

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
SUTTER MEDICAL CENTER,
SACRAMENTO**

*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

April 2014
A-09-13-02024

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

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

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.

Office of Inspector General

<https://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.

Office of Evaluation and Inspections

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.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

EXECUTIVE SUMMARY

Sutter Medical Center, Sacramento, did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$1 million over more than 3 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 represented 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.

Our objective was to determine whether Sutter Medical Center, Sacramento (the Hospital), complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

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

The Hospital is an acute-care hospital located in Sacramento, California. Medicare paid the Hospital approximately \$418 million for 26,975 inpatient and 58,763 outpatient claims for services provided to beneficiaries during CYs 2010 through 2012.

Our audit covered \$2,693,838 in Medicare payments to the Hospital for 182 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 149 inpatient and 33 outpatient claims. Of the 182 claims, 179 claims had dates of service in CYs 2010, 2011, or 2012, and 3 claims (involving inpatient short stays and an outpatient surgery billed with units greater than one) had dates of service in CY 2013.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 65 of the 182 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 117 claims, resulting in overpayments of \$1,043,958 for CYs 2010 through 2012 (115 claims) and CY 2013 (2 claims). Specifically, 98 inpatient claims had billing errors, resulting in overpayments of \$992,272, and 19 outpatient claims had billing

errors, resulting in overpayments of \$51,686. 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 \$1,043,958, consisting of \$992,272 in overpayments for the incorrectly billed inpatient claims and \$51,686 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital did not concur with two of our findings, with \$768,794 in associated questioned costs (73 claims). The Hospital stated that it was not given an opportunity to discuss and agree on some cases before they were reported as incorrect and added that it intended to appeal the majority of the cases through the appropriate CMS channels. For the other findings, the Hospital provided information on actions that it had taken or planned to take, including appropriate reimbursement.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We gave the Hospital an opportunity to discuss all claims with us before we sent them to the independent medical review contractor. We informed the Hospital that it would have an opportunity to respond further to the CMS action official and that the Hospital maintains its right to appeal the claims.

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
Sutter Medical Center, Sacramento	3
How We Conducted This Review.....	3
FINDINGS	3
Billing Errors Associated With Inpatient Claims	4
Incorrect Billing of Medicare Part A for Beneficiary Stays That Should Have Been Billed as Outpatient or Outpatient With Observation Services	4
Incorrect Diagnosis-Related Groups.....	4
Manufacturer Credits for Replaced Medical Devices Not Obtained or Reported.....	4
Incorrect Billing for Patient Discharges That Should Have Been Billed as Transfers	5
Incorrect Billing as a Separate Inpatient Stay.....	6
Billing Errors Associated With Outpatient Claims.....	6
Manufacturer Credits for Replaced Medical Devices Not Reported.....	6
Incorrect Billing of Number of Units.....	7
Insufficiently Documented Service.....	7
Incorrect Billing of Medicare Part B for Outpatient Services Provided During Inpatient Stays	7
Incorrect Billing of Noncovered Dental Services.....	8
RECOMMENDATIONS	8
HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	8
Hospital Comments.....	8
Office of Inspector General Response	9

APPENDIXES

A: Audit Scope and Methodology10

B: Results of Review by Risk Area12

C: Hospital Comments.....13

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 represented 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 Sutter Medical Center, Sacramento (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. 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

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

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

Hospital Claims at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient transfers,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient same-day discharges and readmissions,
- inpatient claims billed for kyphoplasty services,
- outpatient claims for injectable drugs,
- outpatient surgeries billed with units greater than one,
- outpatient claims billed within the DRG payment window,
- outpatient claims billed for doxorubicin hydrochloride, and
- outpatient dental services.

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).

Sutter Medical Center, Sacramento

The Hospital is an acute-care hospital located in Sacramento, California. Medicare paid the Hospital approximately \$418 million for 26,975 inpatient and 58,763 outpatient claims for services provided to beneficiaries during CYs 2010 through 2012.²

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$2,693,838 in Medicare payments to the Hospital for 182 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 149 inpatient and 33 outpatient claims. Of the 182 claims, 179 claims had dates of service in CYs 2010, 2011, or 2012, and 3 claims (in areas with a higher risk of billing errors, i.e., inpatient short stays and an outpatient surgery billed with units greater than one) had dates of service in CY 2013. 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 and subjected 97 inpatient 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 audit scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 65 of the 182 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 117 claims, resulting in overpayments of \$1,043,958 for CYs 2010 through 2012 (115 claims) and CY 2013 (2 claims). Specifically, 98 inpatient claims had billing errors, resulting in overpayments of \$992,272, and 19 outpatient claims had billing errors, resulting in overpayments of \$51,686. 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 These data came from CMS's National Claims History file.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 98 of 149 selected inpatient claims, which resulted in overpayments of \$992,272.

