DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, Texas 75242

February 12, 2002

Common Identification Number: A-06-01-00028

Garoldine Webb
Vice-President and Director of Government Programs
Blue Cross Blue Shield Oklahoma
1215 South Boulder
P.O. Box 3404
Tulsa, OK 74101-3404

Dear Ms. Webb:

Enclosed are two copies of the U.S. Department of Health and Human services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Audit of Observation Service Billings by PPS Hospitals." The audit period covered claims with dates of service from July 1, 1996 through June 30, 2000. A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the which the department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-06-01-00028 in all correspondence relating to this report.

Sincerely yours,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Dr. James R. Farris, MD
Regional Administrator
Center for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF OBSERVATION SERVICE BILLINGS BY PROSPECTIVE PAYMENT SYSTEM (PPS) HOSPITALS

JANET REHNQUIST
Inspector General

FEBRUARY 2002
A-06-01-00028

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 OIG's Office of Audit Services (OAS) provides all 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 in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

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 in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

NOTICES

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

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Audit Services' (OAS) reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, Texas 75242

February 12, 2002

Common Identification Number: A-06-01-00028

Garoldine Webb
Vice-President and Director of Government Programs
Blue Cross Blue Shield Oklahoma
1215 South Boulder
P.O. Box 3404
Tulsa, OK 74101-3404

Dear Ms. Webb:

This report provides you with the results of our audit work related to outpatient observation services billed by St. Francis Hospital (Hospital) in Tulsa, Oklahoma. The objective of our audit was to determine whether outpatient observation services billed by the Hospital met the Medicare reimbursement requirements. Our review covered service dates between July 1, 1996 and June 30, 2000 (fiscal years 1997-2000).

The Hospital billed Medicare for observation services that did not meet Medicare criteria, resulting in an estimated overpayment of $298,549. We audited a statistical sample of 100 claims that contained observation services and determined that 80 percent of the observation services did not meet Medicare requirements. Primarily these services were unallowable because:

- Physician's orders were not documented in the medical records, or
- The medical records contained a standing order for observation.

We are recommending that the fiscal intermediary: (1) recover the overpayment amount for inappropriate observation billings of $298,549 during the Hospital's fiscal years 1997 through 2000, and (2) instruct the Hospital to develop procedures to correct control problems. The fiscal intermediary should review further observation claims to determine the effectiveness of those procedures. The fiscal intermediary concurred with our recommendations. The complete text of their response is included as Appendix C.

INTRODUCTION

Background

Outpatient observation services (revenue code 0762) are defined as those services furnished by a hospital on its premises to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

According to Section 230.6 (A) of the Hospital Manual and 3112.8(A) of the Intermediary Manual published by the Centers for Medicare and Medicaid Services (CMS):

> Observation services are allowable "…only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests."

Additionally, subpart (E) of both manual sections referenced above defines services that are not covered as outpatient observation. These include:

- services which are not reasonable or necessary for the diagnosis or treatment of the patient (e.g., following an uncomplicated treatment or procedure),
- services which are the result of a standing order for observation following outpatient surgery, and
- services which are ordered as inpatient services by the admitting physician, but billed as outpatient.

Prior to August 2000, hospitals were separately reimbursed for observation services on a reasonable cost basis. Outpatient observation services were charged by number of hours, with the first observation hour beginning when the patient is placed in the observation bed (beginning and ending times are rounded to the nearest hour). With the start of Outpatient Prospective Payment System (OPPS) in August 2000, payment for observation services were no longer reimbursable as a separate payment. They were included as part of the OPPS payment amount for outpatient procedures.

Although CMS will continue to package observation services into surgical procedures and most clinic and emergency visits, starting January 1, 2002, CMS will separately pay for observation services involving three medical conditions. As published in the November 30, 2001, Federal Register, CMS will separately pay for observation services relating to chest pain, asthma, and congestive heart failure.

Objective and Scope

The objective of our audit was to determine whether outpatient observation services billed by the Hospital met the Medicare reimbursement requirements. Our review covered service dates between July 1, 1996 and June 30, 2000 (fiscal years 1997-2000). The Hospital billed Medicare for $1,369,277 in observation charges during fiscal years 1997 through 2000.

Our audit work included:

- interviewing fiscal intermediary and Hospital officials,

- reviewing the medical records to determine whether the observation services met the requirements for Medicare reimbursement, and

- calculating the effect of unallowable observation services.

We initially obtained cost report data showing hospitals in Oklahoma with the highest reported observation costs for a two-year period between fiscal years 1997 and 1999. The Hospital is one of two hospitals with significantly more observation costs than any other hospital in Oklahoma. Further analysis showed that the Hospital had consistently high amounts of observation charges from fiscal year 1997 through 2000. Based upon this analysis, we decided to audit the claims related to the four years.

