

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF  
SWEDISH MEDICAL CENTER –  
FIRST HILL**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
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**Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services**

**June 2014  
A-09-13-02048**

# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*Swedish Medical Center – First Hill did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of approximately \$937,000 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 Swedish Medical Center – First Hill (Swedish) 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.

Swedish is an acute-care hospital located in Seattle, Washington. Medicare paid Swedish approximately \$389 million for 30,180 inpatient and 143,467 outpatient claims for services provided to beneficiaries during CYs 2010 through 2012.

Our audit covered \$2,340,888 in Medicare payments to Swedish for 257 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 152 inpatient and 105 outpatient claims. Of the 257 claims, 247 claims had dates of service in CYs 2010, 2011, or 2012, and 10 claims (involving inpatient short stays and outpatient claims for injectable drugs) had dates of service in CY 2009.

### WHAT WE FOUND

Swedish complied with Medicare billing requirements for 81 of the 257 inpatient and outpatient claims we reviewed. However, Swedish did not fully comply with Medicare billing requirements for the remaining 176 claims, resulting in net overpayments of \$937,499 for CYs 2010 through 2012 (166 claims) and CY 2009 (10 claims). Specifically, 81 inpatient claims had billing errors, resulting in overpayments of \$763,685, and 95 outpatient claims had billing

errors, resulting in net overpayments of \$173,814. These errors occurred primarily because Swedish 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 Swedish:

- refund to the Medicare contractor \$937,499, consisting of \$763,685 in overpayments for the incorrectly billed inpatient claims and \$173,814 in net 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, Swedish stated that although it generally agreed with our findings and recommendations related to instances in which documentation was insufficient or coding errors occurred inadvertently, it disagreed with some of the narrative used in our report. Regarding our first recommendation, for the inpatient claims that we found should have been billed as outpatient or outpatient with observation services, Swedish stated that it planned to rebill Medicare Part B as soon as it is permitted to do so. Swedish also stated that, as a result, it believes our draft report significantly overstated the overpayment amount associated with these claims. Regarding our second recommendation, Swedish described corrective actions that it had undertaken to address the recommendation.

We acknowledge that Swedish may rebill Medicare for the incorrectly billed inpatient claims; however, the rebilling issue is beyond the scope of our review. CMS issued the final regulations on payment policies (78 Fed. Reg. 160 (Aug. 19, 2013)). Swedish should contact its Medicare contractor for rebilling instructions.

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## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which 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 Swedish Medical Center – First Hill (Swedish) 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. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

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

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

within each APC group.<sup>1</sup> All services and items within an APC group are comparable clinically and require comparable resources.

### **Hospital Claims at Risk for Incorrect Billing**

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

- inpatient short stays,
- inpatient mechanical ventilation,
- inpatient claims paid in excess of charges,
- outpatient claims for injectable drugs, 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).

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

## **Swedish Medical Center – First Hill**

Swedish is an acute-care hospital located in Seattle, Washington. Medicare paid Swedish approximately \$389 million for 30,180 inpatient and 143,467 outpatient claims for services provided to beneficiaries during CYs 2010 through 2012.<sup>2</sup>

### **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$2,340,888 in Medicare payments to Swedish for 257 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 152 inpatient and 105 outpatient claims. Of the 257 claims, 247 claims had dates of service in CYs 2010, 2011, or 2012, and 10 claims (in areas with a higher risk of billing errors, i.e., inpatient short stays and outpatient claims for injectable drugs) had dates of service in CY 2009. 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 Swedish 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.

For the details of our audit scope and methodology, see Appendix A.

### **FINDINGS**

Swedish complied with Medicare billing requirements for 81 of the 257 inpatient and outpatient claims we reviewed. However, Swedish did not fully comply with Medicare billing requirements for the remaining 176 claims, resulting in net overpayments of \$937,499 for CYs 2010 through 2012 (166 claims) and CY 2009 (10 claims). Specifically, 81 inpatient claims had billing errors, resulting in overpayments of \$763,685, and 95 outpatient claims had billing errors, resulting in net overpayments of \$173,814. These errors occurred primarily because Swedish 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.

