Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF HARTFORD HOSPITAL FOR CALENDAR YEARS 2009 AND 2010

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

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Regional Inspector General

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Office of Inspector General

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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 inpatient hospital 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. 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.

Hartford Hospital (the Hospital), a teaching affiliate of the University of Connecticut School of Medicine, is an 867-bed hospital located in Hartford, Connecticut. Medicare paid the Hospital approximately $429 million for 31,691 inpatient and 122,341 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered $2,148,806 in Medicare payments to the Hospital for 186 claims that we judgmentally selected as potentially at risk for billing errors. These 186 claims had dates of service in CYs 2009 and 2010 and consisted of 124 inpatient and 62 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 115 of the 186 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 71 selected inpatient and outpatient claims, resulting in overpayments totaling $419,510 for CYs 2009 and 2010. Specifically, 42 inpatient claims had billing errors, resulting in overpayments totaling $268,859, and 29 outpatient claims had billing errors, resulting in overpayments totaling $150,651. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $419,510, consisting of $268,859 in overpayments for 42 incorrectly billed inpatient claims and $150,651 in overpayments for 29 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

HARTFORD HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred in part with our findings and recommendations with the exception of 28 cancelled surgeries billed incorrectly as inpatient claims. The Hospital stated that these cancelled surgery claims were medically necessary as inpatient stays. The Hospital stated that CMS rules, at the time that the services in question were billed, did not clearly or conclusively address the issue of cancelled surgeries. In addition, the Hospital stated that billing guidance for cancelled surgeries from its Medicare Administrative Contractor (MAC) and other MACs is inconsistent with CMS rules. The Hospital also stated that certain surgical procedures designated by CMS as “inpatient-only” can be billed only as inpatient regardless of whether the surgery was performed. The Hospital’s comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that our findings and recommendations with regard to cancelled surgeries are correct. These cancelled surgery claims, at our request, underwent medical review by the Hospital’s MAC. As determined by the MAC, for all of these cancelled surgery claims, the medical records did not support the need for inpatient status. CMS billing options for cancelled surgery include the submission of an inpatient claim, if appropriate. However, the patient’s symptoms must be severe enough to warrant an inpatient stay and services must be provided of the requisite intensity. Patients whose elective surgeries have been cancelled, and who exhibit no other severe symptoms and receive no “intensive” inpatient services, would not satisfy this criteria.

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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 types of payments to hospitals using computer matching, data mining, and

[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.

analysis techniques. Examples of these types of claims at risk for noncompliance included the following:

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level DRG codes,
- inpatient and outpatient claims paid in excess of charges,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed with evaluation and management (E&M) services, and
- outpatient observation services that resulted in outlier payments.

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.

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.

Hartford Hospital

Hartford Hospital (the Hospital), a teaching affiliate of the University of Connecticut School of Medicine, is an 867-bed hospital located in Hartford, Connecticut. Medicare paid the Hospital approximately $429 million for 31,691 inpatient and 122,341 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 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 $2,148,806 in Medicare payments to the Hospital for 186 claims that we judgmentally selected as potentially at risk for billing errors (see Appendix A). These 186 claims had dates of service in CYs 2009 and 2010 and consisted of 124 inpatient and 62 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 and subjected only a limited number of claims to focused medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the 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 from November 2011 through March 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 2009 and 2010;
- obtained information on known credits for replacement cardiac medical devices from device manufacturers for CYs 2009 and 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 (124 inpatient and 62 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 submitting Medicare claims;

- used CMS's Medicare contractor medical review staff to determine whether a limited selection of sampled claims met medical necessity requirements;

- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;

- calculated the correct payments for those claims requiring adjustments; and

- discussed the results of our review with Hospital officials.

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 115 of the 186 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 71 claims, resulting in overpayments totaling $419,510 for CYs 2009 and 2010. Specifically, 42 inpatient claims had billing errors, resulting in overpayments totaling $268,859, and 29 outpatient claims had billing errors, resulting in overpayments totaling $150,651. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 42 of 124 sampled inpatient claims, which resulted in overpayments totaling $268,859.