We identified a statistical sample of 100 Medicare claims with outpatient observation services billed by the Hospital over the four fiscal years (See Appendix A). We reviewed the medical records supporting the observation services drawn in our sample to determine if they met the requirements for Medicare reimbursement.

Our approach in determining whether the observation services were unallowable under Medicare requirements was as follows:

- Medicare requirements do not allow for reimbursement of observation services without a physician's order. However, when medical records were identified without physician's orders (or with standing orders), we identified at least one additional attribute in most cases before determining that the observation services were unallowable. Some of the additional attributes identified included observation following an uncomplicated treatment or procedure, and an inappropriate number of observation hours billed.

- Specific language in the medical records such as "zero complications," or "patient tolerated the procedure well" was identified before determining that a treatment or procedure was uncomplicated, and thus not allowable.

With assistance from fiscal intermediary personnel, each claim in our sample was re-priced to determine the amount Medicare reimbursed for observation. The results of our sample were extrapolated to the universe to identify the Hospital's unallowable charges and Medicare overpayment. We estimated the unallowable charges and overpayment at the lower limit of the 90 percent two-sided confidence interval (See Appendix A). Using the lower limit amount increased our confidence level in estimating the overpayment to 95 percent.

We are issuing this report to the fiscal intermediary because it is responsible for adjudicating claims submitted by the Hospital.

Our audit was conducted in accordance with generally accepted government auditing standards. Our audit was limited to determining the appropriateness of past pre-OPPS claims that contained observation services submitted to CMS for payment. We did not review the internal controls of the fiscal intermediary.

Our audit work was performed at the fiscal intermediary, St. Francis Hospital in Tulsa, Oklahoma, and in our Oklahoma City field office during the period of March 2001 through October 2001.

RESULTS OF AUDIT

The Hospital billed Medicare for a large number of observation services that did not meet the requirements for Medicare reimbursement, resulting in an estimated Medicare overpayment of $298,549 (see Appendix A). Eighty percent of the observation services reviewed did not meet Medicare reimbursement criteria. We audited a statistical sample of 100 claims containing observation services with dates of service from July 1, 1996 to June 30, 2000 (Hospital's fiscal years 1997 through 2000). The Hospital charged Medicare $1,369,277 for all observation services during the four fiscal year period.

The observation services did not meet the Medicare requirements primarily because a physician's order was not documented in the medical records, or the medical records contained standing orders for observation. There were a small number of other claims that were not allowable under the Medicare observation requirements for various reasons. These are discussed in more detail under the section titled, "Other Unallowable Observation Services." (See Appendix B for a table showing the reasons each sample claim was not allowed.)

No Physician's Order In The Medical Records

The supporting medical records for 31 of the 80 (or 39 percent) unallowable claims did not include a physician's order for observation. Medicare criteria state that observation services are allowable only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests.

Standing Order In The Medical Records

The supporting medical records for 40 of the 80 (or 50 percent) unallowable claims included standing orders for observation. Medicare criteria state that standing orders for observation services following outpatient surgery are unallowable. A medical review official at the fiscal intermediary told us that standing orders prior to surgery are also unallowable because it is typically for the convenience of the patient, his or her family, or the physician. To illustrate, several claims contained a physician's order that was written several days prior to the patient's admission to the Hospital for a scheduled outpatient procedure.

Other Unallowable Observation Services

The supporting medical records for 9 of the 80 (or 11 percent) unallowable claims did not meet the requirements for Medicare reimbursement for the following reasons:

- Two claims contained documentation that there were no complications following the outpatient procedure. However, it could not be determined if the observation order was written after the procedure because the time on the order was not documented. A medical review official at the fiscal intermediary reviewed these claims and determined that the observation charges on these claims were not allowable.

- Six claims contained documentation that there were no complications following the outpatient procedure, but the observation was ordered during or immediately following the outpatient procedure. A medical review official at the fiscal intermediary reviewed these claims and agreed that there were no complications following the procedure. Thus, the observation charges on these claims were not allowable.

- One claim was ordered as an inpatient claim, but billed as an outpatient claim. A medical review official at the fiscal intermediary reviewed this claim and agreed that it was not allowable because it was ordered as an inpatient claim.

In addition, the great majority of these 80 observation services had other attributes that did not meet the requirements for reimbursement. These additional attributes included observation following an uncomplicated treatment or procedure and an inappropriate number of observation hours billed.

Observation Following an Uncomplicated Treatment or Procedure

The supporting medical records for 71 of the 80 (or 89 percent) unallowable claims documented that there were no complications following an outpatient treatment or procedure. Medicare observation criteria state that services that are not reasonable or necessary, such as observation following an uncomplicated treatment or procedure, are not allowable for Medicare reimbursement.

