

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
HOAG MEMORIAL HOSPITAL
PRESBYTERIAN
FOR CALENDAR YEARS
2008 THROUGH 2011**

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



Lori A. Ahlstrand
Regional Inspector General

December 2012
A-09-12-02012

Office of Inspector General

<https://oig.hhs.gov>

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

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

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

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://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.

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 payments to hospitals using computer matching, data mining, and analysis of claims. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Hoag Memorial Hospital Presbyterian (the Hospital) is an acute-care hospital located in Newport Beach, California. Medicare paid the Hospital approximately \$462 million for 33,013 inpatient and 234,375 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 through 2011 based on CMS's National Claims History data.

Our audit covered \$2,740,669 in Medicare payments to the Hospital for 249 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2008 through 2011 and consisted of 169 inpatient and 80 outpatient claims.

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 126 of the 249 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 123 claims, resulting in overpayments totaling \$487,558 for CYs 2008 through 2011. Specifically, 69 inpatient claims had billing errors, resulting in overpayments totaling \$338,379, and 54 outpatient claims had billing errors, resulting in overpayments totaling \$149,179. These overpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$487,558, consisting of \$338,379 in overpayments for the incorrectly billed inpatient claims and \$149,179 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

In its written comments on our draft report, the Hospital stated that it had no further comments on the contents of the report and had no objections to our recommendations. The Hospital's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION.....	1
BACKGROUND	1
Hospital Inpatient Prospective Payment System	1
Hospital Outpatient Prospective Payment System.....	1
Hospital Payments at Risk for Incorrect Billing.....	1
Medicare Requirements for Hospital Claims and Payments	2
Hoag Memorial Hospital Presbyterian.....	2
OBJECTIVE, SCOPE, AND METHODOLOGY	3
Objective.....	3
Scope.....	3
Methodology.....	3
FINDINGS AND RECOMMENDATIONS	4
BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS.....	4
Incorrectly Billed as Inpatient or Without a Physician Order.....	4
Incorrect Discharge Status	5
Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained.....	5
Incorrect Diagnosis-Related Groups.....	6
Incorrectly Billed as Separate Inpatient Stay.....	6
BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS.....	7
Incorrect Healthcare Common Procedure Coding System Codes	7
Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained.....	7
Lack of a Physician Order	8
Incorrect Billing for Unlabeled Use of a Drug	8
RECOMMENDATIONS	9
HOSPITAL COMMENTS	9
APPENDIX	
HOAG MEMORIAL HOSPITAL PRESBYTERIAN COMMENTS	

INTRODUCTION

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. 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.

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. 106-113.¹ 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 identify and group the services within each APC group.² 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 payments to hospitals using computer matching, data mining, and analysis of claims. Examples of the types of claims at risk for noncompliance included the following:

¹ In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

- inpatient claims for short stays,
- inpatient transfer claims,
- inpatient claims with high severity level DRG codes,
- inpatient claims for blood clotting factor drugs,
- outpatient claims billed prior to and during inpatient stays,
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day),
- inpatient and outpatient claims paid in excess of charges, and
- inpatient and outpatient claims involving 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 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.” 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.

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.

Hoag Memorial Hospital Presbyterian

Hoag Memorial Hospital Presbyterian (the Hospital) is an acute-care hospital located in Newport Beach, California. Medicare paid the Hospital approximately \$462 million for 33,013 inpatient and 234,375 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 through 2011 based on CMS’s National Claims History data.

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 \$2,740,669 in Medicare payments to the Hospital for 249 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2008 through 2011 and consisted of 169 inpatient and 80 outpatient claims.