Incorrectly Billed as Inpatient

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 39 of 124 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient services. The majority of these claims involved cancelled surgical procedures. As a result of these errors, the Hospital received overpayments totaling $250,659.[3]

Incorrectly Billed Medical Device Credits

Federal regulations (42 CFR § 412.89) require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of a 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 code Medicare claims with a combination of condition code 49 or 50, along with value code "FD."

For 3 of 124 sampled claims, the Hospital received a reportable medical device credit for a replaced device from a manufacturer but did not adjust its inpatient claims with the proper value and condition codes to reduce payment as required. The Hospital stated these errors occurred because it did not follow existing procedures to adjust Medicare claims for medical device credits received. As a result of these errors, the Hospital received overpayments totaling $18,200.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 29 of 62 sampled outpatient claims, which resulted in overpayments totaling $150,651.

Incorrectly Billed Medical Device Credits

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

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

[3] The Hospital may bill Medicare Part B for a limited range of services related to some of these 39 incorrect Medicare Part A claims. 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.

provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device.

Billing Requirements for Medical Device Credits

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, explains 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.

Prudent Buyer Principle

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*, part 1, 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 of the *Provider Reimbursement Manual* states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. 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.

For 10 of 62 sampled claims, the Hospital received full credit for replaced devices but did not properly report the "FB" modifier or reduced charges on the claims (8 errors) or did not obtain credits for replaced devices that were available under the terms of the manufacturers' warranties (2 errors). The Hospital stated that the errors occurred because it did not follow existing procedures to adjust Medicare claims for credits received or for identifying credits it should have received. As a result of these errors, the Hospital received overpayments totaling $75,149.

Incorrectly Billed Healthcare Common Procedure Coding System Codes or Number of Units

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." In addition, chapter 4, section 20.4, of the Manual states: "The definition of service units … is the number of times the service or procedure being reported was performed."

For 4 of 62 sampled claims, the Hospital submitted claims to Medicare with either incorrect HCPCS codes (2 errors) or number of units (2 errors). The Hospital stated that these overpayments occurred because of human error. As a result of these errors, the Hospital received overpayments totaling $46,747.

Incorrectly Billed Procedure That Was Already Included in the Hospital's Payment

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 1 of 62 sampled claims, the Hospital incorrectly billed Medicare for a procedure that was already included in the payment for another procedure billed on the same claim. These procedures were related to the insertion of a cardiac medical device. The Hospital stated this overpayment occurred because of human error. As a result of the error, the Hospital received an overpayment of $27,773.

Incorrectly Billed Evaluation and Management Services

The Manual, chapter 12, section 30.6.6(B), states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure.

For 14 of 62 sampled claims, the Hospital incorrectly billed Medicare for E&M services that were part of the usual preoperative or postoperative work of the procedure. The incorrectly billed services were associated primarily with urological and gynecological surgical procedures. The Hospital was not eligible for the E&M payments since the services that the physicians performed were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedures. The Hospital attributed the errors to a single Hospital department that did not completely understand the billing requirements for E&M services. As a result of these errors, the Hospital received overpayments totaling $982.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $419,510, consisting of $268,859 in overpayments for 42 incorrectly billed inpatient claims and $150,651 in overpayments for 29 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

HARTFORD HOSPITAL COMMENTS

In written comments on our draft report, the Hospital concurred in part with our findings and recommendations with the exception of 28 cancelled surgeries billed incorrectly as inpatient claims. The Hospital stated that these cancelled surgery claims were medically necessary as inpatient stays. The Hospital billed the cancelled surgeries as inpatient claims but did not include the cancelled surgical procedure on the claims. The Hospital stated that CMS rules, at the time that the services in question were billed, did not clearly or conclusively address the issue of cancelled surgeries. The Hospital stated, "If the CMS rules relating to canceled surgeries direct the provider to assign a V code to an inpatient claim, it is counterintuitive to conclude that CMS does not allow billing for canceled surgery as inpatient stays."[4]

Furthermore, the Hospital disagreed with National Government Services' (NGS) medical review determinations[5] that the identified cancelled surgery claims represent medically unnecessary inpatient services. The Hospital noted that the medical review concluded that these cancelled surgery claims should have been billed as outpatient claims. The Hospital stated that NGS did not inform the Hospital that it could not submit claims for cancelled surgeries as inpatient claims with a V code assigned. The Hospital stated that it "sees no justifiable link between [the] Medicare Claims Processing Manual and the conclusion that all canceled surgeries must be billed as outpatient surgeries."