Inappropriate Number of Observation Hours Billed

A significant number of the unallowable claims (47 of 80, or 59 percent) had an inappropriate number of observation hours billed. In some claims, the observation time billed by the Hospital began at the time the patient arrived at the hospital for a scheduled procedure, included the time the patient was in the procedure and in a recovery unit, and ended when the patient was discharged. In sample claim 15, for example, the beneficiary entered the hospital a little after 1:00 p.m. and left a little after 11:00 p.m. The hospital billed all 10 hours as observation even though the beneficiary received an outpatient surgical procedure at roughly 3:30 p.m. and then went to the recovery room until 6:00 p.m. Under the observation criteria, time spent prior to a scheduled procedure is not allowable as observation and time spent in surgery and recovery cannot be simultaneously billed as observation. In this case, the five hours from recovery to discharge is the maximum amount of time the hospital could have billed observation services.

> We were unable to determine the appropriate number of hours the Hospital billed for 20 claims. In 16 of the 20 cases, the Hospital reported only one unit of observation service when it was apparent from the amount charged for observation that the Hospital did not report the correct amount of observation hours on the Medicare claim. On sample claim 64, for example, the hospital billed 1 unit (hour) of observation and charged $350 for the service. However, on sample claims 31 and 45 the hospital charged 27 units of observation in both cases and also charged $350 for each service. Fiscal intermediary officials told us that many hospitals were not tracking the number of observation hours or were incorrectly recording several hours of observation during a single day as one unit/day of observation.

Hospital representatives agreed that these 80 claims should not have been billed to Medicare as observation services and cited several factors they believe contributed to the inappropriate observation billing. These factors included: (1) lack of additional training of physicians and staff regarding the terminology to be used when ordering observation services, (2) problems encountered in tracking patient admission types following the implementation of a new electronic medical record system, and (3) problems determining transferred patients' admission status.

Representatives from the Hospital agreed that all of the unallowable claims had inappropriate observation charges. Although Hospital officials chose to submit these claims with observation charges, after seeing our results, they now assert that most of the claims could have been billed as Medicare services other than observation. They believe some claims could have been billed as inpatient claims, and others could have been billed with recovery room charges instead of observation charges.

We do not agree with the Hospital's assertions. Several of the claims that they assert could have been billed as inpatient claims did not contain a physician's order for an inpatient admission. Since the physician did not order an inpatient admission, the Hospital could not have billed them as inpatient claims. Other claims that they now assert could have been billed as recovery room charges were appropriately billed for the actual amount of time that the patient was in the recovery unit. The claims specifically identify the time the patient went to and left from the recovery unit and this was appropriately billed. According to the Manager of Program Integrity at the fiscal intermediary, the Hospital should not be able to add recovery time because the patients were moved from the recovery unit.

CONCLUSIONS AND RECOMMENDATIONS

Medicare reimbursed the Hospital for many outpatient observation services that did not meet the requirements for Medicare reimbursement during the Hospital's fiscal years 1997 through 2000. Eighty percent of the observation services in our sample were not allowable under Medicare criteria. Hospital officials agreed that these claims had inappropriate observation charges. They responded that part of the problem was confusion with their physicians and staff about when observation services could be appropriately billed to Medicare. While we do not agree with the hospital's assertion that these claims are allowable as other Medicare services, the fiscal

intermediary should make this determination. If needed, we will provide additional details for the claims we reviewed.

With the start of OPPS in August 2000, payment for observation services were no longer reimbursable as a separate payment. They were included as part of the OPPS payment amount. However, in the final rule published in the November 30, 2001, Federal Register, for services provided on or after January 1, 2002, CMS will separately pay for observation relating to chest pain, asthma, and congestive heart failure. Unallowable observation services may recur under this new policy.

We recommend that the fiscal intermediary recover the overpayment amount for inappropriate observation billings of $298,549 during the Hospital's fiscal years 1997 through 2000. We further recommend that the fiscal intermediary instruct the Hospital to develop procedures to correct control problems. The fiscal intermediary should review further observation claims to determine the effectiveness of those procedures.

AUDITEE RESPONSE

The fiscal intermediary concurred with our recommendations. In it's formal response to our draft report, the fiscal intermediary will:

- request that the Hospital repay the identified overpayment,
- request a copy of the Hospital's policies and procedures addressing observation services, and
- review observation claims for services on or after January 1, 2002 to evaluate the effectiveness of the policies and procedures.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

APPENDICES

SAMPLE METHODOLOGY RESULTS AND PROJECTION

Objective:

The objective of our review was to determine whether observation services billed by the hospital met the requirements for Medicare reimbursement.

Population:

The population consisted of all paid claims for observation services (revenue code 0762) provided during the hospital's fiscal years 1997 to 2000. The total number of claims with revenue code 0762 was 5,340.

