

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF LOMA LINDA
UNIVERSITY MEDICAL CENTER
FOR 2011 AND 2012**

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Regional Inspector General
for Audit Services**

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Office of Inspector General

<http://oig.hhs.gov>

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

EXECUTIVE SUMMARY

Loma Linda University Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$671,000 over 2 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 Loma Linda University Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned 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 854-bed acute-care hospital located in Loma Linda, California. Medicare paid the Hospital approximately \$250 million for 9,516 inpatient and 114,294 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012.

Our audit covered \$3,233,603 in Medicare payments to the Hospital for 290 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 216 inpatient and 74 outpatient claims and had dates of service in CY 2011 or CY 2012.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 214 of the 290 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 76 claims, resulting in overpayments of \$670,849. Specifically, 59 inpatient claims had billing errors, resulting in overpayments of \$645,908, and 17 outpatient claims had billing errors, resulting in overpayments of \$24,941. The overpayment amount of \$670,849 includes claims outside of the 3-year recovery period. The billing 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 program \$334,642, consisting of \$309,701 in overpayments for the incorrectly billed inpatient claims and \$24,941 in overpayments for the incorrectly billed outpatient claims that are within the 3-year recovery period;
- work with the Medicare administrative contractor to return up to \$336,207 in overpayments outside of the 3-year recovery period in accordance with the 60-day repayment rule; and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital generally agreed with our findings related to 6 inpatient claims and all 17 outpatient claims, with \$103,924 in associated questioned costs. The Hospital provided information on corrective actions that it had taken or planned to take, which includes refunding inappropriate payments. However, the Hospital disagreed with our findings related to 53 inpatient claims, with \$566,925 in associated questioned costs. For 39 of these claims, the Hospital disagreed that it had incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. For the remaining 14 claims, the Hospital disagreed that it had billed Medicare with incorrect DRGs. The Hospital stated that it reserved its right to appeal the reported findings for the 53 claims.

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 the 53 inpatient claims 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 39 inpatient claims as outpatient or outpatient with observation services and that the Hospital billed the 14 inpatient claims with incorrect DRGs.

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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 Loma Linda University Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

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

Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system. 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 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 claims billed with high-severity-level DRG codes,
- inpatient mechanical ventilation,
- inpatient claims billed for kyphoplasty services,
- inpatient claims related to hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient claims paid in excess of charges,
- inpatient claims with canceled elective surgical procedures,
- outpatient surgeries billed with units greater than one,
- outpatient claims billed for Herceptin,
- outpatient manufacturer credits for replaced medical devices,
- outpatient dental services,
- outpatient intensity-modulated radiation therapy (IMRT) planning services,
- outpatient claims billed for Lupron injections,
- outpatient claims billed for doxorubicin hydrochloride,
- outpatient claims billed with evaluation and management services, and
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day).

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

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 to 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).

Loma Linda University Medical Center

The Hospital is an 854-bed acute-care hospital located in Loma Linda, California. Medicare paid the Hospital approximately \$250 million for 9,516 inpatient and 114,294 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 (audit period).²

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$3,233,603 in Medicare payments to the Hospital for 290 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 216 inpatient and 74 outpatient claims and had dates of service in CY 2011 or CY 2012. 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 162 inpatient and 21 outpatient claims to focused medical review to determine whether the services were medically necessary and met coding requirements. 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.

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

FINDINGS

The Hospital complied with Medicare billing requirements for 214 of the 290 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 76 claims, resulting in overpayments of \$670,849. Specifically, 59 inpatient claims had billing errors, resulting in overpayments of \$645,908, and 17 outpatient claims had billing errors, resulting in overpayments of \$24,941. The overpayment amount of \$670,849 includes claims outside of the 3-year recovery period.³ The billing 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.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 59 of 216 selected inpatient claims, which resulted in overpayments of \$645,908.

Incorrectly Billed as Inpatient

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 44 of 216 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. For 5 of the 44 claims, the Hospital stated that the errors were the result of miscommunication among staff members. For the remaining 39 claims, Hospital officials did not offer a cause because they stated that they believed these claims fell under Medicare’s policy for coverage. As a result of the 44 errors, the Hospital received overpayments of \$517,966.⁴

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

³ Our audit report represents the results for all claims within our audit period. Section 1870(b) of the Act governs the recovery of excess payments. This section provides that excess payments identified are barred from recovery 3 years after the year in which the original payment was made. In addition, the Hospital is responsible for reporting and returning overpayments it identified to its Medicare administrative contractor. The 2010 Patient Protection and Affordable Care Act requires the reporting and return of Medicare overpayments along with written notice of the reason for the overpayment within 60 days after the overpayment was identified (60-day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

⁴ 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.