The Hospital also cited an email correspondence with NGS and online material it found from another MAC (Wisconsin Physicians Service) to show inconsistent guidance with CMS rules. The Hospital paraphrased the transcript of one of Wisconsin Physicians Service's teleconferences with hospitals by stating that the contractor is expected to bill inpatient for cancelled "inpatient-only" surgeries and use the appropriate V-codes on the inpatient claim.

The Hospital stated that surgical procedures designated as "inpatient-only" (13 of the 28 claims) can be billed only as inpatient regardless of whether the surgery was performed and that to conclude that every cancelled surgery for every inpatient-only claim results in a medically

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[4] "V code" refers to specific codes addressing cancelled surgical procedures that are included in the American Medical Association's "Official ICD-9-CM Guidelines for Coding and Reporting."

[5] NGS is the Hospital's jurisdictional MAC. We requested NGS to perform a medical review of 37 inpatient claims for which the scheduled surgical procedure was cancelled.

unnecessary stay is to render this "inpatient-only" rule meaningless. The Hospital's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that our findings and recommendations with regard to cancelled surgeries are correct. As with any Medicare service, the basic criteria for coverage is found in section 1862(a)(1)(A) of the Social Security Act, which states that Medicare does not pay for services that are not reasonable and necessary for the diagnosis and treatment of illness or injury. Further, CMS provides guidance to its MACs on their conduct of medical reviews of inpatient hospital claims in Chapter 6 of the Medicare Program Integrity Manual, Pub. 100-08. In section 6.5.2, CMS instructs MACs to conduct reviews of inpatient hospital claims and that the "review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay," and, further, that "[t]he beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis."

Thirty-seven of the inpatient claims we sampled involved a cancelled surgery. Most cancelled surgery claims submitted by the Hospital included room and board charges and minimal, if any, preoperative tests (e.g., labs, electrocardiograms, radiology, etc.). While the level of care provided to the patient appeared minimal, we recognize that, in some instances, an emergent medical condition may cause surgery to be cancelled but the patient may still need to be admitted under an inpatient level of care. Therefore, we requested a medical review of these claims by NGS. The NGS medical review found that for all 37 cancelled surgery claims the medical records did not support the need for inpatient status.

Contrary to the Hospital's statement, NGS's determinations are not based on the interpretation of CMS guidance that requires services provided in the context of a cancelled surgery to always be billed as outpatient services. There are no specific CMS instructions which require the use of a V code and inpatient billing when a surgical procedure is cancelled. CMS billing options for cancelled surgery include the submission of an inpatient claim (if appropriate), an inpatient leave of absence claim, an outpatient claim, or an inpatient Part B claim to recover payment for ancillary services. The patient's symptoms must be severe enough to warrant an inpatient stay and services must be provided of the requisite intensity. Patients whose elective surgeries have been cancelled, and who exhibit no other severe symptoms and who receive no "intensive" inpatient services, would not appear to satisfy this criteria.

In the same WPS transcript referenced by the Hospital in its comments, WPS states that, when billing for inpatient-only procedures, "First, the admission itself must be reasonable [and] necessary." WPS further states in this transcript, "Patients who's (sic) outpatient preoperative clearance has not been completed do not meet admission criteria and should not be admitted for elective procedures regardless of whether they're on that inpatient-only list or not. If the patient has already registered with the hospital when the staff discovers that the preoperative clearance has not been done, this does not suddenly make that admission reasonable and necessary and it should not be billed to Medicare." Thirty-one of the 37 cancelled surgery claims were cancelled

because the patient did not pass preoperative clearance. Since the inpatient admission would not be medically necessary if the preoperative examination were done prior to the admission, it is not medically necessary after admission when the preoperative examination has determined that the patient is not ready for surgery. To the extent that the preoperative examination was done after admission, the belatedness of the preoperative examination—and the belated determination that the patient is not ready for surgery—is not a circumstance that would make the admission medically necessary.

For the remaining six claims, surgeries were cancelled because the Hospital was not prepared with adequate staff or room. For the reasons discussed above, the Hospital's lack of preparedness does not justify the Hospital billing an inpatient claim and the resultant reimbursement.