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

Swedish incorrectly billed Medicare for 81 of 152 selected inpatient claims, which resulted in overpayments of \$763,685.

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<sup>2</sup> These data came from CMS's National Claims History file.

## **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 71 of 152 selected claims, Swedish incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. (Of the 71 claims, 67 claims had dates of service in CYs 2010, 2011, or 2012, and 4 claims had dates of service in CY 2009.) Swedish attributed the patient admission errors primarily to hospital staff not verifying that an inpatient level of care was needed. As a result of these errors, Swedish received overpayments of \$646,789.<sup>3</sup>

## **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 10 of 152 selected claims, Swedish billed Medicare with the incorrect DRGs. For example, for three claims, Swedish billed a DRG for use of a mechanical ventilator for 96 hours or more rather than billing the DRG for use of a mechanical ventilator for fewer than 96 hours. Swedish stated that these errors occurred because of misinterpretation of coding guidelines or human error. As a result of these errors, Swedish received overpayments of \$116,896.

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

Swedish incorrectly billed Medicare for 95 of 105 selected outpatient claims, which resulted in net overpayments of \$173,814.

## **Incorrect Billing of Healthcare Common Procedure Coding System Codes**

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).

For 14 of 105 selected claims, Swedish billed Medicare with incorrect HCPCS codes. (Of the 14 claims, 8 claims had dates of service in CYs 2010, 2011, or 2012, and 6 claims had dates of

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<sup>3</sup> Swedish 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 contractor before issuance of our report.

service in CY 2009.) Swedish stated that the billing system did not select the correct HCPCS codes. As a result of these errors, Swedish received net overpayments of \$128,513. Swedish was overpaid \$128,792 (13 claims) and underpaid \$279 (1 claim).

### **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).

For 81 of 105 selected claims, Swedish billed Medicare with an incorrect number of units for injectable drugs administered. Swedish stated that the billing system had the incorrect unit descriptions for the corresponding HCPCS codes selected. As a result of these errors, Swedish received overpayments of \$45,301.

## **RECOMMENDATIONS**

We recommend that Swedish:

- refund to the Medicare contractor \$937,499, consisting of \$763,685 in overpayments for the incorrectly billed inpatient claims and \$173,814 in net 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, Swedish stated that although it generally agreed with our findings and recommendations related to instances in which documentation was insufficient or coding errors occurred inadvertently, it disagreed with some of the narrative used in our report. Swedish’s comments are included in their entirety as Appendix C.

### **HOSPITAL COMMENTS**

Regarding our first recommendation, for the inpatient claims that we found should have been billed as outpatient or outpatient with observation services, Swedish stated that it planned to rebill Medicare Part B as soon as it is permitted to do so. Swedish also stated that, as a result, it believes our draft report significantly overstated the overpayment amount associated with these

claims. Regarding our second recommendation, Swedish described corrective actions that it had undertaken to address the recommendation.

In addition to addressing our recommendations, Swedish requested clarifications for two issues in our draft report. Specifically, Swedish stated that hospitals do not bill DRGs but report diagnosis codes on inpatient claims to Medicare, which are then grouped by the Medicare contractor to the appropriate DRG. Swedish also stated that seven claims we classified as incorrect DRGs were included in the short stays category.

#### **OFFICE OF INSPECTOR GENERAL RESPONSE**

We acknowledge that Swedish may rebill Medicare for the incorrectly billed inpatient claims; however, the rebilling issue is beyond the scope of our review. CMS issued the final regulations on payment policies (78 Fed. Reg. 160 (Aug. 19, 2013)). Swedish should contact its Medicare contractor for rebilling instructions.

