

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
UNIVERSITY OF CALIFORNIA, DAVIS,
MEDICAL CENTER
FOR 2011 THROUGH 2013**

*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
for Audit Services

November 2015
A-09-14-02036

Office of Inspector General

<http://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.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Section 8M 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.

EXECUTIVE SUMMARY

University of California, Davis, Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$2.4 million over 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 University of California, Davis, 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 a 581-bed acute-care hospital located in Sacramento, California. Medicare paid the Hospital approximately \$694 million for 24,580 inpatient and 689,672 outpatient claims for services provided to beneficiaries during CYs 2011 through 2013.

Our audit covered \$4,680,629 in Medicare payments to the Hospital for 231 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 212 inpatient and 19 outpatient claims and had dates of service in CY 2011, CY 2012, or CY 2013.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 130 of the 231 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 101 claims, resulting in overpayments of \$2,430,502 for CYs 2011 through 2013. Specifically, 92 inpatient claims had billing errors, resulting in overpayments of \$1,884,700, and 9 outpatient claims had billing errors, resulting in overpayments of \$545,802. These overpayments occurred primarily because the Hospital's

controls were not adequate to prevent incorrect billing of these Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$2,430,502, consisting of \$1,884,700 in overpayments for the incorrectly billed inpatient claims and \$545,802 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

Prompted by our review, the Hospital has initiated or completed adjustments to or cancellation of certain claims.

HOSPITAL COMMENTS

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

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
University of California, Davis, Medical Center	2
How We Conducted This Review	3
FINDINGS	3
Billing Errors Associated With Inpatient Claims	3
Incorrectly Billed as Inpatient	3
Incorrectly Billed as Separate Inpatient Stays	4
Manufacturer Credits for Replaced Medical Devices Not Reported	4
Incorrect Diagnosis-Related Group	5
Billing Errors Associated With Outpatient Claims	5
Incorrect Billing of Number of Units	5
Incorrect Billing of Medicare Part B for Outpatient Services Provided During Inpatient Stays	6
Manufacturer Credits for Replaced Medical Devices Not Reported	6
RECOMMENDATIONS	6
HOSPITAL COMMENTS	7
APPENDIXES	
A: Audit Scope and Methodology	8
B: Results of Review by Risk Area	10
C: Hospital Comments	11

INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that 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 University of California, Davis, Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

BACKGROUND

The Medicare Program

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

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

Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000. 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 same-day discharges and readmissions,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims for injectable drugs, and
- outpatient claims for outpatient services billed during an inpatient stay.

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).

University of California, Davis, Medical Center

The Hospital is a 581-bed acute-care hospital located in Sacramento, California. Medicare paid the Hospital approximately \$694 million for 24,580 inpatient and 689,672 outpatient claims for services provided to beneficiaries during CYs 2011 through 2013.²

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

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$4,680,629 in Medicare payments to the Hospital for 231 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 212 inpatient and 19 outpatient claims and had dates of service in CY 2011, CY 2012, or CY 2013.³ 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 200 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 130 of the 231 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 101 claims, resulting in overpayments of \$2,430,502 for CYs 2011 through 2013. Specifically, 92 inpatient claims had billing errors, resulting in overpayments of \$1,884,700, and 9 outpatient claims had billing errors, resulting in overpayments of \$545,802. These overpayments occurred primarily because the Hospital's controls were not adequate to prevent incorrect billing of these 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 92 of 212 selected inpatient claims, which resulted in overpayments of \$1,884,700.

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 86 of 212 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.

³ The 212 inpatient claims had dates of service in CY 2011 or CY 2012 or in CY 2013 before October 1, 2013.

The Hospital stated that human error caused the claims to be billed in error. As a result of these errors, the Hospital received overpayments of \$1,848,317.⁴

Incorrectly Billed as Separate Inpatient Stays

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 2 of 212 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 these errors, the Hospital received overpayments of \$21,455.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require reductions in the IPPS payments 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 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.⁵

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.

⁵ 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.”

For 3 of 212 selected inpatient claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required. The Hospital stated that these errors occurred because of a breakdown in its internal process to identify, obtain, and properly report credits from device manufacturers. As a result of these errors, the Hospital received overpayments of \$9,653.

Incorrect Diagnosis-Related Group

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 1 of 212 selected inpatient claims, the Hospital billed Medicare with an incorrect DRG. For this claim, to determine the DRG, the Hospital used a diagnosis code that was unsupported by the medical record. The Hospital stated that human error caused the incorrect diagnosis code to be selected. As a result of this error, the Hospital received an overpayment of \$5,275.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 9 of 19 selected outpatient claims, which resulted in overpayments of \$545,802.

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 19 selected outpatient claims, the Hospital billed Medicare with the incorrect number of units for injectable drugs administered. The Hospital stated that the incorrect billing was the result of human error. As a result of these errors, the Hospital received overpayments of \$486,326.

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 3 of 19 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 (Medicare Part A) claims. The Hospital stated that the incorrect billing was the result of human error. As a result of these errors, the Hospital received overpayments of \$38,326.

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.⁶ 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 19 selected outpatient claims, the Hospital received full credits for replaced devices but did not report the -FB modifier and reduced charges on its claims. The Hospital stated that these errors occurred because of a breakdown in its internal process to identify, obtain, and properly report credits from device manufacturers. As a result of these errors, the Hospital received overpayments of \$21,150.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$2,430,502, consisting of \$1,884,700 in overpayments for the incorrectly billed inpatient claims and \$545,802 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

Prompted by our review, the Hospital has initiated or completed adjustments to or cancellation of certain claims.

