



September 21, 2011

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

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

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

SUBJECT: Medicare Compliance Review of Baystate Medical Center for Calendar Years 2008 and 2009 (A-01-11-00500); and Medicare Compliance Review of University of California, San Francisco, Medical Center for Calendar Years 2008 and 2009 (A-09-11-02034)

Attached, for your information, are advance copies of our final reports for two of our hospital compliance reviews. We will issue these reports to Baystate Medical Center and the University of California, San Francisco, Medical Center within 5 business days.

These reports are part of a series of the Office of Inspector General's hospital compliance initiative designed to concurrently review multiple issues at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services. The two attached reports are the fourth and fifth reports issued in this initiative.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or your staff may contact the respective Regional Inspectors General for Audit Services:

Baystate Medical Center

Michael J. Armstrong, Regional Inspector General for Audit Services, Region I
(617) 565-2689, email - Michael.Armstrong@oig.hhs.gov

Page 2 – Peter Budetti, Deborah Taylor

University of California, San Francisco, Medical Center

Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX
(415) 437-8360, email – Lori.Ahlstrand@oig.hhs.gov

Attachment

cc:

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



Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

September 21, 2011

Report Number: A-09-11-02034

Mr. Mark Laret
Chief Executive Officer
University of California, San Francisco, Medical Center
500 Parnassus Avenue, 5th Floor
San Francisco, CA 94143-0296

Dear Mr. Laret:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of University of California, San Francisco, Medical Center for Calendar Years 2008 and 2009*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please call Kimberly Kennedy, Senior Auditor, or Alice Norwood, Audit Manager, at (415) 437-8360. Please refer to report number A-09-11-02034 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF UNIVERSITY OF
CALIFORNIA, SAN FRANCISCO,
MEDICAL CENTER FOR
CALENDAR YEARS
2008 AND 2009**



Daniel R. Levinson
Inspector General

September 2011
A-09-11-02034

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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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.

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

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

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these payments to hospitals using computer matching, data mining, and analysis of claims. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

University of California, San Francisco, Medical Center (the Hospital) is an acute-care hospital located in San Francisco, California. Medicare paid the Hospital approximately \$499 million for 17,409 inpatient and 386,492 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 and 2009 based on CMS's National Claims History data.

Our audit covered \$4,394,664 in Medicare payments to the Hospital for 215 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2008 and 2009 and consisted of 160 inpatient and 55 outpatient claims.

OBJECTIVE

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

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 96 of the 215 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare

billing requirements for the remaining 119 claims, resulting in overpayments totaling \$784,277 for CYs 2008 and 2009. Specifically, 98 inpatient claims had billing errors, resulting in overpayments totaling \$754,333, and 21 outpatient claims had billing errors, resulting in overpayments totaling \$29,944. These overpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$784,277, consisting of \$754,333 in overpayments for the incorrectly billed inpatient claims and \$29,944 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital stated that it concurred with most of our findings. Regarding our recommendations, the Hospital stated that it had refunded the full amount of the overpayments and provided information on actions that it had taken to strengthen controls to ensure full compliance with Medicare requirements.

The Hospital did not concur with two of our findings. Regarding the finding related to inpatient claims for beneficiary stays that should have been billed as outpatient services, the Hospital stated that five of the erroneous claims were Medicare managed care claims for which the Hospital received preauthorization for inpatient admission from the Medicare managed care organization. Regarding the finding related to inpatient claims for patient discharges that should have been billed as transfers to other facilities, the Hospital stated that for four of the erroneous claims, the patients decided to seek alternative health care services at other facilities without the Hospital's knowledge.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments on our draft report, we maintain that our findings are valid. Regarding the finding related to inpatient claims for beneficiary stays that should have been billed as outpatient services, we acknowledge that the Hospital received preauthorization for inpatient admission from the Medicare managed care organization. However, as a result of our review, the Hospital subsequently determined that the patients did not meet the severity of illness or level of care required to be admitted as inpatients. Regarding the finding related to inpatient claims for patient discharges that should have been billed as transfers to other facilities, the Hospital is responsible for coding the bill based on its discharge plan for the patient. If the Hospital subsequently determines that postacute care was provided, it is responsible for either coding the original bill as a transfer or submitting an adjusted claim.

