DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza
Room 171
San Francisco, CA 94102

May 29, 2003
Report Number: A-09-03-00031

Mr. Joseph C. Luevanos
Chief Financial Officer
Orthopaedic Hospital
2400 South Flower Street
Los Angeles, California 90007

Dear Mr. Luevanos:

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 " Review of Medicare Outlier Payments Made to Orthopaedic Hospital for the period August 1, 2000 through December 31, 2001." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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.

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To facilitate identification, please refer to report number A-09-03-00031 in all correspondence relating to this report.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:
Regional Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
75 Hawthorne Street, 4th Floor
San Francisco, California 94105

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF MEDICARE OUTLIER PAYMENTS MADE TO ORTHOPAEDIC HOSPITAL FOR THE PERIOD AUGUST 1, 2000 THROUGH DECEMBER 31, 2001

JANET REHNQUIST
Inspector General

MAY 2003
A-09-03-00031

Office of Inspector General

http://oig.hhs.gov

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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 HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

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May 29, 2003
Report Number: A-09-03-00031

Mr. Joseph C. Luevanos
Chief Financial Officer
Orthopaedic Hospital
2400 South Flower Street
Los Angeles, California 90007

Dear Mr. Luevanos:

This report provides you the results of our review of the outpatient prospective payment system (OPPS) claims with Medicare outlier payments made to Orthopaedic Hospital (the hospital), Los Angeles, California, for services provided August 1, 2000 through December 31, 2001. The objective of our review was to determine whether the hospital's outpatient claims with outlier payments were billed to Medicare in accordance with applicable laws and regulations.

Based on our review of 35 judgmentally selected OPPS claims, we found the hospital incorrectly billed Medicare on 7 claims. Due to the billing errors, the hospital was underpaid a net amount of $15,240. The billing errors occurred because the hospital did not correctly implement the OPPS requirement concerning the number of units to use when billing Medicare for drugs. We recommend that the hospital strengthen its billing procedures and resubmit the claims found to be in error to the fiscal intermediary (FI) for adjustments.

In a written response to our draft report, the hospital concurred with our findings and recommendations. The hospital's comments are attached in their entirety as an appendix to this report.

INTRODUCTION

BACKGROUND

The Balanced Budget Act of 1997 mandated that the Centers for Medicare and Medicaid Services (CMS) implement a Medicare prospective payment system for hospital outpatient services. As such, CMS implemented the OPPS. With the exception of certain services, CMS calculated payments for services under OPPS by packaging services into Ambulatory Payment Classification (APC) groups. Services within an APC were determined to be clinically similar and required similar resources. In this respect, some services, such as anesthesia, supplies,

certain drugs, and use of recovery and observation rooms are packaged in APCs and not paid separately. The OPPS became effective for outpatient services provided on or after August 1, 2000.

The Balanced Budget Refinement Act of 1999 established major provisions that affected the development and implementation of OPPS. One of the provisions required that CMS make outlier payments to hospitals to cover some of the additional costs of providing outpatient care that exceeded established thresholds.

Hospitals were required to submit Medicare claims to the FI on standard UB-92 claim forms. Claim information reported by hospitals on the UB-92 needs to be correct to ensure proper and timely Medicare reimbursement. Incorrect data, including incorrect billable units, may cause the Medicare claims processing system to generate outlier payments that are not warranted.

At the time of our audit, the hospital, founded in 1922 and located in Los Angeles, California, was the largest privately owned orthopaedic specialty hospital in the Western United States. The hospital provided a wide spectrum of orthopaedic treatments and services, including hemophilia and blood disorders. The objective of the hospital's Hemophilia Center, established in 1962, was the diagnosis and optimal management of bleeding disorders and their complications.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine whether the hospital's outpatient claims with outlier payments were billed to Medicare in accordance with applicable laws and regulations. Our review included Medicare OPPS claims with outlier payments made to the hospital for services rendered during the period August 1, 2000 through December 31, 2001.

To accomplish our objective, we:

- Used CMS's National Claims History file to identify 93 Medicare OPPS claims with outlier payments totaling $699,627 made to the hospital for services rendered during the period August 1, 2000 through December 31, 2001. For each of the 93 claims, the outlier payment was $2,000 or more and represented at least 90 percent of the total claim paid amount.

- Selected a judgmental sample of 35 claims from the 93 claims identified based on a risk analysis. For the 35 claims, Medicare payments totaled $316,811. Of this amount, $313,533 represented outlier payments.

- Obtained an understanding of the hospital's procedures for accumulating charges, preparing outpatient bills, and submitting Medicare claims.

We limited consideration of the internal control structure to those controls concerning the accumulation of charges, the preparation of bills for outpatient services, and the submission of

Medicare claims. The objective of our review did not require an understanding or assessment of the complete internal control structure at the hospital.

Our audit was performed from October 2002 through March 2003 with fieldwork conducted at the hospital in Los Angeles, California and the FI in Camarillo, California.

FINDINGS AND RECOMMENDATIONS

In recognizing that billing errors had occurred, the hospital performed an internal review of its OPPS claims prior to our audit. Of the 35 claims reviewed during our audit, the hospital had already reviewed and resubmitted 33 claims to Medicare for payment adjustments.

Based on a review of 35 OPPS claims judgmentally selected for review, we found the hospital incorrectly billed Medicare on 7 claims which included:

- 5 claims that were part of the hospital's internal review and resubmitted with computation errors or services previously billed which resulted in overpayments totaling $5,020.

- 2 claims submitted using the number of vials rather than the actual number of immunizing units (IU) administered to the patients which resulted in underpayments totaling $20,260. These claims were not part of the hospital's internal review.

