

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT
SURGERIES BILLED BY
TULARE REGIONAL
MEDICAL CENTER**

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



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

**September 2014
A-09-13-02052**

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

Tulare Regional Medical Center did not comply with Medicare requirements for billing outpatient surgeries, resulting in overpayments of approximately \$179,000 over 2 years.

WHY WE DID THIS REVIEW

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. Using computer matching, data mining, and data analysis techniques, we identified hospital claims for outpatient surgeries that were at risk for noncompliance with Medicare billing requirements because they were billed with units of service greater than one, indicating that the surgeries may have been performed multiple times.

Our objective was to determine whether Tulare Regional Medical Center (the Hospital) complied with Medicare requirements for billing outpatient surgeries on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification. The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). In addition, the Manual states: “The definition of service units ... is the number of times the service or procedure being reported was performed” (chapter 4, § 20.4).

The Hospital is an acute-care hospital located in Tulare, California. Medicare paid the Hospital approximately \$8.4 million for 45,401 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012.

Our audit covered \$192,093 in Medicare payments to the Hospital for 10 outpatient claims for surgeries billed with units greater than 1. Initially, we judgmentally selected nine claims as potentially at risk for billing errors. On the basis of our finding, the Hospital identified an additional claim for our review. All 10 claims had dates of service in CY 2011 or 2012.

WHAT WE FOUND

The Hospital did not comply with Medicare billing requirements for all 10 of the outpatient surgery claims that we reviewed, resulting in overpayments of \$178,647. Specifically, the Hospital billed Medicare with an incorrect number of units for cataract and hip surgeries. These errors occurred because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare for service units on outpatient surgery claims.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$178,647 in overpayments for the 10 incorrectly billed outpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements for billing outpatient surgeries.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations and provided information on actions that it had taken to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

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. Using computer matching, data mining, and data analysis techniques, we identified hospital claims for outpatient surgeries that were at risk for noncompliance with Medicare billing requirements because they were billed with units of service greater than one, indicating that the surgeries may have been performed multiple times.

OBJECTIVE

Our objective was to determine whether Tulare Regional Medical Center (the Hospital) complied with Medicare requirements for billing outpatient surgeries on selected claims.

BACKGROUND

The Medicare Program

Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

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

Hospital Outpatient Prospective Payment System

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

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)).

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

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).

Tulare Regional Medical Center

The Hospital is an acute-care hospital located in Tulare, California. Medicare paid the Hospital approximately \$8.4 million for 45,401 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$192,093 in Medicare payments to the Hospital for 10 outpatient claims for surgeries billed with units greater than 1. Initially, we judgmentally selected nine claims as potentially at risk for billing errors. On the basis of our finding, the Hospital identified an additional claim for our review. All 10 claims had dates of service in CY 2011 or 2012.

We limited our review to the line items on the 10 claims for which the Hospital billed outpatient surgeries. We evaluated compliance with selected billing requirements but did not use medical review to determine whether the services were medically necessary. This report 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.

FINDING

The Hospital did not comply with Medicare billing requirements for all 10 of the outpatient surgery claims that we reviewed, resulting in overpayments of \$178,647. Specifically, the Hospital billed Medicare with an incorrect number of units for cataract and hip surgeries. These errors occurred because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare for service units on outpatient surgery claims.

THE HOSPITAL BILLED THE INCORRECT NUMBER OF UNITS FOR OUTPATIENT SURGERIES

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). 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 all 10 claims that we reviewed, the Hospital billed Medicare with an incorrect number of units for outpatient surgeries:

- For nine claims, the Hospital billed cataract surgeries with multiple units per beneficiary visit.
- For one claim, the Hospital billed a hip surgery with multiple units for a beneficiary visit.

However, in each case, only one unit of service was performed. As a result of these errors, the Hospital received overpayments of \$178,647.²

THE HOSPITAL DID NOT HAVE ADEQUATE CONTROLS TO PREVENT INCORRECT BILLING

The billing errors occurred because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare for service units on outpatient surgery claims. Specifically, the Hospital’s claims processing system lacked edits to identify outpatient surgeries billed with the incorrect number of units. As a result, the Hospital submitted these claims to Medicare for processing without review and revision by the billing department.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$178,647 in overpayments for the 10 incorrectly billed outpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements for billing outpatient surgeries.

