

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
NEBRASKA MEDICAL CENTER
FOR CALENDAR YEARS
2010 AND 2011**

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



Patrick J. Cogley
Regional Inspector General

March 2014
A-07-12-05037

Office of Inspector General

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

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EXECUTIVE SUMMARY

Nebraska Medical Center did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately \$320,000 over more than 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 represents 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.

The objective of this review was to determine whether Nebraska Medical Center (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification. 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.

The Hospital is a 627-bed acute care hospital located in Omaha, Nebraska. Medicare paid the Hospital approximately \$279 million for 180,856 outpatient and 16,357 inpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

Our audit covered \$9,590,001 in Medicare payments to the Hospital for 185 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 71 outpatient and 114 inpatient claims. Of the 185 claims, 178 claims had dates of service in CYs 2010 or 2011, and 7 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 151 of the 185 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 34 claims, resulting in overpayments of \$319,731 for CYs 2010 and 2011 (27 claims) and CY 2009 (7 claims). Specifically, 12 outpatient claims had billing errors, resulting in overpayments of \$170,204, and 22 inpatient claims had billing errors,

resulting in overpayments of \$149,527. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$319,731, consisting of \$170,204 in overpayments for 12 incorrectly billed outpatient claims and \$149,527 in overpayments for 22 incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital concurred with the majority of our findings and recommendations and said that it had filed adjustments for the claims related to the findings with which it concurred.

The Hospital did not concur with our findings on eight inpatient claims, with \$50,278 in associated questioned costs, in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services. The Hospital described its process for internal review of medical necessity and stated that it did not believe that "... the preexisting medical problems and other extenuating circumstances associated with these patients, as documented in the medical records, were fully considered in [OIG's] review of these cases." The Hospital also said that in the case of two of these eight inpatient claims, two external entities had each reviewed one of the claims in question and determined that the claim met the criteria for inpatient admission.

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 eight inpatient claims with which the Hospital disagreed 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 according to Medicare requirements. Based on the contractor's conclusions, we determined, and continue to believe, that the Hospital should have billed the eight inpatient claims as outpatient or outpatient with observation services. We are aware that statutory authority exists under which various external entities, such as the two that the Hospital mentioned, can review the allowability of Medicare claims. However, our own work as the OIG is separate from and independent of the reviews that external entities can conduct. In the case of these eight inpatient claims, our medical review contractor, which itself was separate from and independent of us, determined that these claims had been incorrectly billed.

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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 represents 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 Nebraska Medical Center (the Hospital) complied with Medicare requirements for billing outpatient and inpatient 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 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.

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.

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

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 Claims at Risk for Incorrect Billing

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

- outpatient claims with payments greater than \$25,000,
- outpatient and inpatient claims paid in excess of charges,
- outpatient and inpatient manufacturer credits for replaced medical devices,
- outpatient surgeries billed with units greater than one,
- outpatient claims billed with modifiers -74 and -91,
- outpatient claims billed with modifier -25,
- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient same-day discharges and readmissions,
- inpatient transfers,
- inpatient claims with payments greater than \$150,000, and
- inpatient hospital-acquired conditions and present-on-admission indicator reporting.

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, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 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). In addition, the Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Nebraska Medical Center

The Hospital is a 627-bed acute care hospital located in Omaha, Nebraska. Medicare paid the Hospital approximately \$279 million for 180,856 outpatient and 16,357 inpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$9,590,001 in Medicare payments to the Hospital for 185 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 71 outpatient and 114 inpatient claims. Of the 185 claims, 178 claims had dates of service in CYs 2010 or 2011, and 7 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009.² We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 13 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 scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 151 of the 185 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 34 claims, resulting in overpayments of \$319,731 for CYs 2010 and 2011 (27 claims) and CY 2009 (7 claims). Specifically, 12 outpatient claims had billing errors, resulting in overpayments of \$170,204, and 22 inpatient claims had billing errors, resulting in overpayments of \$149,527. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

² We selected these seven claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 12 of 71 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$170,204.