APPENDIXES

APPENDIX A: RISK AREAS REVIEWED AND BILLING ERRORS

Risk Area	Sampled Claims	Claims With Overpayments	Value of Overpayments
Inpatient Short Stays	47	29	$161,847
Inpatient Claims Paid in Excess of Charges	20	10	$88,812
Inpatient Manufacturer Credits for Replaced Medical Devices	30	3	$18,200
Inpatient Same-Day Discharges and Readmissions	15	0	$0
Inpatient Claims Billed with High Severity Level Diagnosis-Related Group Codes	12	0	$0
Totals	124	42	$268,859
Outpatient Manufacturer Credits for Replaced Medical Devices	26	11	$102,922
Outpatient Claims Paid in Excess of Charges	6	4	$46,747
Outpatient Claims Billed With Evaluation and Management Services	20	14	$982
Outpatient Observation Services that Resulted in Outlier Payments	10	0	$0
Totals	62	29	$150,651

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CERTIFIED MAIL DELIVERY/

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Re: Audit A-01-11-00533-Medicare Compliance Review of Hartford Hospital for Calendar Years 2009 and 2010

Dear Mr. Armstrong:

I am writing on behalf of my client, Hartford Hospital (the "Hospital"), which is in receipt of the above referenced draft audit report. The Hospital has carefully reviewed the findings and accepts most of the findings, but takes exception to certain findings set forth in the audit report category referred to as "Incorrectly Billed as Inpatient".

Specifically, the Hospital disputes twenty-eight (28) claims in this category relating to canceled surgeries. Nineteen (19) of these claims were in the auditor's category A referred to as "Inpatient Short Stays" and nine (9) of the claims were in the auditors category B referred to as "Inpatient Stays Wherein Payment Was Greater than Charges".

Thirteen (13) of the claims in category A are for "inpatient only" admissions, two (2) of the claims relate to a canceled surgery that was never rescheduled, and thirteen (13) remainder claims are for canceled surgeries that were rescheduled at a later date. Hartford Hospital did not bill for any surgeries or procedures in any of these canceled surgery claims. Nevertheless, we have been told by the auditors that National

Government Services ("NGS") has reviewed these claims and made a determination that these claims represent medically unnecessary inpatient claims and therefore, should have all been billed as outpatient claims only. We disagree with the findings relating to canceled surgeries for the reasons discussed below.

I. Canceled Surgeries.

1. At the time that these subject claims were submitted, neither CMS nor NGS provided any clear guidance pertaining to canceled surgeries that would have instructed Hartford Hospital to submit these subject claims as outpatient claims only. If NGS and OIG retroactively apply rules that were not properly promulgated, in effect, OIG is engaging in rulemaking without following proper administrative processes.

NGS never informed Hartford Hospital that it could not submit claims for canceled surgeries as inpatient claims with a V code assigned. Quite the opposite as demonstrated herein. Hartford Hospital has been billing Medicare for services provided to beneficiaries prior to a canceled inpatient surgery by reporting the appropriate ICD-9-CM Diagnostic Code ("V code") with the claim, such as V64.1, V64.2, or V63.3, indicating that a surgical or other procedure was not carried out. NGS has never put Hartford Hospital on either actual or constructive notice that these canceled surgeries should be billed any other way. Moreover, at the time that the Hospital billed for the services in question, CMS rules did not either clearly or conclusively address the issue of canceled surgeries. Medicare Claims Processing Manual, *Chapter 1: General Billing Requirements* (last revised on January 13, 2012) provides: "if conditions for use of Condition Code 44 are *not* met, the hospital may submit a 12x bill type for covered Part B Only services that were furnished to the inpatient. Medicare will still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary." The Medicare manual does not provide that a hospital must submit outpatient claims for services furnished to an inpatient; rather it states that it may if the admission is not medically necessary. At the time of claim submission, Hartford Hospital concluded that these subject inpatient admissions were medically necessary and had these claims reviewed by its utilization review team prior to submitting all of these claims. Hartford Hospital sees no justifiable link between Medicare Claims Processing Manual and the conclusion that all canceled surgeries must be billed as outpatient surgeries. If the CMS rules relating to canceled surgeries direct the provider to assign a V code to an inpatient claim, it is counterintuitive to conclude that CMS does not allow billing for canceled surgery as inpatient stays.

