

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
MEMORIAL HOSPITAL
FOR CALENDAR YEARS
2010 AND 2011**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Patrick J. Cogley
Regional Inspector General

January 2014
A-07-13-01124

Office of Inspector General

<https://oig.hhs.gov/>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

Memorial Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$161,000 over 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Memorial Hospital (Memorial) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Memorial is a nonprofit level II trauma center consisting of three hospitals—Memorial Hospital Central, Memorial Hospital North, and Memorial Hospital for Children, all in Colorado Springs, Colorado—which between them have over 600 beds. Medicare paid Memorial approximately \$90.3 million for 7,277 inpatient and 63,266 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$2,164,461 in Medicare payments to Memorial for 160 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 57 inpatient and 103 outpatient claims with dates of service in CYs 2010 or 2011.

WHAT WE FOUND

Memorial complied with Medicare billing requirements for 112 of the 160 inpatient and outpatient claims we reviewed. However, Memorial did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in overpayments of \$161,355 for CYs 2010 and 2011. Specifically, 15 inpatient claims had billing errors, resulting in overpayments of \$93,594, and 33 outpatient claims had billing errors, resulting in overpayments of \$67,761. These errors occurred primarily because Memorial did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. Specifically, these errors occurred primarily because of human error or lack of training.

WHAT WE RECOMMEND

We recommend that Memorial:

- refund to the Medicare contractor \$161,355, consisting of \$93,594 in overpayments for 15 incorrectly billed inpatient claims and \$67,761 in overpayments for 33 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, Memorial concurred with all but one of our findings and described corrective actions that it had implemented or planned to implement. Of the \$161,355 in overpayments we identified, Memorial concurred with our findings whose questioned costs totaled \$159,820, but did not concur with questioned costs of \$1,535. Specifically, Memorial did not concur with our finding that for nine outpatient claims it incorrectly billed Medicare for services that were already included in the payment for intensity modulated radiation therapy (IMRT) planning services billed on the same claim. Memorial stated that the services in question were performed on separate dates and were not part of IMRT planning.

Memorial's comments did not cause us to change our findings and recommendations. Neither during our review nor in its comments on our draft report did Memorial provide any documentation to support its assertion that certain billed services were not related to the development of an IMRT plan. Accordingly, we maintain that this finding and the associated questioned costs of \$1,535 remain valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

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

BACKGROUND

The Medicare Program

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

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

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

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

within each APC group.¹ All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient claims billed with high severity level DRG codes,
- inpatient and outpatient claims paid in excess of charges,
- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient claims with payments greater than \$150,000,
- inpatient claims billed with kyphoplasty services,
- outpatient claims billed with modifiers,
- outpatient claims with payments greater than \$25,000,
- outpatient intensity modulated radiation therapy (IMRT) planning services,
- outpatient claims billed for anti-cancer drugs,
- outpatient claims billed with observation services that resulted in outlier payments, and
- outpatient surgeries billed with units greater than one.

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

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items or services that “... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a

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

malformed body member” (the Social Security Act (the Act), § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

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

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Memorial Hospital

Memorial is a nonprofit level II trauma center consisting of three hospitals—Memorial Hospital Central, Memorial Hospital North, and Memorial Hospital for Children, all in Colorado Springs, Colorado—which between them have over 600 beds. Medicare paid Memorial approximately \$90.3 million for 7,277 inpatient and 63,266 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS’s National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$2,164,461 in Medicare payments to Memorial for 160 claims that we judgmentally selected as potentially at risk for billing errors. These 160 claims consisted of 57 inpatient and 103 outpatient claims. All of these 160 claims had dates of service in CYs 2010 or 2011. 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 but did not use medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Memorial for Medicare reimbursement.

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

See Appendix A for the details of our scope and methodology.

FINDINGS

Memorial complied with Medicare billing requirements for 112 of the 160 inpatient and outpatient claims we reviewed. However, Memorial did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in overpayments of \$161,355 for CYs 2010 and 2011. Specifically, 15 inpatient claims had billing errors, resulting in overpayments of

\$93,594, and 33 outpatient claims had billing errors, resulting in overpayments of \$67,761. These errors occurred primarily because Memorial did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. Specifically, these errors occurred primarily because of human error or lack of training.

See Appendix B for the results of our review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Memorial incorrectly billed Medicare for 15 of 57 selected inpatient claims, which resulted in overpayments of \$93,594.

Incorrectly Billed Diagnosis-Related Group Codes

Medicare payments may not be made for items or services that "... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act, § 1862(a)(1)(A)). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 9 out of 57 selected claims, Memorial billed Medicare for incorrect DRG codes. Memorial officials attributed this to human error or lack of training. As a result of these errors, Memorial received overpayments of \$73,037.

Incorrectly Billed as Inpatient

Medicare payments may not be made for items or services that "... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act, § 1862(a)(1)(A)).

For 3 out of 57 selected claims, Memorial incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Memorial officials stated that these errors occurred due to human error or lack of training. As a result of these errors, Memorial received overpayments of \$11,833.²

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states:

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

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 2 out of 57 selected claims, Memorial billed Medicare separately for related discharges and readmissions within the same day. Memorial officials stated that these errors occurred due to human error or lack of training. As a result of these errors, Memorial received overpayments of \$4,449.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code "FD" (chapter 3, § 100.8).