Insufficiently Documented Units of Service

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 8 out of 71 selected claims, the Hospital submitted the claims to Medicare with units of service that were unsupported in the medical records. The Hospital attributed the overpayments to system or process issues within the pharmacy and the blood bank responsible for the entry of the charges. As a result of these errors, the Hospital received overpayments of \$149,816.

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). 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.³

For 3 out of 71 selected claims, the Hospital received full credit for replaced medical devices but did not report the “FB” modifier and reduced charges on its claims. (Of the three claims, one had a date of service in CY 2009 and two had dates of service in CY 2011.) These overpayments occurred because the Hospital did not have adequate controls to report the appropriate modifier and charges to reflect credits received from manufacturers. As a result of these errors, the Hospital received overpayments of \$13,859.

Services Not Billable to Medicare

Section 1862(a)(12) of the Act states: “No payment may be made under Part A or Part B for any expenses incurred for items or services where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth....”

³ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

For 1 out of 71 selected claims, the Hospital incorrectly billed Medicare for services related to the removal of teeth. The Hospital stated that its staff had reviewed charges before submission and had identified dental procedures as non-covered. However, at the time of submission, human error occurred and the dental-specific services were not moved to a non-covered status on the claim. As a result of this error, the Hospital received an overpayment of \$6,529.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 22 of 114 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$149,527.

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)).

According to Chapter 1, section 10, of the CMS *Benefit Policy Manual*, factors that determine whether an inpatient admission is medically necessary include:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;
- the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- the availability of diagnostic procedures at the time when and at the location where the patient presents.

For 8 out of 114 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Our medical reviewer determined that inpatient admission was not medically necessary for these beneficiaries. The Hospital disagreed that these claims were billed in error. As a result of these errors, the Hospital received overpayments of \$50,278.⁴

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 the issuance of our report.

Incorrectly Billed Diagnosis-Related Group Codes

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 4 out of 114 selected claims, the Hospital billed Medicare for incorrect DRG codes that, specifically, were not supported in the medical records. The Hospital attributed these overpayments to decisionmaking and the manual nature of industry coding, and added that workflows have the potential for human error from time to time. As a result of these errors, the Hospital received overpayments of \$46,669.

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 device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code "FD" (chapter 3, § 100.8).

For 7 out of 114 selected claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate condition and value codes to reduce payment as required. (Of the seven claims, five had dates of service in CY 2009 and two had dates of service in CY 2010.) These overpayments occurred because the Hospital did not have adequate controls to report the appropriate condition and value codes in order to accurately reflect credits it had received from manufacturers. As a result of these errors, the Hospital received overpayments of \$29,788.

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 out of 114 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital stated that the incorrect billings were a result of human error. As a result of these errors, the Hospital received overpayments of \$20,194.

Incorrect Discharge Status

Federal regulations state that a discharge of a hospital inpatient is considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to home under a written plan of care for the provision of home health services (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 1 out of 114 selected claims, the Hospital incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. Specifically, the claim was billed with discharge status code "7" (which denotes discharged against medical advice) when status code "6" (discharged to home under a written plan of care for the provision of home health services) was appropriate. The Hospital stated that, at the time of discharge, status code "7" was accurate because the patient left against medical advice. The Hospital added that a followup appointment was made for the patient prior to discharge and that its staff did not complete a home health agency referral for the patient. Our analysis of the Medicare billing data for this patient indicated that the patient subsequently received home health services after discharge from the Hospital, and we acknowledge that this information would not have been readily available to or accessible by the Hospital's billing staff. Nevertheless, as a result of this error, the Hospital received an overpayment of \$2,598.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$319,731, consisting of \$170,204 in overpayments for 12 incorrectly billed outpatient claims and \$149,527 in overpayments for 22 incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital concurred with the majority of our findings and recommendations and said that it had filed adjustments for the claims related to the findings with which it concurred.

The Hospital did not concur with our findings on eight inpatient claims, with \$50,278 in associated questioned costs, in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services. The Hospital described its process for internal review of medical necessity and stated that it did not believe that "... the preexisting medical problems and other extenuating circumstances associated with these patients, as documented in the medical records, were fully considered in [OIG's] review of these cases."