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 evaluated compliance with selected billing requirements but did not use 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 claims selected for 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 inpatient and outpatient claims and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital in January and February 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2008 through 2011;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2008 through 2011;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 249 claims (169 inpatient and 80 outpatient claims) for detailed review;

- reviewed available data from CMS’s Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- reviewed the Hospital’s procedures for assigning HCPCS codes and submitting Medicare claims;
- 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 126 of the 249 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 123 claims, resulting in overpayments totaling \$487,558 for CYs 2008 through 2011. Specifically, 69 inpatient claims had billing errors, resulting in overpayments totaling \$338,379, and 54 outpatient claims had billing errors, resulting in overpayments totaling \$149,179. These overpayments occurred primarily because the Hospital’s existing controls did not adequately prevent incorrect billing of these Medicare claims.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 69 of 169 selected inpatient claims, which resulted in overpayments totaling \$338,379.

Incorrectly Billed as Inpatient or Without a Physician Order

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” Federal regulations (42 CFR § 424.13(a)) state that Medicare Part A pays for inpatient hospital services only if a physician certifies and recertifies, among other things, the reasons for continued hospitalization.

For 29 of 169 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient services or outpatient-with-observation services (28 claims) or did not have a physician order to admit the beneficiary for inpatient care (1 claim). The Hospital attributed the patient admission errors primarily to inadequate internal controls over case management for monitoring short stays and attributed the missing physician order to human error. As a result of these errors, the Hospital received overpayments totaling \$59,445.³

Incorrect Discharge Status

Federal regulations (42 CFR § 412.4(b)) state that a discharge of a hospital inpatient is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge. A discharge of a hospital inpatient is also considered to be a transfer when the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to a home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (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 27 of 169 selected inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to other facilities or to the patient’s home for home health services. For each claim, the Hospital should have coded the discharge status as a transfer instead of as “discharged to home” or “left against medical advice”; thus, the Hospital should have received the per diem payment instead of the full DRG payment. The Hospital stated that these errors occurred because of the complexity of the process for coding patient discharge status. As a result of these errors, the Hospital received overpayments totaling \$180,281.

Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

Federal regulations (42 CFR § 412.89(a)) require a reduction in the IPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of the device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device. The Manual, chapter 3, section 100.8, states that to correctly bill for a replacement device that was provided with a credit, hospitals must use the combination of condition code 49 or 50 (which identifies the replacement device) and value

³ We did not include the overpayment for one claim in our calculation because it was recovered by CMS’s Recovery Audit Contractor.

code FD (which identifies the amount of the credit or cost reduction received by the hospital for the replaced device).

Section 2103.A. of the CMS *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties for medical devices. Section 2103.C.4. provides the following example:

Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment supplied.

For 8 of 169 selected inpatient claims, the Hospital received full credit for replaced devices but did not report the value code FD or reduced charges on its claims (7 claims), or the Hospital did not obtain a credit for a replaced medical device that was available under the terms of the manufacturer's warranty (1 claim). The Hospital stated that these errors occurred because of inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result of these errors, the Hospital received overpayments totaling \$42,550.

Incorrect Diagnosis-Related Groups

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." Chapter 1, section 80.3.2.2, of the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For 4 of 169 selected inpatient claims, the Hospital billed Medicare with incorrect DRGs. For example, for three claims, the Hospital billed a DRG specifying that the procedure was unrelated to the primary diagnosis code; however, we determined that the procedure was related to the primary diagnosis code. The Hospital stated that these errors occurred because of a flaw in the Hospital's computer software that did not properly identify the claims for secondary review and because of human error. As a result of these errors, the Hospital received overpayments totaling \$51,541.

Incorrectly Billed as Separate Inpatient Stay

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 onto a single claim.

For 1 of 169 selected inpatient claims, the Hospital incorrectly billed Medicare separately for a related discharge and readmission within the same day. The Hospital stated that this occurred because of human error. As a result, the Hospital received an overpayment of \$4,562.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 54 of 80 selected outpatient claims, which resulted in overpayments totaling \$149,179.