For 1 out of 57 selected claims, Memorial received a reportable medical device credit for a replaced device from a manufacturer but did not adjust its inpatient claim with the proper value and condition codes to reduce payment as required. Memorial officials attributed this error to a lack of proper policies and procedures. As a result of this error, Memorial received an overpayment of \$4,275.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Memorial incorrectly billed Medicare for 33 of 103 selected outpatient claims, which resulted in overpayments of \$67,761.

Insufficiently Documented Services

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

For 4 out of 103 selected claims, Memorial incorrectly billed Medicare for services that were not supported in the medical record. Memorial officials attributed this to human error. As a result of these errors, Memorial received overpayments of \$40,986.

Incorrectly Billed Services With Modifier -59

The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2). It also states: "The '59' modifier is used to indicate a distinct procedural service.... This may represent a different session or patient encounter,

different procedure or surgery, different site or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)” (chapter 23, § 20.9.1.1).

For 8 out of 103 selected claims, Memorial incorrectly billed Medicare for HCPCS codes with modifier -59 even though the services were already included in the payments for other services billed on the same claim. Memorial officials stated that these errors occurred due to human error or lack of training. As a result of these errors, Memorial received overpayments of \$13,671.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

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

For 8 out of 103 selected claims, Memorial submitted the claims to Medicare with incorrect HCPCS codes. Memorial officials attributed this to human error or lack of training. As a result of these errors, Memorial received overpayments of \$10,040.

Incorrectly Billed Intensity Modulated Radiation Therapy Planning Services

The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). It also states that certain services should not be billed when they are performed as part of developing an IMRT plan (chapter 4, § 200.3.2).

For 9 out of 103 selected claims, Memorial incorrectly billed Medicare for services that were already included in the payment for IMRT planning services billed on the same claim. These services were performed as part of developing an IMRT plan and should not have been billed in addition to the HCPCS code for IMRT planning. Memorial officials said that they believed that all nine claims were billed correctly. As a result of these errors, Memorial received overpayments of \$1,535.

Incorrect Number of Units Billed

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833 (e)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). The Manual also 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” (chapter 17, § 90.2.A). If the provider is billing for a drug, according to 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....” (chapter 17, § 70).

For 4 out of 103 selected claims, Memorial incorrectly billed the number of units for chemotherapy drugs charged under HCPCS code J9001. Memorial officials stated that these errors occurred due to human error or lack of training. As a result of these errors, Memorial received overpayments of \$1,529.

RECOMMENDATIONS

We recommend that Memorial:

- refund to the Medicare contractor \$161,355, consisting of \$93,594 in overpayments for 15 incorrectly billed inpatient claims and \$67,761 in overpayments for 33 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, Memorial concurred with all but one of our findings and described corrective actions that it had implemented or planned to implement. Of the \$161,355 in overpayments we identified, Memorial concurred with our findings whose questioned costs totaled \$159,820, but did not concur with questioned costs of \$1,535. Specifically, Memorial did not concur with our finding that it incorrectly billed Medicare for outpatient services that were already included in the payment for IMRT planning services billed on the same claim. Memorial stated that the services in question (“simulations,” in Memorial’s term) were performed on separate dates and were not part of IMRT planning. Specifically, according to Memorial, the initial simulations were for prescription only and were performed before it was decided to administer IMRT to those patients. When it was decided to treat these patients with IMRT, “... no other simulations were done in conjunction with the plan.”

Memorial’s comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

Memorial’s comments did not cause us to change our findings and recommendations. Neither during our review nor in its comments on our draft report did Memorial provide any documentation to support its assertion that certain billed services were not related to the development of an IMRT plan. Accordingly, we maintain that this finding and the associated questioned costs of \$1,535 remain valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$2,164,461 in Medicare payments to Memorial for 160 claims that we judgmentally selected as potentially at risk for billing errors. These 160 claims consisted of 57 inpatient and 103 outpatient claims. All of these 160 claims had dates of service in CYs 2010 or 2011.

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

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

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

We conducted our fieldwork from February through May 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Memorial's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2010 and 2011;
- obtained information on known credits for replaced medical devices from the device manufacturers for CYs 2010 and 2011;
- 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 160 claims (57 inpatient and 103 outpatient) 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 Memorial to support the selected claims;

- requested that Memorial conduct its own review of the selected claims to determine whether the services were billed correctly;
- discussed the incorrectly billed claims with Memorial 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 Memorial officials on May 30, 2013.