The Hospital also said that in the cases of two of these eight inpatient claims, two external entities had each reviewed one of the claims in question and determined that the claim met the criteria for inpatient admission. Specifically, one of the claims "... had previously been successfully appealed and subsequently approved at the QIO [Quality Improvement Organization] level through the appeal process as meeting criteria for the inpatient admission." According to the Hospital, a second claim in our sample "... had previously been reviewed through a RAC [recovery audit contractor] audit and was deemed appropriate as an inpatient admission."⁵

The Hospital's comments are included in their entirety as Appendix C.

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 eight inpatient claims with which the Hospital disagreed 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 according to Medicare requirements.

Based on the contractor's conclusions, we determined, and continue to believe, that the Hospital should have billed the eight inpatient claims as outpatient or outpatient with observation services. We are aware that statutory authority exists under which QIOs, RACs, and other external entities can review the allowability of Medicare claims. However, our own work as the OIG is separate from and independent of the reviews that external entities can conduct. In the case of these eight inpatient claims, our medical review contractor, which itself was separate from and independent of us, determined that these claims had been incorrectly billed.

⁵ In the Medicare program, CMS contracts with QIOs in each State, as required by sections 1152—1154 of the Act. By law, the mission of the QIO program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. Section 302 of the Tax Relief and Health Care Act of 2006, P.L. No. 109-432, established the RAC program. The RACs' mission is to identify Medicare improper payments made on claims of health care services provided to Medicare beneficiaries.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$9,590,001 in Medicare payments to the Hospital for 185 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 71 outpatient and 114 inpatient claims. Of the 185 claims, 178 claims had dates of service in CYs 2010 or 2011, and 7 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 (see footnote 2).

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 13 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 outpatient and inpatient 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 the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital from October 2012 to September 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient and inpatient paid claim data from CMS's National Claims History file for CYs 2010 and 2011;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2009 through 2011;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 185 claims (71 outpatient and 114 inpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled 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;
- used an independent medical review contractor to determine whether 13 selected 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 on September 11, 2013.

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
Outpatient				
Claims With Payments Greater Than \$25,000	26	\$825,563	5	\$114,654
Claims Paid in Excess of Charges	4	73,361	3	35,162
Manufacturer Credits for Replaced Medical Devices	4	14,459	3	13,859
Surgeries Billed With Units Greater Than One	17	194,276	1	6,529
Claims Billed With Modifiers -74 and -91	13	75,120	0	0
Claims Billed With Modifier -25	7	63,287	0	0
Outpatient Totals	71	\$1,246,066	12	\$170,204
Inpatient				
Short Stays	13	\$74,528	8	\$50,278
Claims Billed With High Severity Level DRG Codes	54	2,411,221	4	46,669
Manufacturer Credits for Replaced Medical Devices	7	238,872	7	29,788
Same-Day Discharges and Readmissions	8	88,317	2	20,194
Transfers	1	10,944	1	2,598
Claims With Payments Greater Than \$150,000	22	5,226,070	0	0
Claims Paid in Excess of Charges	8	241,532	0	0
Hospital-Acquired Conditions and Present-on-Admission Indicator Reporting	1	52,451	0	0
Inpatient Totals	114	\$8,343,935	22	\$149,527
Outpatient and Inpatient Totals	185	\$9,590,001	34	\$319,731

Notice: The table above illustrates the results of our review by risk area. In it, we have organized outpatient and inpatient 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 with this report's findings.

APPENDIX C: AUDITEE COMMENTS



January 14, 2014

Patrick J. Cogley
Regional Inspector General for Audit Services
US Department of Health and Human Services
Office of Audit Services Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Re: Report Number A-07-12-05037
The Nebraska Medical Center

Dear Mr. Cogley,

On behalf of The Nebraska Medical Center, comments to the report entitled, "Medicare Compliance Review of Nebraska Medical Center for Calendar Years 2010 and 2011" dated December 2013 are being provided with this correspondence. The Nebraska Medical Center is committed to compliance with all applicable regulations required for the provision health care services and we appreciate the opportunity to provide comments to the draft report related to the findings.

