

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF CEDARS-SINAI
MEDICAL CENTER
FOR THE PERIOD
JANUARY 1, 2008, THROUGH
JUNE 30, 2011**

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



Brian P. Ritchie
Assistant Inspector General

May 2013
A-09-12-02048

Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

Cedars-Sinai Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of \$2.2 million over 3½ 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 are at risk for noncompliance with Medicare billing requirements. For calendar year 2011, Medicare paid hospitals \$151 billion, which represented 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

Our objective was to determine whether Cedars-Sinai 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. 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 an acute-care hospital located in Los Angeles, California. Medicare paid the Hospital approximately \$1.37 billion for 66,467 inpatient and 574,807 outpatient claims for services provided to beneficiaries during the period January 1, 2008, through June 30, 2011.

Our audit covered \$5,590,434 in Medicare payments to the Hospital for 490 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 240 inpatient and 250 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 81 of the 490 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 409 claims, resulting in overpayments of \$2,244,649 for the period January 1, 2008, through June 30, 2011. Specifically, 176 inpatient claims had billing errors, resulting in overpayments of \$1,869,455, and 233 outpatient claims had billing errors, resulting in overpayments of \$375,194. 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 \$2,244,649, consisting of \$1,869,455 in overpayments for the incorrectly billed inpatient claims and \$375,194 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 generally agreed with our findings and provided information on actions that it had taken or planned to take to address our recommendations.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective.....	1
Background.....	1
The Medicare Program	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System.....	1
Hospital Claims at Risk for Incorrect Billing	2
Medicare Requirements for Hospital Claims and Payments	2
Cedars-Sinai Medical Center	3
How We Conducted This Review.....	3
FINDINGS.....	3
Billing Errors Associated With Inpatient Claims	3
Incorrect Billing of Part A for Beneficiary Stays That Should Have Been Billed as Outpatient Services	4
Incorrect Billing for Patient Discharges That Should Have Been Billed as Transfers	4
Incorrect Diagnosis-Related Groups.....	5
Unreported Manufacturer Credits for Replaced Medical Devices	5
Billing Errors Associated With Outpatient Claims.....	5
Incorrect Billing of Healthcare Common Procedure Coding System Code or Number of Units	5
Unreported Manufacturer Credits for Replaced Medical Devices	6
Incorrect Billing for Unlabeled Use of a Drug or Noncovered Dental Services	6
RECOMMENDATIONS.....	7
HOSPITAL COMMENTS	7
APPENDIXES	
A: Audit Scope and Methodology	8
B: Results of Review by Risk Area	10
C: Hospital Comments.....	11

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 are at risk for noncompliance with Medicare billing requirements. For calendar year 2011, Medicare paid hospitals \$151 billion, which represented 45 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether Cedars-Sinai 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.¹ All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient transfers,
- 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,
- outpatient claims billed for Lupron injections,
- outpatient surgeries billed with units greater than one, and
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day).

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, payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)).

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

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

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

Cedars-Sinai Medical Center

The Hospital is an acute-care hospital located in Los Angeles, California. Medicare paid the Hospital approximately \$1.37 billion for 66,467 inpatient and 574,807 outpatient claims for services provided to beneficiaries during the period January 1, 2008, through June 30, 2011.²

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$5,590,434 in Medicare payments to the Hospital for 490 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service during the period January 1, 2008, through June 30, 2011, and consisted of 240 inpatient and 250 outpatient claims. We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not use medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by 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 81 of the 490 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 409 claims, resulting in overpayments of \$2,244,649 for the period January 1, 2008, through June 30, 2011. Specifically, 176 inpatient claims had billing errors, resulting in overpayments of \$1,869,455, and 233 outpatient claims had billing errors, resulting in overpayments of \$375,194. 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 a detailed list of the risk areas that we reviewed and associated billing errors, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 176 of 240 selected inpatient claims, which resulted in overpayments of \$1,869,455. Two claims contained more than one type of error.

² These data came from CMS's National Claims History file.

