

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF UTAH VALLEY  
REGIONAL MEDICAL CENTER  
FOR 2010 AND 2011**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
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**Patrick J. Cogley  
Regional Inspector General  
for Audit Services**

**January 2015  
A-07-13-05048**

# *Office of Inspector General*

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## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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## EXECUTIVE SUMMARY

***Utah Valley Regional Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$173,000 over more than 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) 2012, Medicare paid hospitals \$148 billion, which represents 43 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 Utah Valley Regional Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### BACKGROUND

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

The Hospital is a 367-bed acute care hospital located in Provo, Utah. Medicare paid the Hospital approximately \$101 million for 7,559 inpatient and 44,602 outpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$3,354,833 in Medicare payments to the Hospital for 232 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 194 inpatient and 38 outpatient claims. Of the 232 claims, 211 claims had dates of service in CY 2010 or CY 2011, and 21 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2012.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 183 of the 232 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 49 claims, resulting in overpayments of \$173,132 for CYs 2010 and 2011 (42 claims) and CYs 2009 and 2012 (7 claims). Specifically, 37 inpatient claims

had billing errors, resulting in overpayments of \$117,665, and 12 outpatient claims had billing errors, resulting in overpayments of \$55,467. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

## **WHAT WE RECOMMEND**

We recommend that the Hospital:

- refund to the Medicare contractor \$173,132, consisting of \$117,665 in overpayments for 37 incorrectly billed inpatient claims and \$55,467 in overpayments for 12 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital concurred with our recommendations. Specifically, the Hospital stated that it had refunded the \$173,132 in overpayments, and it described corrective actions that it had taken to further enhance and strengthen its controls.

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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) 2012, Medicare paid hospitals \$148 billion, which represents 43 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 Utah Valley Regional Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### **BACKGROUND**

#### **The Medicare Program**

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

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

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

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

#### **Hospital Outpatient Prospective Payment System**

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

within each APC group.<sup>1</sup> 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 and outpatient manufacturer credits for replaced medical devices,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient claims billed with kyphoplasty services,
- inpatient claims with payments greater than \$150,000,
- inpatient claims with cancelled elective surgical procedures,
- inpatient short stays,
- outpatient surgeries billed with units greater than one, and
- outpatient claims billed with modifiers.

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 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)).

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

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). In addition, the Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

## **Utah Valley Regional Medical Center**

The Hospital is a 367-bed acute care hospital located in Provo, Utah. Medicare paid the Hospital approximately \$101 million for 7,559 inpatient and 44,602 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 \$3,354,833 in Medicare payments to the Hospital for 232 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 194 inpatient and 38 outpatient claims. Of the 232 claims, 211 claims had dates of service in CY 2010 or CY 2011, and 21 claims had dates of service in CY 2009 or CY 2012.<sup>2</sup> We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not subject claims to focused 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 the Hospital for Medicare reimbursement.

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

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

## **FINDINGS**

The Hospital complied with Medicare billing requirements for 183 of the 232 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 49 claims, resulting in overpayments of \$173,132 for CYs 2010 and 2011 (42 claims) and CYs 2009 and 2012 (7 claims). Specifically, 37 inpatient claims had billing errors, resulting in overpayments of \$117,665, and 12 outpatient claims had billing errors, resulting in overpayments of \$55,467. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

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<sup>2</sup> We selected these 21 claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

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

The Hospital incorrectly billed Medicare for 37 of 194 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$117,665.

### **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)).

For 28 out of 194 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain diagnosis or procedure codes were incorrect. The Hospital stated that internal coding reviews are conducted on a sample of claims and do not include every encounter. As a result of these errors, the Hospital received overpayments of \$81,877.

### **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 5 out of 194 selected claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate value and condition codes to reduce payments as required. (Of the five claims, two had dates of service in CY 2009, one had a date of service in CY 2010, one had a date of service in CY 2011, and one had a date of service in CY 2012.) The Hospital stated that the complexities of the regulations as well as the many possible recall and warranty scenarios create the possibility for, and the existence of, errors. As a result of these errors, the Hospital received overpayments of \$21,000.

### **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)).

According to chapter 1, section 10, of the CMS *Benefit Policy Manual* (Pub. No. 100-02), factors that determine whether an inpatient admission is medically necessary include:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;

- the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- the availability of diagnostic procedures at the time when and at the location where the patient presents.

For 1 out of 194 selected claims, the Hospital incorrectly billed Medicare Part A for a beneficiary stay that should have been billed as outpatient or outpatient with observation services. The Hospital stated that internal coding reviews are conducted on a sample of claims and do not include every encounter. As a result of this error, the Hospital received an overpayment of \$11,025.<sup>3</sup>

### **Unsupported Charges**

The Act states: “[N]o such payments shall be made to any provider unless it has furnished such information ... in order to determine the amounts due such provider ... for the period with respect to which the amounts are being paid....” (§ 1815(a)).

For 3 out of 194 selected claims, the Hospital billed Medicare with unsupported charges, resulting in higher outlier payments than were warranted. The Hospital incorrectly included charges for these items in cost outlier computations, thus creating the overpayments. The Hospital stated that internal claims reviews are conducted on a sample of claims and do not include every encounter. As a result of these errors, the Hospital received overpayments of \$3,763.

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

The Hospital incorrectly billed Medicare for 12 of 38 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$55,467.

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

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

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<sup>3</sup> The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor before the issuance of our report.

replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.<sup>4</sup>

For 5 out of 38 selected claims, the Hospital received full credits for replaced medical devices but did not report the “FB” modifier and reduced charges on its claims. (Of the five claims, one had a date of service in CY 2009, one had a date of service in CY 2011, and three had dates of service in CY 2012.) The Hospital stated that the complexities of the regulations as well as the many possible recall and warranty scenarios create the possibility for, and the existence of, errors. As a result of these errors, the Hospital received overpayments of \$51,697.