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 15 of 216 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 1 of the 15 claims, the Hospital stated that human error caused the incorrect diagnosis code to be selected. For the remaining 14 claims, Hospital officials did not offer a cause because they stated that they believed these claims fell under Medicare’s policy for coverage. As a result of the 15 errors, the Hospital received overpayments of \$127,942.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 17 of 74 selected outpatient claims, which resulted in overpayments of \$24,941.

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 to 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 8 of 74 selected outpatient claims, the Hospital billed Medicare with the incorrect number of units of service for surgical procedures (5 claims) or the incorrect number of units for injectable drugs administered (3 claims). The Hospital stated that the software edit in place to prevent this type of error did not automatically adjust the unit quantity to one for operating-room procedure codes, and the second-level review did not catch the error. As a result of these errors, the Hospital received overpayments of \$18,265.

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 1 of 74 selected outpatient claims, the Hospital received full credit for the replaced device but did not report the -FB modifier and reduced charges on its claim. The Hospital stated that this error occurred because a consistent mechanism was not in place to ensure that billing staff received notification of the available credit. As a result of this error, the Hospital received an overpayment of \$3,192.

Incorrect Billing for Noncovered Dental Services

The Act precludes payment under Medicare Part A or Part B for any expenses 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 74 selected outpatient claims, the Hospital billed Medicare for dental services that were not covered under Medicare. The Hospital stated that there was some confusion among the billing staff on what appeared to be ambiguity in Medicare published guidance. According to the Hospital, the billing staff relied on the guidance and believed incorrectly that the services were billed appropriately to Medicare. As a result of this error, the Hospital received an overpayment of \$2,070.

Incorrect Billing for Intensity-Modulated Radiation Therapy Planning Services

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 that certain services should not be billed when they are performed as part of developing an IMRT plan (chapter 4, § 200.3.2).

For 7 of 74 selected outpatient claims, the Hospital incorrectly billed Medicare for services that were already included in the payment for IMRT planning services billed on the same claim. These services were performed as part of developing an IMRT plan and should not have been billed in addition to the HCPCS code for IMRT planning. The Hospital stated that the software edit in place to prevent this type of error did not automatically bundle procedure codes for IMRT planning services. As a result of these errors, the Hospital received overpayments of \$1,414.

⁵ CMS Transmittal 1103, dated Nov. 3, 2006, and the Manual, chapter 4, § 61.3.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$334,642, consisting of \$309,701 in overpayments for the incorrectly billed inpatient claims and \$24,941 in overpayments for the incorrectly billed outpatient claims that are within the 3-year recovery period;
- work with the Medicare administrative contractor to return up to \$336,207 in overpayments outside of the 3-year recovery period in accordance with the 60-day repayment rule; 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 generally agreed with our findings related to 6 inpatient claims and all 17 outpatient claims, with \$103,924 in associated questioned costs. The Hospital provided information on corrective actions that it had taken or planned to take, which includes refunding inappropriate payments. However, the Hospital disagreed with our findings related to 53 inpatient claims, with \$566,925 in associated questioned costs (areas in which we obtained medical review). For 39 of these claims, the Hospital disagreed that it had incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. For the remaining 14 claims, the Hospital disagreed that it had billed Medicare with incorrect DRGs. The Hospital stated that it reserved its right to appeal the reported findings for the 53 claims. 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 (39 of 44 inpatient claims), the Hospital had the following comments:

- The Hospital stated that it has internal controls in place to ensure that inpatient claims submitted to Medicare are billed correctly as inpatient.
- The Hospital stated that 1-day-stay claims that are not on the "Inpatient Only" list are reviewed by a 1-day-stay committee to determine whether the 1-day stay meets inpatient criteria, as well as to assess medical necessity, severity of illness, and intensity of service. The Hospital also stated that the physician representatives of the committee are not part of the treatment team.
- The Hospital stated that, according to Medicare policy for our audit period, an individual was generally admitted as an inpatient if there was an expectation that the individual would remain at least overnight and occupy a bed.

Regarding our finding on incorrect DRGs (14 of 15 inpatient claims), the Hospital stated that it believed these claims fell under Medicare's policy and criteria for correct DRG coding. It also stated that comprehensive coding reviews were carried out and that the principal and secondary diagnosis coding was evaluated against information in the medical record.

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 the 53 inpatient claims 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 39 inpatient claims as outpatient or outpatient with observation services and that the Hospital billed the 14 inpatient claims with incorrect DRGs.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$3,233,603 in Medicare payments to the Hospital for 290 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 216 inpatient and 74 outpatient claims and had dates of service in CY 2011 or CY 2012.

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 162 inpatient and 21 outpatient claims to focused medical review to determine whether the services were medically necessary and met coding requirements.

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 audit from September 2013 to September 2014 and performed our fieldwork at the Hospital's office in San Bernardino, California.