Incorrect Billing of Part A for Beneficiary Stays That Should Have Been Billed as Outpatient Services

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 100 of 240 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient-with-observation services. The Hospital attributed the patient admission errors primarily to late night and weekend admissions through the emergency department and insufficient case management staffing, which resulted in a failure to review all accounts before billing Medicare. As a result of these errors, the Hospital received overpayments of \$1,116,401.³

Incorrect Billing for Patient Discharges That Should Have Been Billed as Transfers

Hospitals must bill inpatient discharges as transfers when (1) the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge or (2) the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to home under a home health agency’s written plan of care for home health services that begin within 3 days after the date of discharge (42 CFR §§ 412.4(b) and (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 56 of 240 selected claims, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers to other facilities.⁴ For these claims, the Hospital should have coded the discharge status as a transfer to home under a written plan of care for the provision of home health services or to an acute-care hospital. However, for a majority of these claims, the Hospital incorrectly coded the discharge status as “discharged to home” or “left against medical advice”; therefore, the Hospital should have received the per diem payment instead of the full DRG payment. The Hospital stated that these errors occurred because (1) patients sought alternative health care services at other facilities without the Hospital’s knowledge, (2) the coding staff did not identify the disposition status information in the plan of care and the physician’s final orders indicated the patient was to be sent home, or (3) the coding staff incorrectly assigned the patient discharge status. As a result of these errors, the Hospital received overpayments of \$522,074.

³ The Hospital may be able to bill Medicare Part B for some services related to some of these incorrect Medicare Part A claims. 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 or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

⁴ For one of these claims, the Hospital also billed Medicare with an incorrect DRG.

Incorrect Diagnosis-Related Groups

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)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 19 of 240 selected claims, the Hospital billed Medicare with incorrect DRGs.⁵ For example, for one claim, the Hospital billed a DRG for a ventricular shunt procedure with major complication or comorbidities rather than billing the DRG for other disorders of the nervous system with major complication or comorbidities. The Hospital stated that code assignment is dependent on clear physician documentation. For a majority of the errors, physician documentation in the medical records was not clear, and the coding staff made code assignment decisions on the basis of the documentation at hand. As a result of these errors, the Hospital received overpayments of \$206,185.

Unreported Manufacturer Credits for Replaced Medical Devices

Federal regulations require a reduction in the IPPS payment 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(a)). 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 (which identifies the replacement device) and value code FD (which identifies the amount of the credit or cost reduction received by the hospital for the replaced device) (chapter 3, § 100.8).

For 1 of 240 selected claims, the Hospital received a reportable medical device credit for a replaced device from a manufacturer but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required. The Hospital stated that this error occurred because of lack of coordination between various departments. As a result, the Hospital received an overpayment of \$24,795.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 233 of 250 selected outpatient claims, which resulted in overpayments of \$375,194.

Incorrect Billing of Healthcare Common Procedure Coding System Code or Number of Units

Medicare payments may not be made 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

⁵ For one of these claims, the Hospital also billed Medicare for a patient discharge that it should have billed as a transfer to another facility.

accurately” (chapter 1, § 80.3.2.2). In addition, the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed” (chapter 4, § 20.4).

For 224 of 250 selected claims, the Hospital submitted claims to Medicare with the incorrect HCPCS code or an incorrect number of units:

- For 219 claims, the Hospital billed Medicare with the incorrect HCPCS code. Specifically, the Hospital billed the incorrect HCPCS code for a drug available in two separate dosages, each assigned its own HCPCS code and separately packaged.
- For five claims, the Hospital billed Medicare with an incorrect number of units. For example, for one claim, rather than billing 1 unit for a procedure performed on the nose, the Hospital billed 76 units.

The Hospital stated that these errors occurred because the Hospital’s cancer center did not have the charge code for the correct HCPCS code and the Hospital’s billing system failed to convert charges for operating-room time to billable units. As a result of these errors, the Hospital received overpayments of \$346,380.

Unreported Manufacturer Credits for Replaced Medical Devices

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(a)). 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.⁶

For 3 of 250 selected claims, the Hospital incurred no cost or received full credit for the replaced device but did not properly report the -FB modifier or reduced charges on its claims. The Hospital stated that these errors occurred because of lack of coordination between various departments. As a result of these errors, the Hospital received overpayments of \$24,478.

Incorrect Billing for Unlabeled Use of a Drug or Noncovered Dental Services

CMS’s *Medicare Benefit Policy Manual* defines an unlabeled use of a drug as a use that is not included as an indication on the drug’s label as approved by the Food and Drug Administration (FDA) (Pub. 100-02, chapter 15, § 50.4.2). This section states that FDA-approved drugs used for indications other than what is indicated on the official label may be covered under Medicare

⁶ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS. 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 (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

if the contractor determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature, and/or accepted standards of medical practice.