² Initially, we judgmentally selected nine claims for review and identified overpayments of \$164,555. On the basis of our finding, the Hospital identified an additional claim for our review. We reviewed the additional claim and identified an overpayment of \$14,092.

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred with our recommendations and provided information on actions that it had taken to address our recommendations. The Hospital's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$192,093 in Medicare payments to the Hospital for 10 outpatient claims for surgeries billed with units greater than 1. Initially, we judgmentally selected nine claims as potentially at risk for billing errors. On the basis of our finding, the Hospital identified an additional claim for our review. All 10 claims had dates of service in CY 2011 or 2012.

We limited our review to the line items on the 10 claims for which the Hospital billed outpatient surgeries. 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 line items for outpatient surgeries 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 does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork from February 2013 to January 2014.

METHODOLOGY

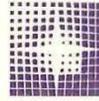
To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient paid claim data from CMS's National Claims History file for CYs 2011 and 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 for detailed review 10 outpatient claims for surgeries billed with units greater than 1, consisting of 9 claims that we initially selected as potentially at risk for billing errors and 1 claim that the Hospital identified on the basis of our finding;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;

- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with Hospital officials to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for all 10 claims; 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: HOSPITAL COMMENTS



Tulare Regional
Medical Center

July 24, 2014

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

Report Number: A-09-13-02052

Dear Ms. Ahlstrand:

I am in receipt of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled *Review of Outpatient Surgeries Billed by Tulare Regional Medical Center*.

On behalf of Tulare Regional Medical Center, I want to thank you for the opportunity to respond to the recommendations on the above-referenced draft report.

A. History

On February 1, 2011, Tulare converted from one hospital-wide computer system to another system. It was confirmed that the previous computer system had an edit that allowed it to adjust the revenue code of 360 from minutes to units of one (1). However, when the computer system was converted, the edit did not transfer to the new system; therefore, resulting in the charge for multiple units.

On April 17, 2011, TRMC outsourced the Business Office to a third party. On December 21, 2011, the Business Department identified an error in the computerized billing system; claims with a revenue code of 360 were not automatically being billed in units. The Business Department contacted their information services provider, who created an automatic edit; it was believed the issue was corrected. However, due to the conversion of TRMC's computer system, the edit did not translate.

On February 15, 2013 and receipt of notification by the OIG Audit Services of the potential billing errors, Tulare ran an audit report for revenue code of 360 for the years 2010 through 2012 for any units greater than one (1). Ten (10) accounts were identified, nine (9) of which had already been identified by the OIG auditing department and one (1) additional account identified through Tulare's audit report.

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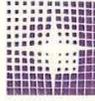
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Tulare Regional Medical Center is a Division of Tulare Local Health Care District



Tulare Regional Medical Center

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B. #1 OIG Recommendation

Tulare Regional Medical Center concurs with the OIG recommendation.

Corrective Action: On March 20, 2013, the nine (9) accounts identified by your office were adjusted to reflect the correct service unit of one (1) and the claim resubmitted. On March 22, 2013, the additional one (1) account was adjusted to reflect the correct service unit of one (1) and the claim was resubmitted. Thereafter, Tulare promptly submitted the revised UB-04 claim forms and adjusted remittance forms to the OIG Audit Services on all corrected claims.

The overpayment for the 10 incorrectly billed outpatient claims was corrected and the overpayment of \$178,647 has been taken back by Medicare.

C. #2 OIG Recommendation

Tulare Regional Medical Center concurs with the OIG recommendation.

Corrective Action: On March 18, 2013, Tulare Regional Medical Center edited its revenue center file to accurately capture the surgical procedures as units of one (1) instead of by minutes. A weekly report was thereafter generated on all surgical cases. Each claim was reviewed to ensure they were accurately billed as units of one (1). The weekly review was conducted for more than 8 weeks, and until the organization was confident the issue had been fully resolved. No further inaccurate claims have been identified.

Please do not hesitate to contact me if you have any questions.

Sincerely,

Julie Gresham

Board of Directors:
Sherrie Bell
Chairwoman and President

Parmod Kumar, MD
Vice Chairman

Richard Torrez
Treasurer

Rosalinda Avitia
Secretary

Laura Gadke
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