Incorrect Healthcare Common Procedure Coding System Codes

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. The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For 50 of 80 selected outpatient claims, the Hospital submitted claims to Medicare with an incorrect HCPCS code. Specifically, the Hospital billed the incorrect HCPCS code for a drug available in two separate dosages, each assigned its own HCPCS code and separately packaged. The Hospital stated that these errors occurred because the Hospital’s pharmacy computer system was configured to select the incorrect HCPCS for this drug. As a result of these errors, the Hospital received overpayments totaling \$105,589.

Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained

Federal regulations (42 CFR § 419.45) 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.

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual explain how a provider should report no-cost and reduced-cost devices under the OPPS. 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.

Pursuant to 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services” The CMS *Provider Reimbursement Manual*, section 2102.1, states:

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item

or service. ... If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

Section 2103.A. of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties for medical devices. Section 2103.C.4. provides the following example:

Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacture for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment supplied.

For 2 of 80 selected outpatient claims, the Hospital received full credit for a replaced device but did not report the -FB modifier or reduced charges on its claim (1 claim), or the Hospital did not obtain a credit for a replaced device that was available under the terms of the manufacturer's warranty (1 claim). The Hospital stated that these errors occurred because of inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result of these errors, the Hospital received overpayments totaling \$41,841.

Lack of a Physician Order

Section 1833(e) of the Act states: "No payment shall be made to any provider of services ... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ... for the period with respect to which the amounts are being paid"

For 1 of 80 selected outpatient claims, the Hospital billed Medicare for a medication administered to the beneficiary but was unable to provide the physician's order for this medication. The Hospital stated that this occurred because of human error. As a result, the Hospital received an overpayment of \$1,112.

Incorrect Billing for Unlabeled Use of a Drug

CMS's *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, section 50.4.2, defines an unlabeled use of a drug as a use that is not included as an indication on the drug's label as approved by the Food and Drug Administration (FDA). This section states that FDA-approved drugs used for indications other than what is indicated on the official label may be covered under Medicare if the contractor determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature, and/or accepted standards of medical practice.

For 1 of 80 selected outpatient claims, the Hospital incorrectly billed Medicare for an unlabeled use of a drug. The Hospital stated that this occurred because of a billing error. As a result, the Hospital received an overpayment of \$637.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$487,558, consisting of \$338,379 in overpayments for the incorrectly billed inpatient claims and \$149,179 in overpayments for the incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS

In its written comments on our draft report, the Hospital stated that it had no further comments on the contents of the report and had no objections to our recommendations. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: HOAG MEMORIAL HOSPITAL PRESBYTERIAN COMMENTS



HOAG MEMORIAL HOSPITAL PRESBYTERIAN
One Hoag Drive, PO Box 6100
Newport Beach, CA 92658-6100

December 4, 2012

Lori Ahlstrand
Regional Inspector General for Audit Services
Office of Inspector General
U.S. Department of Health and Human Services
Via HHS/OIG Delivery Server (per Lillian Yao, Auditor)

Re: Written Comments – Draft Report from U.S. Department of Health and Human Services, Office of Inspector General (A-09-12-02012)

Dear Ms. Ahlstrand:

We have reviewed the report of the Office of Inspector General draft report entitled Medicare Compliance Review of Hoag Memorial Hospital Presbyterian for Calendar Years 2008 and 2011 (Report Number: A-09-12-02012), transmitted to us via email on November 6, 2012.

We have no further comments on the contents of the report, and have no objections to the recommendations set forth therein.

We want to thank you for the professional way in which the audit was conducted and for carefully considering our comments in meetings and on prior drafts.

Sincerely,

A handwritten signature in dark ink, reading "Terri W. Cammarano". The signature is written in a cursive, flowing style.

Terri W. Cammarano
Vice President and General Counsel

cc: Jennifer Mitzner, Senior Vice President and Chief Financial Officer
Randy Ray, Executive Director, Revenue Cycle
Shirley Komoto, Interim Acting Compliance Officer