As noted in the report, the review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, the sample identified hospital claims that were at risk for noncompliance with Medicare billing requirements. The draft report includes \$9,590,001 in Medicare payments to the Hospital for 185 claims that were selected as potentially at risk for billing errors. These claims consisted of 71 outpatient and 114 inpatient claims. Of the 185 claims, 178 claims had dates of service in CYs 2010 or 2011, and 7 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009. During the timeframe of the audit Medicare paid the Hospital approximately \$279 million for 180,856 outpatient and 16,357 inpatient claims for services provided to beneficiaries during CYs 2010 and 2011 based on CMS's National Claims History data.

The report indicated the Hospital complied with Medicare billing requirements for 151 of the 185 outpatient and inpatient claims reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 34 claims, resulting in overpayments of \$319,731 for CYs 2010 and 2011 (27 claims) and CY 2009 (7 claims). Specifically, 12 outpatient claims had billing errors, resulting in overpayments of \$170,204, and 22 inpatient claims had billing errors, resulting in overpayments of \$149,527.

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We have reviewed the draft audit findings and recommendations and generally agree that the 26 of the 185 claims selected for review reflect inadvertent errors. We do not concur on 8 of the total 34 claims where the report has indicated resulted in overpayments and plan to appeal those claims. Also pursuant to instructions during the audit The Nebraska Medical Center has filed adjustments for the claims identified as not complying with Medicare billing requirements where we concurred with the findings of the review to Wisconsin Physicians Services. Copies of the adjustments were provided to your office during the audit timeframe.

The following are the findings and the recommendations and our responses as a result of the audit.

Errors associated with Outpatient Claims

Insufficiently Documented Units of Service

Observations:

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 8 out of 71 selected claims, the Hospital submitted the claims to Medicare with units of service that were unsupported in the medical records. The Hospital attributed the overpayments to system or process issues within the pharmacy and the blood bank responsible for the entry of the charges. As a result of these errors, the Hospital received overpayments of \$149,816

We concur with the audit findings that the hospital received overpayments totaling \$149,816

The errors were attributed to manual entry and /or inconsistent reconciliation of charge entry and/or system errors. As a revision of the control measures, organizational charge accuracy policies have been reviewed and are in place and departments are accountable for ensuring appropriate charging and reconciliation occurs. Additionally, auditors within our Compliance Department audit sample sets of claims prior to submission. In all instances, the identified the pharmaceutical and apheresis claims did not meet the qualifications for audit prior to claim submission and the identified errors were a result of a system or process issues within the pharmacy and the blood bank responsible for the entry of the charges. We have subsequently reviewed our audit criteria and have processes in place for sampling a broader number of claims.

Manufacturer Credits for Replaced Medical Devices Not Reported

Observations:

For 3 out of 71 selected claims, the Hospital received full credit for replaced medical devices but did not report the "FB" modifier and reduced charges on its claims. (Of the three claims, one had a date of service in CY 2009 and two had dates of service in CY 2011.) These overpayments occurred because the Hospital did not have adequate controls to report the appropriate

modifier and charges to reflect credits received from manufacturers. As a result of these errors, the Hospital received overpayments of \$13,859

We concur with the audit findings that the hospital received overpayments totaling \$13,859

We have determined this to be an area of improvement for our organization. Key controls to prevent this type of error were not sufficient. The organization relied upon a communication from procedural areas to notify when a device credit or replacement device was received. The vendor's method of providing a credit for these devices against our outstanding balance was not readily identifiable by Finance, the charging department, or within the Patient Financial Services department.

We have initiated improvements to our policy for identification of when replacement devices are used and have met with the various departments involved with the process to heighten awareness of the importance in communicating when a replacement device is received. We have also taken steps to implement an edit that will not allow billing until review has occurred to assist in the identification of devices that are provided at a reduced cost.