Incorrect Billing of Medicare Part A for Beneficiary Stays That Should Have Been Billed as Outpatient or Outpatient With Observation 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 78 of 149 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. (Of the 78 claims, 77 had dates of service in CYs 2010, 2011, or 2012, and 1 claim had a date of service in CY 2013.) For 14 of the 78 claims, the Hospital stated that the errors were the result of case management staff not following established procedures. The Hospital also stated that high turnover of case management staff resulted in lower staff expertise and competency. However, the Hospital disagreed that the remaining 64 claims were in error. As a result of the 78 errors, the Hospital received overpayments of \$781,420.³

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 9 of 149 selected inpatient claims, the Hospital billed Medicare with incorrect DRGs. For these claims, to determine the DRG, the Hospital used a diagnosis code that was incorrect or unsupported by the medical record. For six of the nine claims, the Hospital stated that human error caused the incorrect diagnosis code to be selected. However, the Hospital disagreed that the remaining three claims were in error. As a result of the nine errors, the Hospital received overpayments of \$99,065.

Manufacturer Credits for Replaced Medical Devices Not Obtained or Reported

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 cost of the device, 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 correctly bill for a

³ 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 issuance of our report.

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).

Federal regulations state: “All payments to providers of services must be based on the reasonable cost of services ...” (42 CFR § 413.9). The CMS *Provider Reimbursement Manual* (PRM), Pub. No. 15-1, reinforces these requirements in additional detail.⁴

For 7 of 149 selected inpatient claims, the Hospital either (1) did not obtain a credit for a replaced medical device for which a credit was available under the terms of the manufacturer’s warranty (5 claims) or (2) received a reportable medical device credit from a manufacturer but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required (2 claims). The Hospital stated that these errors occurred because of inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result of these errors, the Hospital received overpayments of \$48,392.

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

Federal regulations state that a discharge of a hospital inpatient is considered to be a transfer when the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to home under a written plan of care for the provision of home health services (42 CFR § 412.4(c)). A discharge of a hospital inpatient is also 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 (42 CFR § 412.4(b)). 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 3 of 149 selected inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers. 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 (2 claims) or a transfer to an acute-care hospital (1 claim). However, the Hospital incorrectly coded the discharge status as “discharged to home”; therefore, the Hospital should have received the per diem payment instead of the full DRG payment. In some cases, the Hospital attributed the errors to a lack of comprehensive review of discharge status assignments. As a result of these errors, the Hospital received overpayments of \$45,939.

⁴ The PRM states: “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program” (part I, § 2102.1). Section 2103 further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example: “Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.”

Incorrect Billing as a Separate Inpatient Stay

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 1 of 149 selected inpatient claims, the Hospital incorrectly billed Medicare separately for a related discharge and readmission within the same day. The Hospital stated that human error was the cause of billing two separate inpatient stays. As a result of this error, the Hospital received an overpayment of \$17,456.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 19 of 33 selected outpatient claims, which resulted in overpayments of \$51,686.

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(a)).

CMS guidance explains how a provider should report no-cost and reduced-cost devices under the OPPS.⁵ 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.

For 2 of 33 selected outpatient claims, the Hospital received full credit for a replaced device but did not report the -FB modifier and reduced charges on its claim. The Hospital stated that these errors occurred because of inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result of these errors, the Hospital received overpayments of \$28,142.

⁵ CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3.

Incorrect Billing of 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 accurately” (chapter 1, § 80.3.2.2). The Manual also states: “It is ... of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug ... that was used in the care of the patient” (chapter 17, § 90.2.A). If the provider is billing for a drug, according to the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4...” (chapter 17, § 70). 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 4 of 33 selected outpatient claims, the Hospital submitted claims to Medicare with the incorrect number of units for injectable drugs administered (3 claims with dates of service in CYs 2010 and 2012) or the incorrect number of units of service for a surgical procedure (1 claim with a date of service in CY 2013). The Hospital stated that the incorrect drug units were the result of incorrect calculations and the incorrect surgical units were the result of a data entry error. As a result of these errors, the Hospital received overpayments of \$10,443.

Insufficiently Documented Service

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)).

