DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

May 17, 2012

TO: Peter Budetti
Deputy Administrator and Director
Center for Program Integrity
Centers for Medicare & Medicaid Services

Deborah Taylor
Director and Chief Financial Officer
Office of Financial Management
Centers for Medicare & Medicaid Services

FROM: /Brian P. Ritchie/
Assistant Inspector General for the
Centers for Medicare & Medicaid Services Audits

SUBJECT: Medicare Compliance Review of New York Downtown Hospital for the Period July 1, 2008, Through December 31, 2010 (A-02-11-01022) and Medicare Compliance Review of the University of Colorado Hospital for Calendar Years 2008 and 2009 (A-07-11-05009)

Attached, for your information are advance copies of two of our final reports for hospital compliance reviews. We will issue these reports to New York Downtown Hospital and University of Colorado Hospital within 5 business days.

These reports are part of a series of the Office of Inspector General's hospital compliance initiative, designed to review multiple issues concurrently at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov, or your staff may contact the respective Regional Inspectors General for Audit Services:

New York Downtown Hospital
James P. Edert, Regional Inspector General for Audit Services, Region II
(212) 264-4620, email – James.Edert@oig.hhs.gov

University of Colorado Hospital
Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII
(816) 426-3591, email – Patrick.Cogley@oig.hhs.gov

Attachment

cc:
Daniel Converse
Office of Strategic Operations and Regulatory Affairs,
Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION II
JACOB K. JAVITS FEDERAL BUILDING
26 FEDERAL PLAZA, ROOM 3900
NEW YORK, NY 10278

May 22, 2012

Report Number: A-02-11-01022

Mr. Frank Vutrano
Chief Financial Officer
New York Downtown Hospital
59 Maiden Lane, 6th Floor
New York, NY 10038

Dear Mr. Vutrano:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of New York Downtown Hospital for the Period July 1, 2008, Through December 31, 2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Brenda Tierney, Audit Manager, at (518) 437-9390, extension 222, or through email at Brenda.Tierney@oig.hhs.gov. Please refer to report number A-02-11-01022 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 355
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF NEW YORK DOWNTOWN HOSPITAL FOR THE PERIOD JULY 1, 2008, THROUGH DECEMBER 31, 2010

Daniel R. Levinson
Inspector General

May 2012
A-02-11-01022

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. 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.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays 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, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

New York Downtown Hospital (the Hospital) is a 180-bed acute care hospital located in New York, New York. Based on CMS's National Claims History data, Medicare paid the Hospital approximately $93 million for 7,099 inpatient and 25,180 outpatient claims for services provided to beneficiaries during the period July 1, 2008, through December 31, 2010.

Our audit covered $7.6 million in Medicare payments to the Hospital for 127 inpatient and 59 outpatient claims that we identified as potentially at risk for billing errors. These 186 claims had dates of service from July 1, 2008, through December 31, 2010.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 128 of the 186 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 58 selected inpatient and outpatient claims, resulting in overpayments totaling $423,978 for the period July 1, 2008, through December 31, 2010. Specifically, 22 inpatient claims had billing errors resulting in overpayments totaling $423,978, and 36 outpatient claims had billing errors that did not result in any overpayments.

Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and its staff did not fully understand the Medicare billing requirements.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $423,978 and

- strengthen controls to ensure full compliance with Medicare requirements.

NEW YORK DOWNTOWN HOSPITAL COMMENTS

In written comments on our draft report, the Hospital agreed with our findings and described actions that it has taken or planned to take to address them. The Hospital did not agree with our characterizing one outpatient claim that the Hospital incorrectly billed as an inpatient claim as being due to human error. The Hospital stated that the error occurred because its billing department was not notified of the patient's change in status. The Hospital also stated that although documentation was missing for the one inpatient claim with hospital-acquired conditions, it believes that all services provided were appropriate. The Hospital's comments appear in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.[1]

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays 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, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.[2] The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to

[1] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

[2] In 2009, SCHIP was formally redesignated as the Children's Health Insurance Program.

identify and group the services within each APC group.[3] All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Payments at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. The types of payments to hospitals reviewed by this and related audits included payments for claims billed for:

- inpatient same-day discharges and readmissions,
- inpatient short stays,
- inpatient claims paid in excess of charges,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims with payments greater than $150,000,
- outpatient claims billed during an inpatient stay,
- outpatient evaluation and management service claims billed with surgical services,
- outpatient claims billed with modifier -59,
- outpatient claims paid in excess of charges, and
- outpatient and inpatient manufacturer credits for replaced medical devices.