Services Not Billable to Medicare

Observations:

For 1 out of 71 selected claims, the Hospital incorrectly billed Medicare for services related to the removal of teeth. The Hospital stated that its staff had reviewed charges before submission and had identified dental procedures as non-covered. However, at the time of submission, human error occurred and the dental-specific services were not moved to a non-covered status on the claim. As a result of this error, the Hospital received an overpayment of \$6,529.

We concur with the audit finding that the hospital received a single overpayment for \$6,529

Patient charges were reviewed prior to submission and dental procedures were identified as non-covered; however, at the time of submission of the claim human error occurred and the dental specific services were not moved to non-covered on the claim.

Errors associated with Inpatient Claims

Incorrectly Billed as Inpatient

Observations:

For 8 out of 114 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Our medical reviewer determined that inpatient admission was not medically necessary for these beneficiaries. The Hospital disagreed that these claims were billed in error. As a result of these errors, the Hospital received overpayments of \$50,278.

We do not concur with the audit finding in six (6) instances that the hospital received an overpayment for \$50,278.

We do not concur with the medical necessity of determinations of the OIGs medical reviewer for eight (8) of the claims reviewed and determined as being incorrectly billed as inpatient and plan to appeal once adjustments are requested as a result of the review. At the time of this report a request for adjustments has not been received. While we welcome the opportunities to examine and challenge our current processes, we believe the Hospital's medical necessity determination processes are compliant with Medicare requirements and operating effectively. Additionally, one (1) of the claims under review and identified as bill incorrectly as inpatient had previously been successfully appealed and subsequently approved at the QIO level through the appeal process as meeting criteria for the inpatient admission. A second claim in the sample had previously been reviewed through a RAC audit and was deemed appropriate as an inpatient admission.

CMS guidance states medical necessity is a "complex medical judgment which can be made only after the physician has considered a number of factors." Therefore, those conducting the retrospective reviews via the audit, like their physician counterparts, should consider, in their review of the medical record, any pre-existing medical problems or extenuating circumstances that made admission of the beneficiary medically necessary. It can be appreciated the difficulty of performing a medical necessity retrospective review without the benefit of personally examining a patient at the time the patient presents; however, we don't believe the pre-existing medical problems and other extenuating circumstances associated with these patients, as documented in the medical records, were fully considered in the review of these cases.

As required by the Medicare Conditions of Participation, the Hospital has developed a Utilization Review Plan and has implemented a utilization review process. This process includes concurrent reviews of patient admissions and continued patient stays by utilization review case managers utilizing a widely accepted set of utilization screening criteria, at the time services were rendered for these patients. Currently admission reviews not meeting the widely accepted set of utilization screening criteria are referred to an independent, skilled and experienced group of physician advisors for concurrent evaluation. We recognize the concept of medical necessity is based on a "complex medical judgment" of the patients presentation at the time of service rather than a definitive set of criteria, and with the assistance of our physician advisors, education is provided to our medical staff on these concepts, and the treating physician's role in the utilization review process and the importance of complete medical record documentation on an ongoing basis. We have also implemented and utilize a Clinical Documentation team to provide the treating physician education in the elements required for comprehensive documentation.

Incorrectly Billed Diagnosis-Related Group Codes**Observations:**

For 4 out of 114 selected claims, the Hospital billed Medicare for incorrect DRG codes that, specifically, were not supported in the medical records. The Hospital attributed these overpayments to decision making and the manual nature of industry coding, and added that workflows have the potential for human error from time to time. As a result of these errors, the Hospital received overpayments of \$46,669.

We concur with the audit finding that the hospital received an overpayment for \$46,669.

Organizational key controls include two external audits per year as well as an internal quality monitoring program. During the external audits, a sample of records are reviewed which does not include 100% of all records due to sheer volume. Coder quality scores are expected to be 95% or above to meet standards and include all aspects of coding including diagnoses, procedure codes, POA, etc. Though all care in this sample set was medically necessary, the decision making and manual nature of industry coding workflows has the potential for human error from time to time which is what we have identified in these instances.