For 1 of 33 selected outpatient claims, the Hospital billed Medicare for a drug that was not supported by the medical records. The Hospital stated that the drug was administered; however, the nurse did not properly document administration of the drug. As a result of this error, the Hospital received an overpayment of \$6,805.

Incorrect Billing of Medicare Part B for Outpatient Services Provided During Inpatient Stays

Medicare Part A covers certain items and nonphysician services provided to inpatients; consequently, the IPPS rate covers these services (the Manual, chapter 3, § 10.4).

For 11 of 33 selected outpatient claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays that should have been included on its inpatient (Part A) claims to Medicare. The Hospital stated that its controls did not flag these claims in connection with an inpatient stay because they were for recurring services billed at the end of the month. As a result of these errors, the Hospital received overpayments of \$4,932.

Incorrect Billing of Noncovered Dental Services

The Act precludes payment under Medicare Part A or Part B for any expense incurred for items or services related to the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth (§ 1862(a)(12)).

For 1 of 33 selected outpatient claims, the Hospital billed Medicare for dental services that were not covered under Medicare. The Hospital stated that its billing system edits did not prevent billing of dental services. As a result of this error, the Hospital received an overpayment of \$1,364.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$1,043,958, consisting of \$992,272 in overpayments for the incorrectly billed inpatient claims and \$51,686 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital did not concur with two of our findings (areas in which we obtained medical review of 73 claims), with \$768,794 in associated questioned costs. The Hospital described actions taken or planned for each of the other findings. The Hospital's comments are included in their entirety as Appendix C.

HOSPITAL COMMENTS

Regarding our finding on incorrect billing of Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services (an area in which we obtained medical review of 64 claims), the Hospital had the following comments:

- The Hospital stated that it was not given an opportunity to discuss and agree on these cases before they were reported as incorrect. The Hospital added that it intended to appeal the majority of the cases through the appropriate CMS channels.
- The Hospital stated that our third-party medical review contractor conducted the clinical review for the majority of the cases and that it was aware the contractor claim denials “suffer a 72% turnover rate with the Administrative Law Judges ... for inpatient Part A claims.”
- The Hospital noted that a number of the cases involved canceled surgeries but were otherwise appropriate for payment according to CMS billing standards. The Hospital referenced an August 2013 OIG report that stated that hospitals were unclear about the

Medicare requirements for billing canceled inpatient surgeries and that CMS billing requirements were too restrictive. The Hospital stated that it provided appropriate, high-quality medical care to beneficiaries.

Regarding our finding on incorrect DRGs (an area in which we obtained medical review of the nine claims), the Hospital stated that it was not given an opportunity to discuss and agree on these cases before they were reported as incorrect and added that it intended “to aggressively appeal these cases which have been unfairly determined by the OIG to be inappropriately billed.”

Regarding the other findings, the Hospital provided information on actions that it had taken or planned to take, including appropriate reimbursement.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital’s comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether 73 inpatient claims (which included 11 canceled surgeries) met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims in compliance with Medicare requirements. On the basis of the contractor’s conclusions, we determined that the Hospital should have billed the inpatient claims as outpatient or outpatient with observation services (64 claims) and that the Hospital billed inpatient claims with the incorrect DRGs (9 claims).

With respect to the Hospital’s comments that it was not given an opportunity to discuss and agree on these cases before they were reported as incorrect, we gave the Hospital such an opportunity before sending the claims to the medical review contractor. We informed the Hospital that it would have an opportunity to respond further to the CMS action official and that the Hospital maintains its right to appeal the claims. Furthermore, before issuing our draft report, we provided to the Hospital the contractor results. The Hospital agreed that six of nine inpatient claims were billed with the incorrect DRGs and indicated that human error caused the incorrect diagnosis code to be selected, as stated in our report.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$2,693,838 in Medicare payments to the Hospital for 182 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 149 inpatient and 33 outpatient claims. Of the 182 claims, 179 claims had dates of service in CYs 2010, 2011, or 2012, and 3 claims (in areas with a higher risk of billing errors, i.e., inpatient short stays and an outpatient surgery billed with units greater than one) had dates of service in CY 2013.