We agree that hospitals provide data elements on claims, such as diagnosis codes, which are grouped by the Medicare contractor into the appropriate DRG. However, hospitals indirectly bill Medicare for the DRG because they provide the data elements that determine the DRG. Regarding the seven claims that we classified as incorrect DRGs, these claims were originally selected from the “Short Stays” risk area shown in Appendix B. Because we organized the report’s findings by the types of billing errors we found, these claims were correctly classified as incorrect DRGs.

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

### **SCOPE**

Our audit covered \$2,340,888 in Medicare payments to Swedish for 257 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 152 inpatient and 105 outpatient claims. Of the 257 claims, 247 claims had dates of service in CYs 2010, 2011, or 2012, and 10 claims (in areas with a higher risk of billing errors, i.e., inpatient short stays and outpatient claims for injectable drugs) had dates of service in CY 2009.

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 Swedish'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 Swedish for Medicare reimbursement.

We conducted our fieldwork at Swedish from December 2012 to September 2013.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Swedish's inpatient and outpatient paid claim data from CMS's National Claims History file;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 257 claims (152 inpatient and 105 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 Swedish 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 Swedish to support the selected claims;
- reviewed Swedish's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with Swedish 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 Swedish 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**

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Billing Errors</b>	<b>Value of Net Overpayments</b>
<b>Inpatient</b>				
Short Stays	144	\$1,396,389	78	\$675,711
Mechanical Ventilation	5	161,056	3	87,974
Claims Paid in Excess of Charges	3	163,159	0	0
<b>Inpatient Totals</b>	<b>152</b>	<b>\$1,720,604</b>	<b>81</b>	<b>\$763,685</b>
<b>Outpatient</b>				
Claims for Injectable Drugs	100	\$598,478	94	\$174,093
Claims Billed With Modifier -59	5	21,806	1	(279)
<b>Outpatient Totals</b>	<b>105</b>	<b>\$620,284</b>	<b>95</b>	<b>\$173,814</b>
<b>Inpatient and Outpatient Totals</b>	<b>257</b>	<b>\$2,340,888</b>	<b>176</b>	<b>\$937,499</b>

**Notice:** The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at Swedish. 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

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April 18, 2014

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

Re: Swedish Medical Center – First Hill’s Response to Draft Report No. A-09-13-02048

Swedish Medical Center  
Ballard

Swedish Medical Center  
Cherry Hill

Swedish Medical Center  
Edmonds

Swedish Medical Center  
First Hill

Swedish Medical Center  
Issaquah

Swedish Medical Center  
Mill Creek

Swedish Medical Center  
Redmond

Dear Ms. Ahlstrand:

We are writing on behalf of Swedish Medical Center-First Hill (“Swedish”) to respond to the OIG’s Draft Audit Report No. A-09-13-02048 entitled *Medicare Compliance review of Swedish Medical Center-First Hill* (“Draft Report”). The Draft Report identified a total alleged overpayment of \$937,499 based on a universe of 257 claims that the OIG specifically selected as being at risk for billing errors, covering a four year period (CY 2009-2012) in which Swedish was paid approximately \$389 million. The bulk of the noted overpayments involved inpatient short stays, with relatively smaller overpayments noted related to DRG assignments on 3 cases and outpatient claims for injectable drugs (either HCPCS or unit errors). We appreciate the opportunity to comment on the Draft Report, to provide input on areas of requested clarification, and to respond to the OIG’s recommendations. As noted below, although Swedish generally agreed with the OIG’s findings and recommendations related to instances where documentation was insufficient or coding errors occurred inadvertently, and took immediately corrective actions related thereto, we disagree with the accuracy of some of the narrative used in the Draft Report.

We would also like to communicate how much we appreciated the opportunity to work collaboratively with your audit staff to review the claims at issue and to reach shared conclusions as to instances where inadvertent errors may have been made. In addition, we wish to emphasize that in all instances noted in the Draft Report, the patients at issue received reasonable and medically necessary services that contributed to their well-being and quality of life. Swedish takes very seriously its compliance with federal healthcare programs, and strives to keep abreast of the ever-changing and increasingly complex regulatory requirements associated with those programs. As a result, we viewed the OIG’s audit in this matter as a learning experience through which we could further staff education and improve upon Swedish’s ongoing compliance program and efforts.

