicin Hydrochloride	39	144,373	25	11,114
Manufacturer Credits for Replaced Medical Devices	1	27,929	1	10,985
Claims Billed for Lupron Injections	4	12,526	4	10,404
Claims Billed for Surgeries With Units Greater Than One	4	13,896	3	6,641
Claims Billed for Intensity Modulated Radiation Therapy Planning Services	32	258,163	0	0
Claims Billed With Modifiers	20	113,184	1	(1,969)
<b>Outpatient Totals</b>	<b>164</b>	<b>\$1,836,159</b>	<b>67</b>	<b>\$134,586</b>
<b>Inpatient</b>				
Claims Billed With High Severity Level Diagnosis-Related Group Codes	39	\$1,677,471	3	\$63,320
Claims Paid in Excess of Charges	33	1,172,320	1	24,738
Transfers	1	44,191	1	21,258
Claims With Payments Greater Than \$150,000	1	668,622	1	12,074
Psychiatric Facility Emergency Department Adjustments	5	39,133	5	283
<b>Inpatient Totals</b>	<b>79</b>	<b>\$3,601,737</b>	<b>11</b>	<b>\$121,673</b>
<b>Outpatient and Inpatient Totals</b>	<b>243</b>	<b>\$5,437,896</b>	<b>78</b>	<b>\$256,259</b>

**Notice:** The table above illustrates the results of our review by risk area. In it, we have organized outpatient and inpatient 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 University of Utah 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 B: AUDITEE COMMENTS



March 5, 2013

Patrick H. Cogley  
Regional Inspector General for Audit Services - DHHS OIG  
Office of Audit Services – Region VII  
601 E. 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

RE: Report Number A-07-12-01107

Dear Mr. Cogley:

The University received your report titled, “Medicare Compliance Review of University of Utah Hospital for Calendar Years 2009 and 2010” on January 30, 2013, and appreciates the opportunity to respond to the findings.

The University understands that the Office of Inspector General (OIG) specifically selected the claims subjected to review due to the OIG’s determination that the claims were at special risk for billing errors.<sup>1</sup>

**Findings:**

- 67 outpatient claims contained errors. The University agrees.
  - 59 claims contained errors that resulted in overpayments totaling \$90,421.
  - 7 claims contained errors but the OIG could not calculate the overpayment amount.
  - 1 claim contained an error related to the implantation of a manufacturer-credited cardiac lead and a non-discounted pacemaker. This claim will require resubmission to the contractor for re-pricing of the claim as it was originally billed and paid as a 12X bill type.
- 11 Inpatient Claims contained errors. The University agrees.
  - 11 claims contained errors that resulted in overpayments of \$121,673.

**Recommendations:**

- Refund the overpayments to Medicare. The University agrees and has already started reprocessing the claims.
- Resubmit the claims for which the correct payment amount could not be determined. The University agrees and will resubmit these claims accordingly.

---

<sup>1</sup> The University notes that one inpatient claim originally included in the scope of the audit but subsequently removed by the OIG was underpaid by approximately \$200,000. The University is currently working with its Medicare Administrative Contractor to correct this underpayment.

- Strengthen the controls to ensure full compliance with Medicare requirements. The University operates a robust compliance program. The University has thoroughly reviewed each identified error, supplied training, and implemented process improvements. While no policy, procedure, or process can completely eliminate all errors resulting from an extraordinarily complex regulatory environment, the University conducts regular education, reviews, and audits in an effort to ensure that we are submitting claims appropriately and accurately.

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

Sincerely,



Brian Watts  
Director  
University Health Care Billing Compliance