The Act states that no payment may be made under Medicare Part A or Part B for any expenses incurred for items or services “where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth ...” (§ 1862(a)(12)).

For 6 of 250 selected claims, the Hospital billed Medicare for services that were not allowable for Medicare reimbursement. For five claims, the Hospital billed Medicare for the unlabeled use of a chemotherapy drug without confirming with the Medicare contractor that the unlabeled use was medically accepted. For one claim, the Hospital billed Medicare for noncovered dental services (i.e., routine care, treatment, and removal of teeth). The Hospital stated that these errors occurred because the billing system did not prevent billing for the unlabeled use of a drug (five claims) and a billing system edit to prevent billing for dental services was overridden (one claim). As a result of these errors, the Hospital received overpayments of \$4,336.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$2,244,649, consisting of \$1,869,455 in overpayments for the incorrectly billed inpatient claims and \$375,194 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 generally agreed with our findings and provided information on actions that it had taken or planned to take to address our recommendations. The Hospital’s comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$5,590,434 in Medicare payments to the Hospital for 490 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service during the period January 1, 2008, through June 30, 2011 (audit period), and consisted of 240 inpatient and 250 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not use medical review to determine whether the services were medically necessary.

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 CMS's 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 February 2012 to January 2013.

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 the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 490 claims (240 inpatient and 250 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;
- 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 objectives.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Billing Errors	Value of Overpayments
Inpatient				
Short Stays	171	\$3,163,836	108	\$1,120,404
Transfers	61	1,472,884	61	548,442
Claims Paid in Excess of Charges	6	174,284	5	141,366
Claims Billed With High-Severity-Level DRG Codes	1	43,405	1	34,448
Manufacturer Credits for Replaced Medical Devices	1	32,364	1	24,795
Inpatient Totals	240	\$4,886,773	176	\$1,869,455
Outpatient				
Claims Billed for Lupron Injections	224	\$508,013	224	\$292,979
Surgeries Billed With Units Greater than One	5	45,546	5	30,930
Claims Paid in Excess of Charges	3	34,359	1	26,807
Manufacturer Credits for Replaced Medical Devices	3	38,732	3	24,478
Claims Billed With Modifier -59	15	77,011	0	0
Outpatient Totals	250	\$703,661	233	\$375,194
Inpatient and Outpatient Totals	490	\$5,590,434	409	\$2,244,649

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 this report's findings.

APPENDIX C: HOSPITAL COMMENTS



April 15, 2013

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

RE: **Draft Report – Medicare Compliance Review of Cedars-Sinai Medical Center for the Period January 1, 2008, Through June 30, 2011, dated March 27, 2013 (A-09-12-02048)**

Dear Ms. Ahlstrand:

We are responding on behalf of Mr. Thomas M. Priselac, President and Chief Executive Officer of Cedars-Sinai Medical Center.

We have reviewed in detail your office's findings in the draft report. In general, we agree that 409 of the 490 claims audited were found to contain some form of error that affects reimbursement. We have begun and will continue the process to reimburse the full overpayment amount as determined by your audit. We will also continue the process of strengthening billing controls to ensure compliance with Medicare requirements; many of these controls were actually initiated prior to this audit.

We would also offer more specific comments and responses in regards to the following categories of findings:

1) Billing Errors Associated With Inpatient Claims:

a) Incorrect Billing of Part A for Beneficiary Stays That Should Have Been Billed as Outpatient Services:

Comment on Causes of Errors:

In addition to issues associated with late night and weekend admissions through the Emergency Department, Cedars-Sinai has also experienced, in the past, issues in some procedural areas where patient admissions, post-procedure, were not effectively managed by knowledgeable case management staff. The actions described below are addressing both these issues.

8700 Beverly Blvd. ■ Los Angeles, CA 90048
Office (323) 866-7875 ■ FAX (323) 866-7871

Cedars-Sinai's Corrective Action Plan:

Prior to this audit, Cedars-Sinai was well aware of the clinical and operational challenges associated with patient classifications in the case short-stay patients admitted for needed hospital services. Over the course of the past three years, Cedars-Sinai has instituted the following measures all aimed at strengthening billing control for short stay Part A Medicare claims:

- In August of 2010, Cedars-Sinai began a robust program with Case Management and Billing Compliance to review pre and post procedure patient class orders. The goal was to review the orders against InterQual criteria as well as risk stratification for appropriateness for procedural patients. If there was an issue with an order or class, or the lack of a clearly documented order, then the case manager contacted the physician and got proper orders prior to the patient being discharged. Some specialized procedural areas such as the cardiac cath lab and interventional radiology developed guides based on InterQual criteria (as well as the CMS inpatient only list) to help physicians document proper orders on their patients. Additionally, several IT systems were streamlined and standardized to help get orders and patient class options aligned from scheduling to post-operative orders.
- In September 2011 Cedars-Sinai contracted with the company Executive Health Resources (EHR) to assist with second level case management reviews for our Medicare patients admitted via the Emergency Department. They provide physician level review against InterQual criteria as well risk stratification for our patients and assist with observation management as well. Regardless of resource, whether internal Cedars-Sinai case management staff or physicians or external consultants, Cedars-Sinai is aware of the CMS condition code 44 requirements as well as InterQual guidelines and risk stratification and make admission decisions accordingly.
- In February 2012 Cedars-Sinai created robust billing edits to catch accounts for Medicare inpatients with a stay that is less than 24 hours in length for review prior to billing for appropriateness of patient class. Accounts deemed to have errors with patient class are only billed for ancillary services on a TOB 121 per MAC directive.
- In 2012 a case manager was stationed in the Emergency Department to review all orders for admissions and observation for appropriateness and documentation.
- InterQual criteria became electronically available to case managers and others in 2012 thereby facilitating their use for proper patient placement.
- Finally, Cedars-Sinai implemented a full electronic health record (EPIC EMR) including electronic physician order entry in 2012. We are now able to better track physicians' orders and changes to orders in the system. This greatly improves our timeliness and efficiency in the review of patient class and medical necessity.

b) Incorrect Billing for Patient Discharges That Should Have Been Billed as Transfers:

Comment on Causes of Errors:

In those cases where the patient sought medical care at another facility or resumed home care, there was a clearly documented plan of care for the patient to be discharged home without services. In such cases, Cedars-Sinai is totally dependent upon notification by the Medicare Contractor, or by the other facility, in order to bill with a proper discharge status.

Cedars-Sinai's Corrective Action Plan:

In addition to continuing to work with the Medicare Contractor to improve communications regarding Common Working File edits, Cedars-Sinai has retained a consultant who conducts analysis of and necessary follow-up on Medicare payments for possible payment errors, to include:

- Unpaid or underpaid claims (or amounts) including any and all deficiencies in payments due to Medical Center from the Medicare Part A or Part B programs, where Medical Center's patient account for such claim has been closed or inactive (i.e., there has been no further insurance follow-up activity by Medical Center personnel) for a period of 180 days or more. Unpaid or underpaid amounts do not include additional amounts owed by individual patients.
- Overpaid claims including any and all payments to Medical Center from the Medicare Part A or Part B Programs in excess of what should have been paid, where Medical Center's patient account for such claim has been closed or inactive (i.e., there has been no further insurance follow-up activity by Medical Center personnel) for a period of 180 days or more.
- Cedars-Sinai maintains an internal Coding Compliance Audit team whose primary objective is coding education and monitoring of coding quality. The Coding Audit team performs monthly reviews of inpatient and outpatient claims to include but not be limited to DRG assignment, code selection, and discharge disposition. Patient Financial Services maintains a process in which each Medicare Inpatient claim is reviewed prior to billing in which the Medicare Direct Data Entry system is accessed to review if there is indication of a secondary service claim. If a claim is identified, the Cedars-Sinai claim disposition is updated to reflect the information. If a claim is identified through the Common Working File edit notification, the claim is corrected per Medicare instruction and re-submitted.

c) Incorrect Diagnosis-Related Groups:

Comments on Causes of Error:

To reiterate the OIG's findings, coding staff are fully dependent upon the completeness and accuracy of physician documentation.

Cedars-Sinai's Corrective Action Plan:

Cedars- Sinai will take the following corrective actions regarding these errors:

- Provide additional education regarding sequencing and selection of the principal diagnosis to coding staff.
- Address documentation opportunities with physician staff through the *Clinical Documentation Improvement Program*. Improved, clear documentation of reason for admission will assist coding staff in proper clinical selection of the principal diagnosis.
- Provide focused education on the selection of procedure codes in regards to the three accounts in which code assignment determined the DRG selection.
- Provide additional education on secondary diagnosis code and the qualifying factors for conditions to be coded as a secondary code.

d) Unreported Manufacturer Credits for Replaced Medical Devices

Comment on Causes of Error:

No additional comment.