Sampling Unit:

The sample unit is a paid claim that includes revenue code 0762. One claim might have multiple units of revenue code 0762 as the code is billed per hour of service (one unit equals one hour).

Sample Design:

A simple random sample was used for reporting the results of our review.

Sample Size:

A sample size of 100 units was used.

Estimation Methodology:

We used the Office of Audit Services statistical software for unrestricted variable appraisal sampling to project the overpayment associated with the unallowable services. We estimated the overpayment and recommend recovery at the lower limit of the 90 percent two-sided confidence interval.

SAMPLE METHODOLOGY RESULTS AND PROJECTION

Sample Results: The results of our review of 100 sample items are as follows:

Sample Size	Value of Sample Reimbursement	Number of Non-Zero Errors[1]	Value of Reimbursement Errors (Overpayment)
100	7,848.62	78	$6,290.78

Variable Projection:	Overpayment
Point Estimate	$335,928
90% Confidence Interval	
Lower Limit	$298,549
Upper Limit	$373,306

[1] Of the 80 unallowable claims, 2 were Medicare Secondary Payer (MSP) claims. After the primary insurer's payment was calculated, Medicare's share of the payment was zero.

SCHEDULE OF UNALLOWABLE SERVICES
100 CLAIM SAMPLE, ST. FRANCIS HOSPITAL
JULY 1, 1996, THROUGH JUNE 30, 2000

Claims With No Physician Orders			
Sample Numbers	No Complications	Inpatient As Outpatient	Inappropriate Hours
2	X		X
3		X	X
4	X		X
9	X		
16	X		X
25	X		
27	X		
29	X		X
32	X		
36			X
37			X
38	X		
40	X		
41	X		X
48	X		
60	X		X
63	X		
65			
67	X		X
70	X		
73	X		X
76	X		X
77			
80	X		X
83	X		
88	X		
92	X		
93	X		X
95	X		
98	X		X
100			
Total Claims = 31			

Claims With Standing Orders			
Sample Numbers	No Complications	Inpatient As Outpatient	Inappropriate Hours
1	X		X
6	X		
7	X		X
8	X		X
10	X		X
12	X		X
13	X		X
14	X		
15	X		X
18	X		X
19	X		X
20	X		X

SCHEDULE OF UNALLOWABLE SERVICES (CONTINUED)

Claims With Standing Orders (continued)			
Sample Numbers	**No Complications**	**Inpatient As Outpatient**	**Inappropriate Hours**
22	X		X
23	X		X
24	X		X
26	X		
31	X		X
33		X	
35	X		
39	X		X
42	X		
44	X	X	
45	X		X
50	X		X
52	X		
53	X		
55	X		X
61	X		X
64	X		
66	X		X
68	X		X
71			X
74	X		X
81	X		X
86	X		
89	X		X
90	X		
94	X		
96	X		
97	X		
Total Claims = 40			
Claims With Other Unallowable Observation Services[1]			
Sample Numbers	**No Complications**	**Inpatient As Outpatient**	**Inappropriate Hours**
51		X	X
57	X		X
62	X		
69	X		X
72	X		X
75	X		X
78	X		X
84	X		
91	X		X
Total Claims = 9			
Total Number of Unallowable Claims = 80			

[1] See p.5 of the report for explanations.

HCFA
Health Care Financing Administration

Medicare
Part A

GAROLDINE (GERRI) WEBB
Vice President and Director
Government Programs
Telephone: (918) 560-2090
Fax: (918) 560-5506

January 18, 2002

James Hargrove, Audit Manager
U.S. Department of Health and Human Services
3625 N.W. 56th Street, Room 101
Oklahoma City, Oklahoma 73112

Dear Mr. Hargrove:

RE: Comments on Draft Report on Audit of Observation Services
Common Identification Number: A-06-01-00028

Thank you for the opportunity to comment on the referenced draft report. Observation Service reimbursement is quite complex and we appreciate the conciseness of the audit procedures followed by your staff.

1. We will develop an overpayment letter requesting repayment of the identified overpayment. We will need the sample information used to develop the overpayment in order to provide the specific information in our letter to the provider.

2. We agree that the provider must take corrective action to ensure that observation services are correctly billed to Medicare for services on or after January 1, 2002. We will request a copy of the provider's policies and procedures developed to address the billing errors for observation.

3. We will review observation claims for services on or after January 1, 2002 to evaluate the effectiveness of the observation policies and procedures. This review will consist of a probe review sometime in the second or third quarter of calendar year 2002.

If you have any questions regarding our comments, please contact Mark Smith at 918-560-3312.

Sincerely,

Garoldene Y. Webb

Garoldine Y. Webb, Vice President
Government Programs

cc: Terry Bird, CMS Contractor Manager
Mark Smith, BCBSOK Medicare Program Integrity Manager