

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
UNIVERSITY OF MISSOURI
HEALTH CENTER
FOR 2010 AND 2011**

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**Patrick J. Cogley
Regional Inspector General
for Audit Services**

**December 2014
A-07-13-05050**

Office of Inspector General

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

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

University of Missouri Health Center did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately \$189,000 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 University of Missouri Health Center (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification. 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.

The Hospital is a 274-bed acute care hospital located in Columbia, Missouri. Medicare paid the Hospital approximately \$233 million for 274,615 outpatient and 12,413 inpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$5,895,785 in Medicare payments to the Hospital for 183 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 31 outpatient and 152 inpatient claims. Of the 183 claims, 177 claims had dates of service in CY 2010 or CY 2011, and 6 claims (involving outpatient and inpatient 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 159 of the 183 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 24 claims, resulting in overpayments of \$188,627 for CYs 2010 and 2011 (19 claims) and CYs 2009 and 2012 (5 claims). Specifically, 10 outpatient claims had billing errors, resulting in overpayments of \$106,083, and 14 inpatient claims had billing errors,

resulting in net overpayments of \$82,544. 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 \$188,627, consisting of \$106,083 in overpayments for 10 incorrectly billed outpatient claims and \$82,544 in net overpayments for 14 incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital concurred with all of our findings and described corrective actions that it had taken to implement our recommendations.

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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 University of Missouri Health Center (the Hospital) complied with Medicare requirements for billing outpatient and inpatient 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 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.

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

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 Claims at Risk for Incorrect Billing

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

- outpatient and inpatient manufacturer credits for replaced medical devices,
- outpatient claims with payments greater than \$25,000,
- outpatient surgeries billed with units greater than one,
- outpatient claims billed with modifiers,
- outpatient and inpatient claims paid in excess of charges,
- inpatient same-day discharges and readmissions,
- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims with payments greater than \$150,000, and
- inpatient DRG verification.

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)).

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).

University of Missouri Health Center

The Hospital is a 274-bed acute care hospital located in Columbia, Missouri. Medicare paid the Hospital approximately \$233 million for 274,615 outpatient and 12,413 inpatient 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 \$5,895,785 in Medicare payments to the Hospital for 183 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 31 outpatient and 152 inpatient claims. Of the 183 claims, 177 claims had dates of service in CY 2010 or CY 2011, and 6 claims had dates of service in CY 2009 or CY 2012.² 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. 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 159 of the 183 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 24 claims, resulting in overpayments of \$188,627 for CYs 2010 and 2011 (19 claims) and CYs 2009 and 2012 (5 claims). Specifically, 10 outpatient claims had billing errors, resulting in overpayments of \$106,083, and 14 inpatient claims had billing errors, resulting in net overpayments of \$82,544. 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.

² We selected these six 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 OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 10 of 31 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$106,083.

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 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.³

For 7 out of 31 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 seven claims, one had a date of service in CY 2009, three had dates of service in CY 2010, two had dates of service in CY 2011, and one had a date of service in CY 2012.) The Hospital stated that these overpayments occurred because its billing department depends on its charging departments for notification of device recall or replacement, but in these cases that notification did not occur. As a result of these errors, the Hospital received overpayments of \$77,187.

Unsupported Charges

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 1 out of 31 selected claims, the Hospital billed Medicare for a medication whose administration was unsupported in the medical record. The Hospital stated that this overpayment occurred because of a clerical error. As a result of this error, the Hospital received an overpayment of \$25,295.

Incorrect 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 (§ 1833(e)).

For 1 out of 31 selected claims, the Hospital billed Medicare with the incorrect number of units of service. The Hospital stated that this overpayment occurred due to human error—specifically, that Hospital staff had received corrected data but had then entered those data into the wrong system. As a result of this error, the Hospital received an overpayment of \$3,255.

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

Unsupported Code

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 1 out of 31 selected claims, the Hospital billed Medicare with an incorrect modifier. The Hospital stated that this overpayment occurred because the charges were based on the physician's preliminary report rather than on the final report. The Hospital also noted that while its charging systems have edits in place to attempt to identify coding issues, the changes made during the processing of this claim were not identified by the current edits. As a result of this error, the Hospital received an overpayment of \$346.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 14 of 152 selected inpatient claims that we reviewed. These errors resulted in net overpayments of \$82,544.

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states:

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 152 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital stated that it has edits in place to trigger a review of all visits that were discharged and readmitted in the same day, but added that in these cases the original reviewer erroneously determined that the claims were not related. As a result of these errors, the Hospital received overpayments of \$64,719.

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 6 out of 152 selected claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate condition and value codes to reduce payments as required. (Of the six claims, two had dates of service in CY 2009,

one had a date of service in CY 2010, two had dates of service in CY 2011, and one had a date of service in CY 2012.) The Hospital stated that these overpayments occurred because its billing department depends on its charging departments for notification of device recall or replacement, but in these cases that notification did not occur. As a result of these errors, the Hospital received overpayments of \$17,209.