### **Incorrectly Billed Number of Units**

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

For 6 out of 38 selected claims, the Hospital billed Medicare with units of service that were unsupported in the medical records. The Hospital stated that internal coding reviews are conducted on a sample of claims and do not include every encounter. As a result of these errors, the Hospital received overpayments of \$2,967.

### **Insufficiently Documented Procedure**

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

For 1 out of 38 selected claims, the Hospital billed Medicare with a procedure code that was unsupported in the medical record. The Hospital stated that internal coding reviews are conducted on a sample of claims and do not include every encounter. As a result of this error, the Hospital received an overpayment of \$803.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$173,132, consisting of \$117,665 in overpayments for 37 incorrectly billed inpatient claims and \$55,467 in overpayments for 12 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

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

## **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital concurred with our recommendations. Specifically, the Hospital stated that it had refunded the \$173,132 in overpayments, and it described corrective actions that it had taken to further enhance and strengthen its controls.

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

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered \$3,354,833 in Medicare payments to the Hospital for 232 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 194 inpatient and 38 outpatient claims. Of the 232 claims, 211 claims had dates of service in CY 2010 or CY 2011, and 21 claims (involving inpatient and outpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2012 (footnote 2).

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not subject claims to focused 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 inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

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

We conducted our fieldwork at the Hospital from June 2013 to August 2014.

### **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 2010 and 2011;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2009 through 2012;
- 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 232 claims (194 inpatient and 38 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 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 August 29, 2014.

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**

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Over-payments</b>	<b>Value of Over-payments</b>
<b>Inpatient</b>				
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	94	\$1,258,446	22	\$43,281
Claims Paid in Excess of Charges	14	173,910	3	22,880
Manufacturer Credits for Replaced Medical Devices	18	288,383	5	21,000
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	59	774,321	3	15,716
Claims Billed With Kyphoplasty Services	1	11,025	1	11,025
Claims With Payments Greater Than \$150,000	3	497,070	3	3,763
Claims With Cancelled Elective Surgical Procedures	2	21,790	0	0
Short Stays	3	18,607	0	0
<b>Inpatient Totals</b>	<b>194</b>	<b>\$3,043,552</b>	<b>37</b>	<b>\$117,665</b>
<b>Outpatient</b>				
Manufacturer Credits for Replaced Medical Devices	19	\$188,239	5	\$51,697
Surgeries Billed With Units Greater Than One	6	30,351	6	2,967
Claims Paid in Excess of Charges	10	64,476	1	803
Claims Billed With Modifiers	3	28,215	0	0
<b>Outpatient Totals</b>	<b>38</b>	<b>\$311,281</b>	<b>12</b>	<b>\$55,467</b>
<b>Inpatient and Outpatient Totals</b>	<b>232</b>	<b>\$3,354,833</b>	<b>49</b>	<b>\$173,132</b>

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

## APPENDIX C: AUDITEE COMMENTS



36 South State Street  
Salt Lake City, UT 84111  
801.442.2000

November 21, 2014

Mr. Patrick J. Cogley  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Audit Services, Region VII  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

Re: Report Number: A-07-13-05048

Dear Mr. Cogley:

This letter is in response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled *Medicare Compliance Review of Utah Valley Regional Medical Center for 2010 and 2011*, dated November 18, 2014.

The Office of Inspector General audit covered \$3,354,833 in Medicare payments for the 232 claims (194 inpatient and 38 outpatient claims). We understand that these claims were selected by the OIG as potentially at risk for billing errors. As a result of the detailed review, the OIG identified 49 claims with billing errors, totaling \$173,132 in net overpayments for CYs 2009 through 2012.

Utah Valley Regional Medical Center has reviewed the findings and concurs with the recommendations noted in the draft report. The OIG recommendations and Utah Valley Regional Medical Center's statements of concurrence are set forth below:

1. The OIG recommends Utah Valley Regional Medical Center *refund to the Medicare contractor \$173,132, consisting of \$117,665 in overpayments for 37 incorrectly billed inpatient claims and \$55,467 in overpayments for 12 incorrectly billed outpatient claims.*

Utah Valley Regional Medical Center concurs with the recommendation and has refunded the \$173,132 in overpayments.

2. The OIG recommends Utah Valley Regional Medical Center *strengthen controls to ensure full compliance with Medicare requirements.*

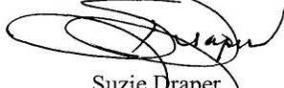
Utah Valley Regional Medical Center takes the OIG audit findings and recommendations seriously as we continually strive to be compliant in all coding and billing requirements. We continue to further develop our internal controls, which includes providing additional education to coding and billing staff and creating additional edits as part of our own internal corrective action plans. Similar to the OIG Medicare Compliance Audit, we audit on specific high risk areas. We also engage in less focused, random audits with the goal to routinely

review a sample of claims across all coders in order to better ensure ongoing quality and accuracy.

Utah Valley Regional Medical Center appreciates the opportunity to respond to the findings of this OIG audit. Utah Valley Regional Medical Center's goal is to ensure our inpatient and outpatient claims are submitted timely and accurately and are in compliance with Medicare regulations and guidance through continued improvement of internal controls.

If you like additional information on the specific corrective actions that have been completed or are in progress for each issue, please contact me at 801.442.1502.

Sincerely,



Suzie Draper  
Vice President of Business Ethics and Compliance  
Intermountain Healthcare