It is well established administrative law that a federal agency cannot adopt new rules and regulations without engaging in a formal administrative rulemaking process that allows for a public comment period. To retroactively apply a rule that concludes that all or

most inpatient canceled surgeries cannot be billed as an inpatient admission, because it would be by definition a medically unnecessary admission, is the equivalent of engaging in rulemaking without following proper administrative processes.

2. There is inconsistent interpretation of CMS rules among various CMS contractors on the issue of canceled surgeries.

Wisconsin Physician Services Health Insurance ("WPS"), "*Ask-the-Contractor Teleconference: Inpatient Admission Decisions" Transcript* (February 8, 2012): While addressing billing for canceled inpatient procedures, WPS stated that where a provider chooses to discharge a patient after canceling a scheduled inpatient surgery, the provider is expected to bill an inpatient claim because inpatient-only procedures cannot be billed on an outpatient claim.

According to WPS, in order to report charges for any services provided prior to the procedure being canceled, a provider should: (i) code one of the appropriate V codes indicating that the surgical or other procedure was not carried out, and then (ii) place an additional diagnosis code on the claim to indicate the reason the procedure was not performed.

In a May 8, 2012, a NGS Jurisdiction 13 CERT Educational Consultant, in an email to Hartford Hospital's Director of Case Coordination stated that in situations where inpatient surgeries are canceled after the furnishing of pre-operative services, hospitals should utilize the applicable V code and submit them as inpatient claims.

Hartford Hospital's email to NGS:

> Hello....
>
> I met you at the presentation at the Hospital of Central Connecticut this week. Thank you for a very informative session. You requested that I email you my question about canceled inpatient surgeries.
>
> So this is the dilemma:
>
> Patient admitted to the hospital for a planned elective inpatient surgery. For some reason (this varies) the surgery is canceled. This occurs after the patient's arrival, all pre-op clearances have been secured, some treatments may have already begun.
>
> The surgery is then canceled.
> The options include:

> 1. Placing the patient in outpatient status and billing as such (we are essentially not changing the patient status, simply discharging them home; also there is no order to do this, nor is the beneficiary notified as per Condition Code 44 guidelines).
>
> 2. The inpatient status remains in place as per the original MD order, and a V-code modifier is placed on the bill to notify CMS of the canceled surgery.
>
> So then how is the hospital reimbursed for the services it has provided to the patient, while maintaining absolute compliance with billing rules and beneficiary rights.
>
> Thanks so much for your reply.
> [Director, Hartford Hospital's Case Coordination]

NGS' response:

"The inpatient claim should be submitted with the applicable "V" diagnosis code (V641, V642, V643), but the surgical procedure should not be billed, since it was not performed. Individual services performed during the stay can be billed.

Please bear in mind that there are no specific Medicare rules regarding this particular situation, so the advice offered here has been proferred by NGS Part A billing experts who have not previously encountered this issue."

As recently as September 18, 2012 week at an NGS educational program for Hartford Hospital, a representative from NGS stated that she could not advise the Hospital on billing for canceled surgeries and said that she would have to get back to the Hartford Hospital on the issue. The following was NGS's response to Hartford Hospital's Director, Case Coordination on October 8, 2012:

> Good afternoon [Director, Case Coordination],
>
> I've checked back and, yes, the information below is what I have as the most current advice for the billing steps when a scheduled inpatient service is cancelled. Please go ahead and follow this guidance and, if you do encounter problems, let me know.
>
> *" The inpatient claim should be submitted with the applicable ‚€œV‚€ diagnosis code (V641, V642, V643), but the surgical procedure should not be billed, since it was not performed. Individual services performed during the stay can be billed.*
>
> *Condition Code 44 is not applicable in this situation, since the patient was discharged, rather than transitioned to outpatient status. Since the patient will most probably be re-admitted, the patient's status may be changed to Leave of Absence (LOA)‚€.*
>
> *Please bear in mind that there are no specific Medicare rules regarding this particular situation, so the advice offered here has been proffered by NGS Part A billing experts who have not previously encountered this "*

As for the beneficiary notification on Condition Code 44, please refer to the following:

MLN Matters # SE 0622 was written on 09/10/04 and updated on 10/01/12...it states the following:

"Q8. Why has CMS required that the patient still be in the hospital when his or her status is changed from that of an inpatient to outpatient? Most hospitals have agreements with QIOs for UR, and determinations about medically unnecessary admissions can be decided days or weeks after the patient leaves the hospital.