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 152 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 this error occurred due to the subjective nature of medical judgment in the application and interpretation of inpatient admission criteria. As a result of this error, the Hospital received an estimated overpayment of \$6,564.⁴

Unsupported 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 5 out of 152 selected claims, the Hospital billed Medicare with incorrectly coded claims. Specifically, certain diagnosis codes were not supported in the medical records. The Hospital stated that coding is complex in nature because of the introduction of new codes and ever-

⁴ 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.

changing coding guidelines and regulations. As a result of these errors, the Hospital received a net underpayment of \$5,948.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$188,627, consisting of \$106,083 in overpayments for 10 incorrectly billed outpatient claims and \$82,544 in net overpayments for 14 incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital concurred with all of our findings and described corrective actions that it had taken to implement our recommendations.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$5,895,785 in Medicare payments to the Hospital for 183 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 31 outpatient and 152 inpatient claims. Of the 183 claims, 177 claims had dates of service in CY 2010 or CY 2011, and 6 claims (involving outpatient and inpatient 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 outpatient and inpatient 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 outpatient and inpatient 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 183 claims (31 outpatient and 152 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 August 21, 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

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments/ (Under-payments)	Value of Over-payments/ (Under-payments)
Outpatient				
Manufacturer Credits for Replaced Medical Devices	10	\$118,722	7	\$77,187
Claims With Payments Greater Than \$25,000	16	869,116	1	25,295
Surgeries Billed With Units Greater Than One	1	6,510	1	3,255
Claims Billed With Modifiers	2	43,004	1	346
Claims Paid in Excess of Charges	2	18,669	0	0
Outpatient Totals	31	\$1,056,021	10	\$106,083
Inpatient				
Same-Day Discharges and Readmissions	2	\$144,641	2	\$64,719
Manufacturer Credits for Replaced Medical Devices	6	128,875	6	17,209
Short Stays	19	138,546	1	6,564
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	39	794,563	1	5,209
Claims With Payments Greater Than \$150,000	11	2,408,402	0	0
Claims Paid in Excess of Charges	24	486,833	0	0
Diagnosis-Related-Group Verification	51	737,904	4	(11,157)
Inpatient Totals	152	\$4,839,764	14	\$82,544
Outpatient and Inpatient Totals	183	\$5,895,785	24	\$188,627

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 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



FINANCE DEPARTMENTS
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October 27, 2014

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
801 East 12th Street, Room 0429
Kansas City, Missouri 64106

RE: Report #: A-07-13-05050

Dear Mr. Cogley:

Thank you forwarding a copy of the draft report of our Medicare Compliance Review. It is our understanding that the Office of the OIG is seeking a response from our offices on "concurrency" that describes the nature of the corrective action taken or planned as well as the reason for any "non-concurrency" and alternative corrective action taken or planned.

Our comments are below:

Manufacturer Credit for Replaced Medical Devices Not Reported

University of Missouri Healthcare concurs with this finding. The Hospital Billing Department depends on charging departments notification when a device recall or replacement is in progress. This step did not occur on these cases.

Since this issue was brought to our attention as a result of this audit, meetings with the charging departments have been held and a notification process has been implemented that will prevent this type of error from occurring in the future. All refunds have been processed.

Unsupported Charges

University of Missouri Healthcare concurs with this finding. To address the clerical error, the clinical ordering and dispensing process in the hospital-based outpatient clinics is currently under review. In addition, on-going re-education of both Pharmacy and Clinic staff has been implemented. All refunds have been processed.

Incorrect Number of Units

University of Missouri Healthcare concurs with this finding. The correction of billed units failed due to the user entering corrections in FISS instead of reproducing claim directly from our Patient Accounting System and allowing our claim logic to generate claim with correct units. Staff re-education has occurred. All refunds have been processed.

Unsupported Code

University of Missouri Healthcare concurs with this finding. Process changes have been implemented to work with physicians regarding timeliness and completeness of documentation so that the technical charges are submitted based on the physician's final report. In addition, a review of current edits and implementation of additional ones has been addressed with the Information Technology Department staff. All refunds have been processed.

Incorrectly Billed as Separate Inpatient Stays

University of Missouri Healthcare concurs with this finding. HIM staff have been re-educated on the review of the edits and the rules regarding separate stays. All refunds have been processed.

Manufacturer Credit for Replaced Medical Devices Not Reported

University of Missouri Healthcare concurs with this finding. The Hospital Billing Department depends on charging departments notification when a device recall or replacement is in progress. This step did not occur on these cases.

Since this issue was brought to our attention as a result of this audit, meetings with the charging departments have been held and a notification process has been implemented that will prevent this type of error from occurring in the future. All refunds have been processed.

Incorrectly Billed as Inpatient

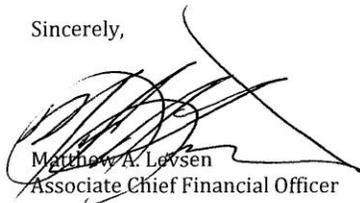
University of Missouri Healthcare concurs with this finding. We provide constant and recurring education to the coding staff to ensure proper code assignment. Over the past year we have enhanced our pre-billing and post-billing reviews to ensure issues are identified and addressed in a timelier manner. We have also enhanced the coding workflow through the implementation of Computer Assisted and Auto-suggested coding and through a change in coding leadership. All refunds have been processed.

Unsupported Codes

University of Missouri Healthcare concurs with this finding. As noted above, we provide constant and recurring education to the coding staff to ensure proper code assignment. Over the past year we have enhanced our pre-billing and post-billing reviews to ensure issues are identified and addressed in a timelier manner. We have also enhanced the coding workflow through the implementation of Computer Assisted and Auto-suggested coding and through a change in coding leadership. All refunds have been processed.

University of Missouri Healthcare appreciates the assistance provided by the Office of Inspector General during this audit process.

Sincerely,



Matthew A. Levens
Associate Chief Financial Officer

CC: Mitch Wasden
Peggy Ford