For the purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas."

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and 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." In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment.

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

New York Downtown Hospital

New York Downtown Hospital (the Hospital) is a 180-bed acute care hospital located in New York, New York. Based on CMS's National Claims History data, Medicare paid the Hospital approximately $93 million for 7,099 inpatient and 25,180 outpatient claims for services provided to beneficiaries during the period July 1, 2008, through December 31, 2010.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims**.**

Scope

Our audit covered $7,619,221 in Medicare payments to the Hospital for 127 inpatient and 59 outpatient claims that we identified as potentially at risk for billing errors. These 186 claims had dates of service from July 1, 2008, through December 31, 2010.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We based our review on selected billing requirements and did not include a focused medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review enabled us to establish 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 May through July 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for the period July 1, 2008, through December 31, 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 186 claims (127 inpatient and 59 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled 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 sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Hospital officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 128 of the 186 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 58 selected inpatient and outpatient claims, resulting in overpayments totaling $423,978 for the period July 1, 2008, through December 31, 2010. Specifically, 22 inpatient claims had billing

errors resulting in overpayments totaling $423,978, and 36 outpatient claims had billing errors that did not result in any overpayments.

Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and its staff did not fully understand the Medicare billing requirements.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 22 of the 127 sampled inpatient claims that we reviewed.[4] These errors resulted in overpayments totaling $423,978.

Inpatient Short Stays

Section 1862(a)(1)(A) of the Act states that 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." Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if, "with respect to inpatient hospital services ... which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment …."

For 11 of the 34 sampled claims, the Hospital incorrectly billed Medicare Part A for inpatient claims that should have been billed as outpatient or outpatient-with-observation services (10 claims) or did not have a valid physician order to admit the beneficiary for inpatient care (1 claim). The Hospital stated that it provided the services in an inpatient setting because, at the time, Hospital staff believed it was necessary for the patients' care. As a result, the Hospital received overpayments totaling $107,662.[5]

Inpatient Same-Day Discharges and Readmissions

The Manual, chapter 3, section 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 on a single claim.

[4] The total number of claims reviewed in each of the error categories (94 sample claims) does not equal the total number of inpatient claims reviewed (127 sample claims) because not all of the categories we reviewed contained errors.

[5] The Hospital may bill Medicare Part B for a limited range of services related to some of the 10 incorrect Medicare Part A short-stay claims billed as outpatient or outpatient-with-observation services. 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 or adjudicated by the MAC prior to the issuance of our report.

Section 1814(a)(3) of the Act states that payment for services furnished to an individual may be made only to providers of services that are eligible and only if, "with respect to inpatient hospital services … which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment …."

For 8 of the 15 sampled claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day (7 claims) or lacked a valid physician order to admit a beneficiary for inpatient care (1 claim). The Hospital stated that the errors occurred because an existing billing system edit did not function as designed. As a result, the Hospital received overpayments totaling $114,744.

Inpatient Claims Paid in Excess of Charges

Section 1862(a)(1)(A) of the Act states that 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."

For one of the eight sampled claims, the Hospital incorrectly billed Medicare for a claim that should have been billed as outpatient. The Hospital stated that this error occurred because of human error. As a result, the Hospital received an overpayment totaling $34,409.

Inpatient Claims With High Severity Level Diagnosis-Related Group Codes

Section 1862(a)(1)(A) of the Act states that 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."

For 1 of the 20 sampled claims, the Hospital incorrectly billed Medicare for a claim with an incorrect DRG code. The Hospital stated that this error occurred because of human error. As a result, the Hospital received an overpayment totaling $17,614.

Inpatient Claims With Hospital-Acquired Conditions

Section 1815(a) of the Act precludes payment to any provider unless it has furnished information to determine the amount due to the provider.

For 1 of the 17 sampled claims, the Hospital billed Medicare for services for which documentation did not support the services provided. Specifically, the medical record lacked documentation to support diagnoses, services, and/or procedures billed. The Hospital stated that the error occurred because of human error. As a result, the Hospital received an overpayment totaling $149,549.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 36 of 59 sampled outpatient claims that we reviewed.[6] There were no overpayments associated with these billing errors.