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HOSPITAL COMMENTS

INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.¹

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. For beneficiary stays incurring extraordinarily high costs, section 1886(d)(5)(A) of the Act provides for additional payments (called outlier payments) to Medicare-participating hospitals.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.² The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.³ All services and items within an APC group are comparable clinically and require comparable resources.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, requires CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

² In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

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

Hospital Payments at Risk for Incorrect Billing

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

- inpatient claims for short stays,
- inpatient claims with post-acute-care transfers,
- inpatient claims with high severity level DRGs,
- inpatient claims for blood clotting factor drugs,
- outpatient claims billed before and/or during inpatient stays,
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day),
- inpatient and outpatient claims paid in excess of charges, and
- inpatient and outpatient claims involving manufacturer credits for replaced medical devices.

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

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items 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, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 3, section 10, of the Manual states that a hospital may bill only for services provided. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

University of California, San Francisco, Medical Center

University of California, San Francisco, Medical Center (the Hospital) is an acute-care hospital located in San Francisco, California. Medicare paid the Hospital approximately \$499 million for 17,409 inpatient and 386,492 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 and 2009 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our audit covered \$4,394,664 in Medicare payments to the Hospital for 215 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2008 and 2009 and consisted of 160 inpatient and 55 outpatient claims.

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

This report focuses on selected inpatient and outpatient 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 from March to July 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2008 and 2009;

- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2008 and 2009;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 215 inpatient and outpatient claims for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims (through questionnaires and interviews with Hospital personnel);
- 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.

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

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 96 of the 215 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 119 claims, resulting in overpayments totaling \$784,277 for CYs 2008 and 2009. These overpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

Of 160 selected inpatient claims, 98 claims had billing errors, resulting in overpayments totaling \$754,333:

- For 40 claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient services or lacked a physician order to admit the patient to inpatient care.
- For 39 claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to other facilities.
- For 14 claims, the Hospital submitted claims to Medicare with incorrect DRGs.
- For four claims, the Hospital submitted claims to Medicare with incorrect charges that resulted in incorrect outlier payments.
- For one claim, the Hospital incorrectly billed Medicare for a same-day readmission that should have been combined with the initial inpatient stay in a single claim rather than billed as separate claims.

Of 55 selected outpatient claims, 21 claims had billing errors, resulting in overpayments totaling \$29,944:

- For 14 claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes or an incorrect number of units.
- For seven claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays. These services should have been included on the Hospital's inpatient (Part A) claims to Medicare.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 98 of 160 selected inpatient claims, which resulted in overpayments totaling \$754,333.

Incorrectly Billed as Inpatient

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

For 40 of 160 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for these claims as inpatient:

- For 39 claims, the Hospital incorrectly billed for beneficiary stays that should have been billed as outpatient services. The Hospital subsequently reviewed each of the claims and

determined that the patient did not meet the severity of illness or level of care required to be admitted as an inpatient.

- For one claim, the Hospital incorrectly billed for an inpatient stay that lacked a physician order to admit the patient to inpatient care.

The Hospital stated that the 39 errors occurred because the Hospital either relied upon physician orders to admit the patients as inpatients or did not initially use an evidence-based clinical decision support tool⁴ to evaluate the conditions of the patients. In some instances, the Hospital followed a clinical evaluation process; however, retrospective review of the complete stay provided additional information to modify the patient status. In addition, for the one claim that lacked a physician order, the Hospital stated that the patient left the hospital before the physician wrote an order for admission. As a result of these errors, the Hospital received overpayments totaling \$376,953.

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 39 of 160 selected inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to other facilities. For the majority of these claims, the Hospital should have coded the discharge status as a transfer to another facility instead of as a discharge to a home; thus, the Hospital should have received the per diem payment instead of the full DRG payment. The Hospital stated that these errors occurred because of the complexity of the process for coding patient discharge status. As a result of these errors, the Hospital received overpayments totaling \$237,082.

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, section 80.3.2.2, of the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

⁴ The Hospital uses McKesson Corp.'s InterQual evidence-based clinical decision support criteria to answer critical questions about the appropriateness of levels of care and resource use.

For 14 of 160 selected inpatient claims, the Hospital submitted claims to Medicare with incorrect DRGs. For example, for one claim, the Hospital used the DRG for major chest procedures with complication/comorbidity rather than using the DRG for major chest procedures without complication/comorbidity. The Hospital stated that the 14 errors occurred because the Hospital erroneously entered diagnosis codes or procedure codes on isolated cases that resulted in incorrect DRGs. As a result of these errors, the Hospital received overpayments totaling \$130,574.