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 2011 and 2012;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers 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 290 claims (216 inpatient and 74 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 and CMS's Medicare administrative contractor to determine whether 162 selected inpatient and 21 selected outpatient claims, respectively, met medical necessity and coding 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;
- calculated the overpayments that were within the 3-year claims recovery period; 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 Over-payments
Inpatient				
Short Stays	173	\$1,975,454	53	\$481,100
Claims Billed With High-Severity-Level DRG Codes	22	434,108	4	104,119
Mechanical Ventilation	2	115,043	1	39,245
Claims Billed for Kyphoplasty Services	1	21,444	1	21,444
Claims Related to Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	11	213,665	0	0
Claims Paid in Excess of Charges	3	134,485	0	0
Claims with Canceled Elective Surgical Procedures	4	39,916	0	0
Inpatient Totals	216	\$2,934,115	59	\$645,908
Outpatient				
Surgeries Billed With Units Greater Than One	11	\$34,538	6	\$12,613
Claims Billed for Herceptin	7	61,863	3	7,722
Manufacturer Credits for Replaced Medical Devices	1	3,206	1	3,192
Intensity-Modulated Radiation Therapy Planning Services	12	143,673	7	1,414
Claims Billed for Lupron Injections	21	27,519	0	0
Claims Billed for Doxorubicin Hydrochloride	3	17,747	0	0
Claims Billed With Evaluation and Management Services	5	6,332	0	0
Claims Billed With Modifier -59	14	4,610	0	0
Outpatient Totals	74	\$299,488	17	\$24,941
Inpatient and Outpatient Totals	290	\$3,233,603	76	\$670,849

Notice: The table on the previous page 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



LOMA LINDA UNIVERSITY
MEDICAL CENTER

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

April 9, 2015

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

Re: OIG Report Number: A-09-13-02056
Medicare Compliance Review of Loma Linda University Medical Center for 2011 and 2012

Dear Ms. Ahlstrand,

Loma Linda University Medical Center appreciates the opportunity to respond to your March 10, 2015 report entitled *Medicare Compliance Review of Loma Linda University Medical Center for 2011 and 2012* (“Report.”) In its Report, the OIG concluded that for the 290 claims judgmentally selected for review, Loma Linda University Medical Center complied with Medicare billing requirements for 214 of those cases. The OIG concluded that Loma Linda University Medical Center did not fully comply with Medicare billing requirements for the remaining 76 claims, resulting in overpayments of \$670,849 representing 59 inpatient claims and 17 outpatient claims.

As part of a strong commitment to compliance with Medicare program requirements, Loma Linda University Medical Center has critical controls in place to prevent and detect billing errors and continuously strives to identify opportunities to strengthen its existing controls. Generally, Loma Linda University Medical Center is in agreement with the OIG’s findings related to outpatient claims. The OIG’s findings related to inpatient claims are mostly focused on One-Day Stays in Acute Care, and generally, Loma Linda University Medical Center is not in agreement with the findings.

Loma Linda University Medical Center has provided below its specific response to the OIG’s findings and recommendations. The response is organized by the alleged billing errors (not risk

areas) identified by the OIG, consistent with the OIG's organization method used in its Report. Please note that the headings, and the summaries of OIG findings discussed below, do not constitute a concurrence by Loma Linda University Medical Center with the OIG's findings. Unless otherwise stated herein, Loma Linda University Medical Center retains the right to appeal any and all findings in the Report.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

A. INCORRECTLY BILLED AS INPATIENT

The OIG found that for 44 of 216 selected inpatient claims, Loma Linda University Medical Center incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services.

Disagree

For 39 of the 44 claims, Loma Linda University Medical Center disagrees with the OIG's findings. Loma Linda University Medical Center has internal controls in place to ensure that inpatient claims submitted to Medicare are billed correctly as inpatient. For the OIG review period to present, one-day stay cases that are not on the "Inpatient Only" list are reviewed on a pre-bill basis by a medical staff appointed multi-disciplinary One-Day Stay committee comprised of at least two physicians, and case management, billing, compliance and legal representatives who review each case based on Medicare policy and determine if the one-day stay meets inpatient criteria as well as medical necessity, severity of illness and intensity of service. The physician representatives of the One-Day Stay Committee are not part of the treatment team.

In assessing whether a case meets inpatient criteria, determinations made by physician representatives of the One-Day Stay Committee control; at least two physician representatives must agree on any finding. Where the physician representatives of the committee determine that a case does not meet inpatient criteria, it is deemed to be Part B only.