### Background

Swedish Medical Center-First Hill (“Swedish”) is a 624-bed, non-profit acute care hospital that has been serving the Seattle area for over 100 years. Swedish donated over \$35 million in direct charity care to its community in 2012, and has been consistently named by independent research organizations as one of the Seattle area’s best hospitals, with the best doctors, nurses, and care in a variety of specialty areas.

### Response to Recommendations and Request for Clarifications

The Draft Report contained two recommendations, including that Swedish: (1) refund to the Medicare contractor \$937,499 consisting of \$763,685 in overpayments for the incorrectly billed inpatient claims and \$173,814 for the incorrectly billed outpatient claims; and (2) strengthen controls to ensure full compliance with Medicare requirements. Swedish responds to each of these recommendations below:

With respect to the first recommendation, as noted in the Draft Report, on page 4, at footnote 3, there were actually \$646,789 in payments made on 71 inpatient claims that should have been billed as outpatient stays, for which Swedish is eligible to re-bill Medicare Part B for all services (other than those specifically requiring an outpatient order) and/or to appeal the denial. Accordingly, Swedish disputes that there were \$763,685 in overpayments for incorrectly billed inpatient claims (as noted in the Table provided on page 8 of the Draft Report), and notes that this dollar amount is by far the largest portion of the overall alleged overpayment. Swedish will rebill the 71 claims at issue as soon as it is permitted to do so. As a result, Swedish believes that the Draft Report significantly overstates the total amount of overpayment identified in the course of this audit.

With respect to the second recommendation, Swedish agrees that it can work continuously at strengthening internal controls and its compliance activities related to Medicare requirements, and we have undertaken a number of corrective actions in this regard to date, including but not limited to: (1) working with our Medicare contractor to correct claims noted to be in error in the Draft Report; (2) educating physicians and case management staff on documentation requirements for inpatient short stays (which, as you are likely aware, is an area that is often contested between Medicare contractors and hospitals and, as a result, is currently undergoing extensive revisions in CMS’s rules and guidance); (3) updating systems and workflow redesign to avoid recurrence of noted errors in coding or unit errors; and (4) otherwise engaging Swedish leadership, case management, revenue cycle, and compliance staff in a review of internal controls related to the Draft Report findings.

In addition to the foregoing, there is a technical error in the Draft Report for which Swedish requests correction:

- Hospitals do not bill DRGs to Medicare, but rather they report diagnosis codes (ICD-9 codes) on inpatient claims to Medicare, which are then grouped by the Medicare Administrative Contractor to the appropriate DRG. Accordingly, Swedish believes that the references on page 4 to Swedish having billed incorrect DRGs associated with patients on a mechanical ventilator should instead refer to incorrect reporting of the ICD-9 codes associated with the 3 cases at issue. Also, per page 4, there were an additional 7 cases that involved incorrect DRG, but those were included by the OIG in the short stay denial category.

#### Conclusion

Thank you again for the opportunity to work with your audit staff collaboratively during the course of this audit, and to comment on the Draft Report. Swedish respectfully requests that the OIG consider the above-noted comments and requests for clarification, prior to finalizing the Draft Report.

We take great pride in the quality and cost effectiveness of the care we provide to our patients, and we strive for continuous improvement in all areas of our operations, including staff education, ensuring complete and accurate documentation, and maintaining a robust compliance program. We are confident that the corrective measures that Swedish has undertaken in response to this audit will fully address the identified errors. If you have any questions regarding this response or our ongoing compliance efforts, please feel free to contact me.

Sincerely,

/Elise Myers/

Elise Myers  
System Director, Revenue Cycle  
Swedish Health Systems  
747 Broadway  
Seattle, WA 98122