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

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Claims Billed With High Severity Level Diagnosis-Related Group Codes	26	\$801,095	4	\$46,669
Claims Paid in Excess of Charges	6	114,598	5	26,368
Short Stays	5	18,958	3	11,833
Same-Day Discharges and Readmissions	4	29,313	2	4,449
Manufacturer Credits for Replaced Medical Devices	2	53,853	1	4,275
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	12	200,891	0	0
Claims With Payments Greater Than \$150,000	1	191,003	0	0
Claims Billed With Kyphoplasty Services	1	9,907	0	0
Inpatient Totals	57	\$1,419,618	15	\$93,594
Outpatient				
Claims Billed With Modifiers	45	\$253,098	9	\$27,132
Claims With Payments Greater Than \$25,000	4	183,737	2	26,050
Claims Paid in Excess of Charges	12	15,111	8	11,345
Intensity Modulated Radiation Therapy Planning Services	12	89,853	10	1,705
Claims Billed for Anti-Cancer Drugs	8	44,167	4	1,529
Manufacturer Credits for Replaced Medical Devices	5	99,015	0	0
Claims Billed With Observation Services That Resulted in Outlier Payments	9	39,463	0	0
Surgeries Billed With Units Greater Than One	8	20,399	0	0
Outpatient Totals	103	\$744,843	33	\$67,761
Inpatient and Outpatient Totals	160	\$2,164,461	48	\$161,355

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at Memorial. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX C: AUDITEE COMMENTS



Memorial Hospital

UNIVERSITY OF COLORADO HEALTH

November 25, 2013

Mr. Patrick J. Cogley
Regional Inspector General of Audit Services
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: Report Number: A-07-13-01124

Dear Mr. Cogley

We are in receipt of your draft report entitled *Medicare Compliance Review of Memorial Hospital for Calendar Years 2010 and 2011*. In response to your request, this letter contains Memorial Hospital's comments with respect to the draft report. We would like to thank the auditors involved in this review. They were very thorough, professional and helpful. We concur with the auditor's findings as reported except where noted below. Memorial has developed a corrective action plan addressing each of the billing errors, as follows:

Incorrectly Billed Diagnosis Related Group Codes

We concur with the auditors' findings. Memorial has provided additional education for the inpatient coding staff on the selection of principal and/or secondary diagnosis codes when applying the ICD-9 coding guidelines and conventions. Additionally, the coding department continues to audit coders on a regular basis with the compliance department monitoring its activity.

Incorrectly Billed as Inpatient

We concur with the auditors' findings. The case management department has increased the number of employees and hours of operation to provide timely review of admissions including in the emergency department. Case management will continue to educate physicians on an ongoing basis regarding the criteria needed for both inpatient and observation. In addition, the case managers review physician orders for any status change and communicate with the physicians regarding any needed updates.

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Incorrectly billed as Separate Inpatient Stays

We concur with the finding. In order to ensure better communication between the relevant departments, case management will continue to document in the billing system, but will also notify a designated contact person by e-mail on how to handle a readmission. The contact person will follow up to ensure correct billing. The billing department has updated their protocol for the conflict report to review billing notes. Both accounts will be reviewed for case management's documentation regarding their determination on how the accounts should be billed. The billers have been educated on this new process.

Manufacturer Credits for Replaced Medical Devices Not Reported

We concur with the finding. An edit has been placed within our billing system to stop a claim with a diagnosis code that indicates there was a device replacement. This will ensure that all of these claims will be reviewed and the appropriate condition and/or value codes will be applied as needed.

Insufficiently Documented Services

We concur with the finding. Memorial has recently implemented the Epic software package for electronic medical records. The system will eliminate the wide spread use of paper records and limit the possibility of documentation not being available.

Incorrectly Billed Services with Modifier – 59

We concur with the finding. Memorial has provided training to its coding staff with respect to the proper use of Modifier – 59.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

We concur with the finding. Memorial has provided training to its coding staff with respect to the issues identified through this audit, e.g. coding for ear irrigation, coding for components of a surgery when completed through the same incisions, etc.

Incorrectly Billed Intensity Modulated Radiation Therapy Planning Services

We do not concur with the findings. Based on our understanding of the manual's requirements from chapter 4, § 200.2.2, we believe there are two key considerations that need to be addressed in determining if certain services should be billed as part of developing an IMRT plan. First, we need to determine if those certain services such as the simulation was performed on the same day as the IMRT planning. With respect to the claims in question, the services were performed on different dates. Then, we need to determine if those services, i.e. the simulation, was performed as part of developing the IMRT plan. The key statement in the rule regarding those certain services is "...when directly linked to

and performed as part of developing an IMRT plan..." With regards to the claims in question, they were not part of the IMRT planning. When the initial simulation was done, it was for prescription only and it wasn't known whether the patient would get IMRT at that point in time. When it was decided if patient's treatment would be IMRT, no other simulations were done in conjunction with the plan. These were separate events at different points in time with different intents.

Incorrect Number of Units Billed

We concur with the findings. Memorial has educated its staff on the proper billing of chemotherapy drugs charged under HCPCS code J9001.

Memorial is committed to compliant and accurate billing and coding. By way of its Compliance Program, Memorial will continue to work to identify areas of risk for non-compliance and implement stronger controls and, if necessary, promptly resolve identified deficiencies.

If you have any questions or concerns, feel free to contact me at (719) 365-2309 or john.wyckoff@uchealth.org.

Sincerely,



John D. Wyckoff, CPA

Regional Compliance Officer

Memorial Hospital part of UCHealth formerly known as Memorial Health System