For patients whose stays unexpectedly terminate less than 24 hours from admission (e.g., due to improvement, release against orders or death), medical records are reviewed and the admitting physician is contacted to confirm/affirm the physician's inpatient admission determination and to assess medical necessity. If it is determined that the admission was medically necessary, the claim will be submitted as an inpatient claim once coding is completed. The appropriateness of inpatient admission determinations is and should be evaluated based on the information available to the physician at the time of admission; and not whether the patient, for unforeseeable reasons, stayed for less than 24 hours.

Per Medicare policy for the OIG review period 2011/2012, in general, an individual is admitted as an inpatient if there is an expectation that the relevant individual will remain at least overnight and occupy a bed, even though it later develops that the individual can be discharged or transferred to another hospital and not actually use a hospital bed overnight. Prior to the effective date of the two midnight rule, which was not effective during the OIG's review period, physicians were instructed per Medicare policy to use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. As noted above, Loma Linda University Medical Center reserves its right to appeal these 39 claims.

Agree

Loma Linda University Medical Center generally agrees with the OIG's findings for 5 of the 44 claims. As described above, Loma Linda University Medical Center has internal controls in place to ensure that inpatient claims submitted to Medicare are billed correctly as inpatient, including the review of claims on a pre-bill basis through a physician represented, multi-disciplinary One-Day Stay Committee. It is the policy of Loma Linda University Medical Center that admission determinations should be made by a treating physician, taking into account information available at the time of admission and the patient's medical history, if known.

The 5 claims billed in error were determined by the One-Day Stay Committee to be billed as outpatient but were billed incorrectly as inpatient as a result of miscommunication that occurred among members of the One-Day Stay Committee. For these specific claims, the committee failed to select an individual to communicate the determination that the admissions should be billed as Part B to billing staff.

In light of this isolated instance, Loma Linda University Medical Center has strengthened its mechanism for ensuring that One-Day Stay Committee decisions are communicated to billing. Further, Loma Linda University Medical Center has added additional billing representatives to the One-Day Stay Committee, to ensure that committee decisions are effectively communicated to billing staff. In addition, Loma Linda University Medical Center, on a pre-bill and real-time basis, will continue to review short stay cases against Medicare criteria and policy. Loma Linda University Medical Center will continue conducting quality assurance reviews on a pre-bill basis to ensure that claims determined to be outpatient by the physician-represented One-Day Stay Committee are correctly billed as outpatient.

Loma Linda University Medical Center has returned to the Medicare contractor the claim amounts represented by the 5 inpatient claims.

B. INCORRECT DIAGNOSIS-RELATED GROUPS

The OIG found that for 15 of 216 selected inpatient claims, Loma Linda University Medical Center billed Medicare with incorrect DRGs.

Disagree

For 14 of the 15 claims, Loma Linda University Medical Center disagrees with the OIG's findings and believes that these cases fall under Medicare's policy and criteria for correct DRG coding. Comprehensive coding reviews were carried out and the principal and secondary ICD-9 diagnosis coding was evaluated against information in the medical record. Loma Linda University Medical Center reserves its right to appeal these 14 claims.

Agree

Loma Linda University Medical Center generally agrees with the OIG findings for 1 of the 15 claims. With respect to the one claim for which Loma Linda University Medical Center is in agreement, continued internal evaluations will be conducted to assess and improve upon the strength of existing coding policies, procedures and training for coding staff. Loma Linda University Medical Center has returned to the Medicare contractor the claim amount represented by the one inpatient claim.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The OIG found that for 17 of 74 selected outpatient claims, Loma Linda University Medical Center billed Medicare incorrectly for:

- (a) number of units (8 claims),
- (b) replaced medical devices (1 claim),
- (c) non-covered dental services (1 claim), and
- (d) Intensity-Modulated Radiation Therapy planning services (7 claims).

Loma Linda University Medical Center generally agrees with the OIG's findings for the identified 17 of the 74 claims and has put in place supplemental quality control review processes, training, and additional technical and procedural controls where applicable to strengthen existing controls that prevent and detect potential billing errors. Loma Linda University Medical Center has rebilled 16 of the identified 17 claims; for the sole remaining claim, Loma Linda University Medical Center is awaiting remittance advice. Loma Linda University Medical Center will return to the Medicare contractor or refund to the Medicare program the amount of any overpayments that result from the rebillings mentioned above.

Thank you for the opportunity to respond to the findings and recommendations contained in the Report. Loma Linda University Medical Center takes compliance with Medicare program billing requirements seriously and will continue its efforts to evaluate the strength of its billing related processes and take action for overall improvements. Loma Linda University Medical Center appreciates the OIG's efforts during this audit process and will utilize the findings contained in the Report to further strengthen and enhance its overall processes to minimize the potential for billing errors. If you have any questions, please do not hesitate to let us know.

Sincerely,



Kerry L. Heinrich
Chief Executive Officer
Loma Linda University Medical Center