Outpatient Claims Billed With Modifier -59

The Manual, chapter 23, section 20.9.1.1, states: "The '-59' modifier is used to indicate a distinct procedural service …. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)." The Manual, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

For 36 of the 37 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that did not require modifier -59. The Hospital stated that these errors occurred primarily because it did not have an edit in place to flag the claims for additional review by coding staff, or because of human error. There were no overpayments associated with these billing errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $423,978 and
- strengthen controls to ensure full compliance with Medicare requirements.

NEW YORK DOWNTOWN HOSPITAL COMMENTS

In written comments on our draft report, the Hospital agreed with our findings and described actions that it has taken or planned to take to address them. The Hospital did not agree with our characterizing one outpatient claim that the Hospital incorrectly billed as an inpatient claim as being due to human error. The Hospital stated that the error occurred because its billing department was not notified of the patient's change in status. The Hospital also stated that although documentation was missing for the one inpatient claim with hospital-acquired conditions, it believes that all services provided were appropriate. The Hospital's comments appear in their entirety as the Appendix.

[6] The total number of claims reviewed in the error category (37 sample claims) does not equal the total number of outpatient claims reviewed (59 sample claims) because not all of the categories we reviewed contained errors.

APPENDIX

APPENDIX: NEW YORK DOWNTOWN HOSPITAL COMMENTS

NEW YORK
DOWNTOWN
HOSPITAL

4/4/2012

Report Number: A-02-11-01022

Brenda Tierney
Audit Manager
Office of Inspector General
Jacob K Javits Federal Building
26 Federal Plaza- Room 3900
New York, NY 10038

Dear Ms Tierney:

New York Downtown Hospital is in receipt of and has reviewed the findings of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), and draft report entitled *Medicare Compliance Review of New York Downtown Hospital for the Period July 1, 2008 Through December 31, 2010.* As requested by your office, New York Downtown Hospital has reviewed the recommendations and has included a statement for each occurrence below:

Inpatient Short Stays:
New York Downtown Hospital agrees with your findings. Recently, the facility has increased its efforts to conduct medical necessity reviews of all short stays admissions. The hospital has a physician reviewing these short stay admissions and has intensified its effort with the utilization committee.

Inpatient Same-Day Discharges and Readmissions:
New York Downtown Hospital agrees with your findings. These errors occurred because our system edit to flag re-admissions was not functioning as designed; we have since re-configured the edit to appropriately flag and hold admissions within thirty days of discharge.

Inpatient Claims Paid in Excess of Charges:
New York Downtown Hospital agrees with your findings, however, we disagree with the characterization of human error. The identified case was reviewed by our physician adviser prior to billing and it was determined that the admission should have been downgraded to an Outpatient status; however, the billing department was not notified. The hospital wants to emphasize that it does have a notification policy in place when accounts status needs to be changed from inpatient to outpatient status. Unfortunately, in this case, the billing department was not notified. Management will follow up with the timeliness of such notifications.

Inpatient Claims with High Severity Level-Related Group Codes:

New York Downtown Hospital agrees with your findings. This was the result of a coding error where the principal diagnosis was incorrectly assigned. Our coding staff has been in-serviced regarding the selection of the principal diagnosis.

Inpatient Claims with Hospital-Acquired Condition:

Your finding on this case states that the medical record lacked documentation to support diagnosis, services, and/or procedures billed. Parts of the medical record could not be located; the reviewers were unable to validate some of the services that were performed. Unfortunately, the complete medical record could not be located at the off-site storage facility after several attempts were made. However, the hospital believes that all services provided were appropriate.

Outpatient Claims Billed With Modifier:

New York Downtown Hospital agrees with your findings, however, we would like to note that some of the coding guidelines regarding the use of modifier 59 when Neuro stimulators are implanted are somewhat ambiguous. As a result of this audit, we have received clarification from the RAC monitor and other coding consultants regarding the use of modifier 59. Our coding staff has been in-serviced regarding the appropriate use of modifier 59 and we are in the process of obtaining and implementing an Outpatient coding compliance tool which is designed to flag these types of errors.

We would like to thank you for your support and cooperation during this audit review. If you have any questions, please do not hesitate to contact me at 212-312-5646.

Sincerely,

Frank Vutrano
Senior Vice President, Chief Financial Officer