Two of the four identified errors did have documentation within the record to indicate the original coded diagnosis; however, a conservative approach was taken and the diagnoses were either removed or changed due to the minimal amount of documentation within the record.

Manufacturer Credits for Replaced Medical Devices Not Reported**Observations:**

For 7 out of 114 selected claims, the Hospital received reportable medical device credits from manufacturers but did not adjust its inpatient claims with the appropriate condition and value codes to reduce payment as required. (Of the seven claims, five had dates of service in CY 2009 and two had dates of service in CY 2010.) These overpayments occurred because the Hospital did not have adequate controls to report the appropriate condition and value codes in order to accurately reflect credits it had received from manufacturers. As a result of these errors, the Hospital received overpayments of \$29,788.

We concur with the audit finding that the hospital received an overpayment for \$29,788.

We have determined this to be an area of improvement for our organization. Key controls to prevent this type of error were not sufficient. The organization relied upon a communication from procedural areas to notify when a device credit or replacement device was received. The vendor's method of providing a credit for these devices against our outstanding balance was not readily identifiable by Finance, the charging department, or within the Patient Financial Services department.

We have initiated improvements to our policy for identification of when replacement devices are used and have met with the various departments involved with the process to heighten

awareness of the importance in communicating when a replacement device is received. We have also taken steps to implement an edit that will not allow billing until review has occurred to assist in the identification of devices that are provided at a reduced cost.

Incorrectly Billed as Separate Inpatient Stays

For 2 out of 114 selected claims, the Hospital billed Medicare separately for related discharges and readmissions that occurred within the same day. The Hospital stated that the incorrect billings were a result of human error. As a result of these errors, the Hospital received overpayments of \$20,194.

We agree with the audit finding that the hospital received an overpayment for \$20,194

Internal controls include a review by HIM Coding Department to assess whether same day admissions are related stays. All same day readmissions are reviewed and a determination made prior to claim submission. In both instances, the determination was made after review that the stays were not related resulting in coding and billing occurring as separate stays.

Both cases are a result of human error.

Incorrect Discharge Status

For 1 out of 114 selected claims, the Hospital incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. Specifically, the claim was billed with discharge status code "7" (which denotes discharged against medical advice) when status code "6" (discharged to home under a written plan of care for the provision of home health services) was appropriate. The Hospital stated that, at the time of discharge, status code "7" was accurate because the patient left against medical advice. The Hospital added that a follow up appointment was made for the patient prior to discharge and that its staff did not complete a home health agency referral for the patient. Our analysis of the Medicare billing data for this patient indicated that the patient subsequently received home health services after discharge from the Hospital, and we acknowledge that this information would not have been readily available to or accessible by the Hospital's billing staff. Nevertheless, as a result of this error, the Hospital received an overpayment of \$2,598.

We agree with the audit finding that the hospital received an overpayment for \$2,598.

At the time of discharge, disposition 07 was accurate as the patient left against medical advice which is clearly documented in the record. A follow up appointment was made for the patient prior to discharge; however no HHA referral was completed prior to the patient leaving. The Nebraska Medical Center would have had no knowledge that the patient subsequently received Home Health Services after discharge from our facility.

Our current controls and process include documentation of patient discharge disposition within the record from social work. Additionally, we have excellent relationships with surrounding

HHA's to notify us if we have referred a patient who subsequently refuses HHA services. The case above would not have been identified by social work or our HHA partners due to the circumstances in which the patient left against medical advice.

The Nebraska Medical Center appreciates the opportunity to respond to the draft audit report from the OIG, and take these findings seriously. We are committed to improving our processes and believe our subsequent interventions will reduce the likelihood of the issues identified in the future. If there are questions following your review of the information provided, please let us know so we may respond appropriately.

Sincerely,

A handwritten signature in black ink, appearing to read 'William S. Dinsmoor', with a stylized flourish at the end.

William S. Dinsmoor
CEO Clinical Enterprise
Nebraska Medical Center

cc. Diana Headley, Manager Compliance and Accreditation, Nebraska Medical Center