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 and subjected 97 inpatient claims to focused medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from 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 in April and May 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 CYs 2010 through 2012 and for CY 2013 for 3 claims;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2010 through 2012;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 182 claims (149 inpatient and 33 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;
- used an independent medical review contractor to determine whether 97 selected inpatient claims met medical necessity requirements;
- 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 Over-payments	Value of Overpayments
Inpatient				
Short Stays	108	\$1,062,062	82	\$761,915
Manufacturer Credits for Replaced Medical Devices	27	963,270	8	91,706
Transfers	4	153,711	4	79,769
Claims Billed With High-Severity-Level DRG Codes	7	208,800	2	27,842
Same-Day Discharges and Readmissions	2	31,852	1	17,456
Claims Billed for Kyphoplasty Services	1	13,584	1	13,584
Inpatient Totals	149	\$2,433,279	98	\$992,272
Outpatient				
Manufacturer Credits for Replaced Medical Devices	7	\$165,140	2	\$28,142
Claims for Injectable Drugs	7	32,784	3	7,285
Surgeries Billed With Units Greater Than One	2	29,308	1	5,957
Claims Billed Within the DRG Payment Window	14	19,933	11	4,932
Claims Billed for Doxorubicin Hydrochloride	2	12,030	1	4,006
Dental Services	1	1,364	1	1,364
Outpatient Totals	33	\$260,559	19	\$51,686
Inpatient and Outpatient Totals	182	\$2,693,838	117	\$1,043,958

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



February 18, 2014

FROM: Carrie Owen-Plietz
Chief Executive Officer
Sutter Medical Center, Sacramento
2800 L Street
Sacramento, CA 95816

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

RE: MEDICARE COMPLIANCE REVIEW OF SUTTER MEDICAL CENTER SACRAMENTO

Ms. Ahlstrand:

This communication is in response to your letter dated January 28, 2014 pertaining to the *Medicare Compliance Review of Sutter Medical Center, Sacramento [A-09-13-02024]* draft report. In that letter, you asked us to consider the facts and reasonableness of the report and provide written comments including a statement of concurrence or nonconcurrence along with a statement describing the nature of the corrective action taken or planned for each recommendation.

There are several pertinent areas that we are not in concurrence which represent a significant portion of the reimbursement impact.

The following is a description of our nonconcurrence with respect to the OIG's finding. We have included a description of actions taken or planned, corrective or otherwise, for each of the identified risk areas as appropriate.

BILLING ERRORS ASSOCIATED WITH INPATIENT STAYS

INCORRECT BILLING OF MEDICARE PART A FOR BENEFICIARY STAYS THAT SHOULD HAVE BEEN BILLED AS OUTPATIENT OR OUTPATIENT-WITH-OBSERVATION SERVICES

Based on the OIG's process and timing, Sutter Medical Center Sacramento was not given an opportunity to discuss and agree upon these cases before they were declared and reported as incorrect in the *opinion* of the Office of Audit Services of the OIG. We have reviewed the claims in question and intend to appeal the majority of these cases through the appropriate CMS channels.

We note that, per the OIG's footnote on page 4 of the report, the report claims the entire value of the inpatient claim as being paid in error when, in fact, we have the option of billing Part B services where applicable. As such, the overpayment amount in the OIG's report is an overstatement of paid amounts in question.

We are aware that Maximus Federal Services, the OIG's third-party medical review company, conducted the clinical review for the majority of the cases in question. We are also aware that Maximus Federal Services denials suffer a 72% turnover rate with the Administrative Law Judges (ALJs) for inpatient Part A claims¹. The majority of the cases identified as being incorrectly billed were assessed under our professional utilization review company, Executive Health Resources (EHR). EHR has >90% success rate when appealing Sutter Medical Center Sacramento's inpatient admission claim denials through the ALJ level of appeal.

We note a number of cases revolved around surgeries which had been cancelled, but which were otherwise appropriate for payment according to CMS billing standards. The OIG recently identified reasons for errors in billing cancelled surgical procures.² The first and second reasons for such errors, according to the OIG, were: (1) the *hospitals were unclear* about the Medicare requirements for billing canceled inpatient surgeries; (2) the *Centers for Medicare & Medicaid Services (CMS) billing requirements are too restrictive*, particularly with regard to changing a beneficiary's status from inpatient to outpatient after discharge. Director Tavenner concurred with the recommendation that "CMS strengthen guidance to better explain the Medicare rule

¹ Pub OIG-02-10-00340. Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals, November 2012.