Incorrect Charges Resulting in Incorrect Outlier Payments

The Manual, chapter 3, section 10, states that a hospital may bill only for services provided. In addition, chapter 1, section 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 160 selected inpatient claims, the Hospital submitted claims to Medicare with incorrect charges that resulted in incorrect outlier payments. The Hospital stated that these errors occurred because of clerical mistakes. As a result of these errors, the Hospital received overpayments totaling \$1,773.

Incorrectly Billed as Separate Inpatient Stay

The Manual, chapter 3, section 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 1 of 160 selected inpatient claims, the Hospital incorrectly billed Medicare for a same-day readmission that should have been combined with the initial inpatient stay in a single claim rather than billed as separate claims. The original claim and the claim involving subsequent readmission were related to the same medical condition and thus should have been billed as a continuous stay. However, the Hospital did not adjust the original claim by combining the original and subsequent stays into a single claim. The Hospital stated that this error occurred because the patient returned to the hospital’s emergency department shortly before midnight on the date of the initial discharge. As a result, the Hospital received an overpayment of \$7,951.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 21 of 55 selected outpatient claims, which resulted in overpayments totaling \$29,944.

Incorrect Healthcare Common Procedure Coding System Codes 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, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 4, section 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 14 of 55 selected outpatient claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes or an incorrect number of units:

- For nine claims, the Hospital billed Medicare using incorrect HCPCS codes. For example, for 1 claim, the Hospital used the HCPCS code for destruction of a malignant lesion less than 0.5 centimeters rather than using the HCPCS code for destruction of up to 14 benign lesions, the procedure actually performed.
- For five claims, the Hospital billed Medicare for an incorrect number of units. For example, for 1 claim, rather than billing for 26 units of a cancer drug, the Hospital billed for 260 units.

The Hospital stated that these errors occurred because of clerical mistakes. As a result of these errors, the Hospital received overpayments totaling \$26,773.

Incorrectly Billed as Outpatient

The Manual, chapter 3, section 10.4, states that Medicare Part A covers certain items and nonphysician services furnished to inpatients and consequently the inpatient prospective payment rate covers these services.

For 7 of 55 selected outpatient claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays. These services should have been included on the Hospital’s inpatient (Part A) claims to Medicare. The Hospital stated that these errors occurred because of a flaw in the Hospital’s prebill edit software that accepted orders for outpatient services scheduled before the beneficiaries’ inpatient admissions. As a result of these errors, the Hospital received overpayments totaling \$3,171.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$784,277, consisting of \$754,333 in overpayments for the incorrectly billed inpatient claims and \$29,944 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital stated that it concurred with most of our findings. Regarding our recommendations, the Hospital stated that it had refunded the full amount of the overpayments and provided information on actions that it had taken to strengthen controls to ensure full compliance with Medicare requirements.

The Hospital did not concur with two of our findings:

- Regarding the finding related to inpatient claims for beneficiary stays that should have been billed as outpatient services, the Hospital stated that five of the erroneous claims were Medicare managed care claims for which the Hospital received preauthorization for inpatient admission from the Medicare managed care organization. The Hospital also stated that it continues to seek clarification from CMS regarding the discrepancy with conflicting authorizations for managed care and Medicare patients.
- Regarding the finding related to inpatient claims for patient discharges that should have been billed as transfers to other facilities, the Hospital stated that for four of the erroneous claims, the patients decided to seek alternative health care services at other facilities without the Hospital's knowledge. The Hospital also stated that the fiscal intermediary did not notify the Hospital of these occurrences and cited a reference in the Federal Register stating that the fiscal intermediary is required to notify a hospital of the need to submit an adjusted claim when a patient is discharged to another hospital.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments on our draft report, we maintain that our findings are valid:

- Regarding the finding related to inpatient claims for beneficiary stays that should have been billed as outpatient services, we acknowledge that the Hospital received preauthorization for inpatient admission from the Medicare managed care organization. However, as a result of our review, the Hospital subsequently determined that the patients did not meet the severity of illness or level of care required to be admitted as inpatients.
- Regarding the finding related to inpatient claims for patient discharges that should have been billed as transfers to other facilities, the Federal Register⁵ emphasizes that the Hospital is responsible for coding the bill based on its discharge plan for the patient. If the Hospital subsequently determines that postacute care was provided, it is responsible for either coding the original bill as a transfer or submitting an adjusted claim.

⁵ 63 Fed. Reg. 40979, 40980 (July 31, 1998).