⁶ CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3.

HOSPITAL COMMENTS

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$4,680,629 in Medicare payments to the Hospital for 231 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 212 inpatient and 19 outpatient claims and had dates of service in CY 2011, CY 2012, or CY 2013.⁷

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 200 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 audit from June 2014 to June 2015. Our fieldwork included contacting the Hospital in Sacramento, 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 through CY 2013;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2011 through 2013;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 231 claims (212 inpatient and 19 outpatient claims) for detailed review;

⁷ The 212 inpatient claims had dates of service in CY 2011 or CY 2012 or in CY 2013 before October 1, 2013.

- 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 200 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	205	\$3,909,781	87	\$1,853,592
Same-Day Discharges and Readmissions	4	43,433	2	21,455
Manufacturer Credits for Replaced Medical Devices	3	112,306	3	9,653
Inpatient Totals	212	\$4,065,520	92	\$1,884,700
Injectable Drugs	14	\$533,397	4	\$486,326
Outpatient Services Billed During an Inpatient Stay	3	38,326	3	38,326
Manufacturer Credits for Replaced Medical Devices	2	43,386	2	21,150
Outpatient Totals	19	\$615,109	9	\$545,802
Inpatient and Outpatient Totals	231	\$4,680,629	101	\$2,430,502

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

UNIVERSITY OF CALIFORNIA, DAVIS

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

OFFICE OF THE CHIEF EXECUTIVE OFFICER
UC DAVIS MEDICAL CENTER
2315 STOCKTON BOULEVARD
SACRAMENTO, CALIFORNIA 95817

October 8, 2015

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 University of California Davis Medical Center for 2011 to 2013
Office of Inspector General ("OIG") Report Number: A-09-14-02036 (the "Report")

Dear Ms. Ahlstrand:

We write in follow-up to the above-referenced report issued by your office in August 2015, following the OIG's review of 231 judgmentally-selected hospital claims for calendar years 2011 through 2013. We appreciate the opportunity to comment on the validity of the facts and reasonableness of the recommendations in the Report. Our responses to the recommendations, summarized on page six of the Report, are as follows:

Refunds to the Medicare contractor: We concur with the requested refunds. The University of California, Davis, Medical Center (UCDMC) submitted these refunds to the appropriate Medicare contractor between November 7, 2014 and July 7, 2015. Refund verification was provided to the OIG between May 29, 2015 and August 4, 2015.

Strengthen controls to ensure full compliance with Medicare requirements: UCDMC concurs that controls should be in place to ensure full compliance with Medicare requirements. As such, the hospital has employed and will continue to employ significant controls via internal policies and procedures, training, and audit activities to ensure program compliance. Specific to the areas identified in the Report, UCDMC has the following controls in place to ensure Medicare program compliance:

- *Inpatient Claims that Should Have Been Billed As Outpatient/Observation:* The inpatient claims included in the OIG's review were for services provided between 2011 and 2013. Since this time period, the billing rules have changed significantly with the inception of the "two-midnight rule." UCDMC has implemented significant internal controls to ensure compliance with the current Medicare guidance.

More specifically, initially, a patient's admission status (e.g., inpatient, outpatient or observation) is determined by the admitting physician based on his or her clinical judgment of medical necessity. As such, significant efforts have been undertaken to educate providers about the two-midnight rule and related Medicare billing requirements.

Following admission, inpatient orders for Medicare patients undergo a "real-time" review by the utilization review committee which is responsible for validating that a stay meets inpatient criteria, as well as medical necessity. Complicated admissions or cases of non-concurrence will also undergo an independent physician review conducted by a contracted vendor.

In addition to the "real-time" reviews conducted upon admission, there is also a retrospective "two-midnight rule" audit process that requires a final review of all Medicare claims for patients whose total length of time in the facility is two midnights or less. These claims hit a work queue prior to billing and require a final utilization review prior to claims submission.

- *Manufacturer Credits for Replaced Devices Not Recorded:* We concur that for 5 of the selected 231 claims, UCDCM did not properly adjust the claims to reflect the device credits received. Presently, a multidisciplinary workgroup has been formed, comprised of representatives from applicable clinical areas (e.g., cardiology and operative services), Finance and Compliance to review and refine the internal processes for identifying, recording and auditing device credits.
- *Incorrect Billing of Number of Units:* UCDCM concurs that the OIG review identified 4 outpatient claims with the incorrect number of units for injectable drugs administered. Based on this finding, UCDCM's Compliance Department will proactively audit outpatient claims to ensure that the units of drug administration are being billed appropriately. Following this review, an interdisciplinary workgroup will be convened to review the audit findings and implement any necessary corrective actions, including the refunding of any overpayments, if identified.
- *Additional Findings Related to Human Error:* Finally, the OIG identified 1 erroneous claim for discharge/readmission on the same day, 1 incorrect DRG, and 3 claims billed with outpatient services during an inpatient stay. UCDCM found that these errors occurred as a result of human error. All applicable staff, clinical and administrative areas responsible for these limited errors will receive additional training to prevent future re-occurrence.

We appreciate the opportunity to respond to the recommendations contained in the Report and the OIG's efforts during the review process. UCDCM takes its responsibility to comply with the Medicare program requirements very seriously, and will continue to evaluate and strengthen internal processes to decrease billing errors and ensure overall program compliance. If you have any questions about this response, please feel free to contact Teresa Porter, Chief Compliance Officer, at (916) 734-8808.

Sincerely,

Ann Madden Rice
Chief Executive Officer
University of California, Davis, Medical Center