In total, we determined that the hospital was underpaid a net amount of $15,240. We recommend that the hospital strengthen its billing procedures and periodically monitor claims to ensure services are billed to Medicare correctly. Also, the hospital should resubmit the claims found to be in error to the FI for payment adjustments.

In a written response to our draft report, the hospital concurred with our findings and recommendations. The hospital's comments are summarized below and attached in their entirety as an appendix to this report.

THE HOSPITAL'S INTERNAL REVIEW OF OPPS CLAIMS

Based on an internal review prior to our audit, the hospital determined that it had incorrectly billed Medicare for outpatient services under OPPS. The billing errors occurred because the hospital did not correctly implement the OPPS requirement concerning the number of units to use when billing Medicare for drugs.

Prior to OPPS, the billing unit did not impact the amount paid because the Medicare payment was calculated using billed charges rather than the number of billing units. When OPPS was implemented, Medicare regulations required providers to include the number of units that reflected the actual dosage of IUs of the drug furnished to the patient on the claim.

When the hospital began receiving payments under the new OPPS, it noticed that the amounts paid on the claims were low. With the assistance of the FI and a consultant, the hospital determined its billing procedures had not been revised to identify billing units as the actual dosage of IUs of the drug furnished to the patient. Instead, the hospital was using the number of vials as the billing unit. To correct the problem, the hospital reviewed most of its previously billed OPPS claims, canceled incorrectly billed claims, and resubmitted them to the FI.

The table below illustrates the impact on the Medicare payment amounts when vials rather than IUs were used as the billing unit.

Description	**Initial Claim** (Billing vials as units)	**Resubmitted Claim** (Billing IUs as units)
Units Billed	20 vials	23,400 IUs
APC Payment	$ 15	$ 17,784
Outlier Payment	$ 11,157	0
Total Medicare Payment	**$ 11,172**	**$ 17,784**

For the claim depicted in the table, the hospital initially used a vial as the billing unit for the hemophilia drug dispensed. By billing 20 vials, the hospital received a total Medicare payment of $11,172, which included an APC payment and an outlier payment. For this claim, the hospital should have used IU as the billing unit. The medical records indicated that each vial contained 1,170 IUs. By resubmitting the claim with the correct number of billing units, 23,400 IUs, the hospital received a total Medicare payment of $17,784, which included only an APC payment and no outlier payment was generated. Thus, understating the billing units on the OPPS claim resulted in an underpayment of $6,612.

OIG REVIEW OF OPPS CLAIMS

We reviewed 35 OPPS claims and found that the hospital incorrectly billed the Medicare program on 7 claims. In total, the hospital was underpaid $15,240. It overclaimed $5,020 of Medicare reimbursement on five claims, and underclaimed $20,260 of Medicare reimbursement on two claims.

Medicare Reimbursement Overclaimed

For five OPPS claims, the hospital overclaimed $5,020 of Medicare reimbursement. The hospital erroneously computed the number of IUs for the hemophilia drug dispensed when resubmitting four claims to the FI. As a result, the hospital received overpayments totaling $4,576. For the remaining claim, the hospital was reimbursed for units of the drug Monarc-M that had already been billed and reimbursed on a previous claim. The duplication resulted in an overpayment of $444.

Medicare Reimbursement Underclaimed

For two OPPS claims, the hospital underclaimed $20,260 of Medicare reimbursement. The two claims were inadvertently overlooked by the hospital during its internal review of OPPS claims. The claims were billed using the number of vials rather than actual IUs administered. The billing units were, therefore, understated resulting in the lower APC payments and unnecessary outlier payments as depicted in the table above.

RECOMMENDATIONS

We recommend that the hospital

- Strengthen its billing procedures and periodically monitor claims to ensure that services are billed to Medicare correctly.

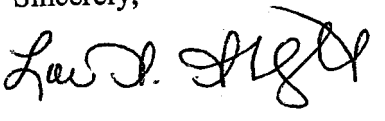
- Resubmit the claims found to be in error to the FI for payment adjustments.

THE HOSPITAL'S COMMENTS

In a letter dated May 7, 2003, the hospital concurred with our recommendations by indicting that (1) the billing procedures have been modified and selected accounts will be reviewed monthly, and (2) the seven claims found in error have been corrected and resubmitted to the FI for adjustment.

To facilitate identification, please refer to report number A-09-03-00031 in all correspondence relating to this report.

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

APPENDIX

May 7, 2003

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health & Human Services
Region IX
50 United Nations Plaza
Room 171
San Francisco, Ca 94102

Re: Response to Medicare Outlier Payment Report Number: A-09-03-00031

Dear Ms. Ahlstrand:

Orthopaedic Hospital concurs with the findings and recommendations contained in the above referenced report for the period from August 1, 2000 through December 31, 2001. The report made two recommendations regarding billing procedures and resubmittal of claims found to be in error. The following actions have been taken on these two recommendations:

Billing procedures have been modified to bill for the blood products in units consistent with discussions between the FI and the hospital. Selected accounts will be reviewed by the Director of Pharmacy monthly to insure that the units ordered and used are the same as the billed quantities.

The seven (7) claims found in error have been corrected and resubmitted to the FI for adjustment.

We would like to thank the members of the audit team for their diligent efforts and cooperation. Please do not hesitate to contact me at (213) 742-1130 if you have any questions or require additional information.

Sincerely,

Joseph C. Luevanos
Chief Financial Officer

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ACKNOWLEDGMENTS

This report was prepared under the direction of Lori A. Ahlstrand, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Jerry McGee, *Audit Manager*
Danuta Biernat, *Senior Auditor*
Dennis Ensminger, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.