APPENDIX

APPENDIX: HOSPITAL COMMENTS

University of California
San Francisco



A Health Sciences Campus

School of Dentistry
School of Medicine
School of Nursing
School of Pharmacy
The Graduate Division
UCSF Medical Center
The Research Institutes

Elizabeth A. Boyd, Ph.D.
Associate Vice Chancellor
Chief Ethics and Compliance
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August 30, 2011

Lori A. Ahlstrand
Regional Inspector General
For Audit Services
Department of Health and Human Services
Office of Audit Services, Region IX
90-7TH Street, Suite 3-650
San Francisco, CA 94103

RE: Report Number A-09-11-02034

Dear Ms. Ahlstrand:

On behalf of the University of California San Francisco Medical Center and Mark Laret, Chief Executive Officer, I am providing comments to the report entitled "Medicare Compliance Review of the University of California San Francisco Medical Center for Calendar Years 2008 and 2009". I appreciate the opportunity to respond to the draft report.

As noted in the draft report, the Office of Inspector General (OIG) reviewed 215 claims that were judgmentally selected as potentially at risk for billing errors. These claims covered 12 specific areas that were determined to be at risk for non-compliance based on the OIG's prior audits, investigations and inspection at many hospitals throughout the nation. This audit covered \$4,394,664 in Medicare payments to the University of California San Francisco Medical Center.

The University of California San Francisco Medical Center concurs with most of the Office of Inspector General's (OIG's) findings that of 215 sampled claims, 119 claims did not fully comply with Medicare billing requirements resulting in overpayments totaling \$782,604* for CYs 2008 and 2009. No errors were identified for the issues of Outpatient Payment Exceeding Charge and Inpatient Hemophilia Billing.

The University of California San Francisco Medical Center has made the necessary refunds and has taken steps to strengthen controls to ensure full compliance with Medicare requirements.

Our responses to the OIG's recommendations are set forth below:

1. Refund to the Medicare contractor overpayments of \$782,604.
The University of California San Francisco Medical Center has refunded the full amount of the overpayments to Medicare.
2. Strengthen controls to ensure full compliance with Medicare requirements.
The University of California San Francisco Medical Center regularly conducts coding and compliance education, monitoring and auditing. In order to strengthen these efforts and address the issues raised by the OIG's findings, we have implemented

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* **Office of Inspector General Note:** Because of adjustments made after issuance of the draft report, the overpayments for the 119 erroneous claims totaled \$784,277. The Hospital stated that it has submitted all of the adjustments to the Medicare contractor.

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several measures, including the following:

- Provide additional coding education and training and monitoring;
- Simplify, clarify, and streamline processes and documentation as warranted;
- Provide additional training and monitoring on the application of InterQual criteria to enhance consistent application;
- Update pre bill edit software to provide adequate control reviews.

3. In regard to the OIG's findings in two specific risk areas, the University of California San Francisco Medical Center does not concur. They are as follows:
 - In the risk category of short stays, 5 of the 39 claims selected, reviewed, and determined to be in error by the OIG, were Medicare Managed Care claims for which the University of California San Francisco Medical Center sought and received pre-authorization for inpatient admission from the Medicare Managed Care Organization.

While the University of California San Francisco Medical Center will apply Inter Qual criteria for this patient population, conflicting authorizations will create challenges. We continue to seek clarification from CMS regarding this discrepancy with Medicare Managed Care patients and Medicare patients.

The University of California San Francisco Medical Center will expand the concurrent Case Management review process to include Medicare and Medicare Managed Care populations.

- In the risk category of discharge disposition, 4 of the 39 claims selected, reviewed and determined to be in error by the OIG, the University of California San Francisco Medical Center discharged the patient to home and, without our knowledge, the patient decided to seek other alternative health care services at other external facilities. We were not notified by our fiscal intermediary of these occurrences. We are including a reference in the Federal Register that supports our position. The reference is as follows:

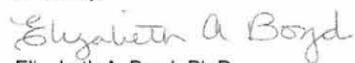
Federal Register, Vol. 68, 45405

"We recognize that, in some cases, a hospital cannot know the patient will go to another hospital. However, we note the claims processing system can identify cases coded as discharges where the date of discharge matches the admission date at another hospital. In these cases, the fiscal intermediary will notify the hospital of the need to submit an adjustment claim."

Therefore, the University of California San Francisco Medical Center will continue to rely on Palmetto to provide this information absent clarification from CMS.

The University of California San Francisco Medical Center takes these obligations very seriously, and will continue to monitor and audit claims and institute additional controls as indicated above.

Sincerely,



Elizabeth A. Boyd, Ph.D.
Chief Ethics & Compliance Officer
University of California San Francisco