² Medicare Could Save Millions By Strengthening Billing Requirements For Canceled Elective Surgeries, OIG HHS, August 2013, A-01-12-00509

that a clinical condition requiring inpatient care must exist for hospitals to bill for Part A prospective payments for elective surgeries that were canceled..."³ In essence, the OIG is attempting to impose penalties on Sutter Medical Center Sacramento for failure to follow weak, unclear, excessively restrictive guidance. In these cases, Sutter Medical Center Sacramento rendered appropriate, high-quality medical care to beneficiaries. The Medicare Administrative Contractor (MAC) paid the claims without question. It is unreasonable to attempt to enforce ambiguous guidance especially when such guidance was unenforced by the MAC.

INCORRECT DIAGNOSIS-RELATED GROUPS

Based on the OIG's process and timing, Sutter Medical Center Sacramento was not given an opportunity to discuss and agree upon these cases before they were declared and reported as incorrect in the opinion of the Office of Audit Services of the OIG. Therefore, it is our intention to aggressively appeal these cases which have been unfairly determined by the OIG to be inappropriately billed.

MANUFACTURER CREDITS FOR REPLACED MEDICAL DEVICES NOT OBTAINED OR REPORTED

We have reviewed the 7 claims in question and have made the appropriate reimbursement corrections. Medical devices are now being reviewed through a multi-disciplinary channel to ensure that replaced devices are sent to the appropriate manufacturer and that credits are confirmed, received and credited to the appropriate patient account.

INCORRECT BILLING FOR PATIENT DISCHARGES THAT SHOULD HAVE BEEN BILLED AS TRANSFERS

We have reviewed the 3 cases in question and have made the appropriate reimbursement. Audits were conducted in 2013 and will continue into 2014 to evaluate the accuracy of discharge disposition assignment to ensure that claims are paid appropriately.

³ Medicare Could Save Millions By Strengthening Billing Requirements For Canceled Elective Surgeries, OIG HHS, August 2013, A-01-12-00509, Appendix D

INCORRECT BILLING AS A SEPARATE INPATIENT STAY

The single error in this category was a result of human error in determining whether the stays should be billed separately or together based on the patient's underlying condition. Patient discharges and admissions that occur on the same day are evaluated by the billing department to ensure that accounts are combined when they occur on the same day or within the time period required by Medicare guidelines.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT STAYS

MANUFACTURER CREDITS FOR REPLACED MEDICAL DEVICES NOT REPORTED

We have reviewed the 2 claims in question and have made the appropriate reimbursement corrections. Medical devices are now being reviewed through a multi-disciplinary channel to ensure that replaced devices are sent to the appropriate manufacturer and that credits are confirmed, received and credited to the appropriate patient account.

INCORRECT BILLING OF NUMBER OF UNITS

In 2013, we implemented a self-monitoring process to evaluate the administration of infusion drugs to assess appropriate billing and charging procedures. We will also be evaluating units of service for infusion therapy as part of a comprehensive medical record review audit in 2014.

INSUFFICIENTLY DOCUMENTED SERVICE

We have reviewed the claim in question and have made the appropriate reimbursement corrections. The error appears to be an isolated documentation deficiency without patient impact.

INCORRECT BILLING OF MEDICARE PART B FOR OUTPATIENT SERVICES PROVIDED DURING INPATIENT STAYS

We have reviewed the 11 claims in question and have made the appropriate reimbursement corrections. System reports are being generated to identify potential overlap claims between

inpatient and outpatient services to ensure that outpatient services are incorporated into the inpatient payment.

INCORRECT BILLING OF NON-COVERED DENTAL SERVICES

We have reviewed the claim in question and have made the appropriate reimbursement corrections. System edits have been established to stop outpatient dental services before being billed to the Medicare program to ensure appropriate reimbursement for these services.

If you have further questions pertaining to the responses in this letter or the outcome of the review, please feel free to contact Jim Passey, Director, Compliance Auditing & Monitoring, Sutter Health, at 916.614.2543 or via e-mail at PasseyJ@sutterhealth.org. You may also contact me directly at 916.733.8999 or via e-mail at OwenCA@sutterhealth.org. Thank you.

Sincerely,



Carrie Owen-Plietz, MHA, FACHE
Chief Executive Officer
Sutter Medical Center, Sacramento

cc: James Conforti, Regional President, Sacramento-Sierra Region
Jeff Sprague, Senior Vice President, Financial Operations, Sutter Health
Brian Hunter, Vice President, Shared Services, Revenue Cycle, Sutter Health
Ginger Chappell, Vice President, Chief Compliance Officer, Sutter Health
Barbara Martinson, Regional Compliance Officer, Sacramento-Sierra Region
Tory Starr, Care Coordination Executive, Sacramento-Sierra Region