Cedars-Sinai's Corrective Action Plan:

Cedars Sinai will take the following corrective actions regarding these errors:

- Interdepartmental communication has been streamlined among clinical services areas, purchasing, accounts payable, and patient financial services (hospital billing). When credits are received, corrected billing occurs if initial claim has already been submitted.
- Claims logic was created to pull payment adjustment data into the claim per billing guidelines.
- Additionally, on accounts where we know in advance from the clinical department that a device is a replacement, we have created claim logic to hold claims from initial billing until credits are received.

2) Billing Errors Associated With Outpatient Claims:

a) Incorrect Billing of Healthcare Common Procedure Coding System Code or Number of Units:

Comment on Causes of Error – Procedure Code:

Our own review of these accounts showed that while the patient was given the correct, ordered dosage, the account was charged with the incorrect HCPCS for Lupron. Charges were for J1950 (3.75mg) instead of J9217 (7.5mg). This billing error resulted in an overpayment, as the payment rate for J1950 is higher than that for J9217. The overpayment ranged from \$200.26 to \$2029.53, depending on the dosage provided.

Comment on Causes of Error – Number of Units (OR Time):

The issue of errors in number of units billed occurred because of the manner in which Cedars-Sinai charges for OR time. We charge one unit for the initial hour of time, and then in subsequent minutes. These additional minutes are intended to come over into the billing system as a unit of one. In March 2009 Cedars-Sinai converted its patient accounting system. Claims logic in the legacy system would automatically roll these additional units into a unit of one but that logic failed to migrate to production at the time of conversion into the new system. This system error was quickly identified and corrected.

Cedars-Sinai's Correction Action Plan – Procedure Code Errors

Cedars-Sinai had, in fact, initiated corrected actions regarding this type of coding error prior to findings in the OIG audit.

- In August of 2010, it was identified that the Cedars-Sinai cancer center did not have but would now need the charge code for HCPCS J9217. This change was implemented on a go-forward basis. However, at that time, it was not known that the 'incorrect' HCPCS had been used in the past. Thus, there were no internal audit findings of incorrect coding prior to August 2010
- Further changes were made in September 2012 when the cancer center converted to the electronic pharmacy system, Willow (an Epic product that is now part of Cedars-Sinai's electronic health record). Now, HCPCS codes that reside in that application are sent through to the billing application. All medications that are used at Cedars-Sinai are built into Willow that provides a robust system for clinical care as well as 'housing' HCPCS codes and base units.

Cedars-Sinai's Corrective Action Plan - Number of Unit (OR Time)

As indicated above, the system issue associated with this error has been identified and resolved.

b) Unreported Manufacturer Credits for Replaced Medical Devices

[See 1-d. above]

c) Incorrect Billing for Unlabeled Use of a Drug or Noncovered Dental Services

Comment on Causes of Error:

No additional comment.

Cedars-Sinai's Corrective Action Plan – Unlabeled Use of Drug

Cedars-Sinai pharmacy personnel will continue to consult with physicians about what drugs are considered off-label for certain conditions. Additionally, billing staff will continue to review NCDs and LCDs for coverage determinations and share them with clinical partners if/when errant trends are identified. Staff will also continue to use CMS Contractor edits to know when certain medications may be considered off label and/or not covered.

Cedars-Sinai's Corrective Action Plan - Noncovered Dental Services

Cedars-Sinai will continue to notify procedural areas, surgery schedulers, registrars and physicians about services that are and are not covered by the Medicare program. Cedars-Sinai will continue to rely on standard claim edits in the patient accounting system, additional edits in the clearinghouse and CMS' DDE to identify such claims with non-covered services.

Finally, we would like to thank the OIG auditors who conducted the review of Cedars-Sinai Medicare claims for their professionalism, collegiality, and cooperation. Please contact David Blake at 323-866-7875 or david.blake@cshs.org with any questions you may have regarding our responses.

Sincerely,

/David C. Blake, PhD, JD/

/Patricia Emmett Kittell/

David C. Blake, PhD, JD
Vice President
Chief Compliance & Privacy Officer

Patricia Emmett Kittell
Vice President
Patient Financial Services

cc: Thomas M. Priselac; President and CEO
Edward Prunchunas, Senior Vice President, Finance & CFO