A8. The patient rights CoP in §482.13 of the regulations require a hospital to protect and promote each patient's rights. Medicare beneficiaries have the right to participate in treatment decisions and to know their treatment choices. Beneficiaries are also entitled to receive information about co-insurance and deductibles. CMS has a duty to protect these rights. Requiring that the decision resulting in a change in patient status be made before the beneficiary is discharged is intended to ensure that the patient is fully informed about the change in status and its impact on the co-insurance and deductible for which the beneficiary would be responsible. For example, if a patient has already met her Part A deductible, informing the beneficiary a month after discharge that that she will now be responsible for additional coinsurance as an outpatient could impose a financial hardship."

That said, our internal provider education experts have weighed in and are advising hospitals to put this notification in writing and obtain a beneficiary signature, with a copy of the document included in the record. This will be the hospital's only defined way to demonstrate that the beneficiary's rights have been protected.

Thanks for your patience in awaiting my response on these issues...hope the information is helpful....

J 13 CERT Educational Consultant
National Government Services
Wellpoint

The fact that CMS contractors have given and continue to give inconsistent advice is evident that there is no clear policy, rules or regulations to either guide them or support the interpretation being applied in the above referenced audit report.

3. According to CMS guidelines, some of the subject claims may only be billed as inpatient claims.

CMS guidelines require that certain procedures be billed as inpatient only. Thirteen (13) of the twenty-eight (28) subject claims fall within inpatient only procedures. To conclude that every canceled surgery for every inpatient only claim results in a medically unnecessary stay is to render this inpatient only rule meaningless.

4. The medical necessity for the inpatient admission was determined at the time of the admission prior to the surgery being performed and all of the subject 26 claims were subject to utilization review by Hartford Hospital prior to Hartford Hospital submitting the claims for payment.

The decision that the patient needed to be admitted was made by the admitting physician based upon a variety of factors including, the nature of the surgery and the patient's co morbidities relating to the planned surgery. Therefore, medical necessity of the inpatient procedure should not be considered after the patient was admitted and the surgery was canceled. If that was done, presumably all inpatient admissions wherein surgery is canceled would be considered medically unnecessary and then there would be little reason to assign a V code to an inpatient admission involving a canceled surgery.

5. While the surgery relating to the subject claims was canceled, there were considerable costs incurred by Hartford Hospital with respect to these claims.

The costs associated with the inpatient admission are unique to the inpatient admission. At a minimum, with an inpatient admission, the patient receives preoperative diagnostic testing, preadmission nursing instruction, extensive operational processes are associated with the inpatient admitting process, and once the patient is admitted to the unit, extensive nursing assessments are performed, hospitalists may see the patient and preoperative nursing services are provided. These costs are not recoverable when the admission is billed as an outpatient stay.

6. The only CMS rule relates to a possible leave of absence as discussed in Medicare Claims Processing Manual, Sec. 40.2.5.

This rule is further evidence that not all inpatient admissions involving canceled surgeries should be billed as outpatient stays. Notwithstanding for risk management reasons, Hartford Hospital does not view it as appropriate to place its patients on leave of absence status.

7. The OIG in it 2013 Work Plan supports the notion that inpatient claims not followed by a rescheduled admission should be paid as inpatient and further recognizes that Medicare is paying for two inpatient claims.

This is further evidence that Hartford Hospital's submission of the subject claims is not only consistent with current practices but also consistent with the rules and the understanding of most providers.

For the reasons described above, we respectfully request that you review these subject claims relating to canceled surgery and reverse your findings.

II. Other Audit Findings.

With respect to the other audit findings in the audit report, Hartford Hospital has the following comments:

1. Category A-Inpatient Short Stays.

The OIG auditors reviewing Hartford Hospital's claims in this category had 29 findings. Of these, Hartford Hospital is in disagreement with nineteen (19) of the cases relating to canceled surgeries and believes that these claims should be reimbursed as inpatient stays for the reasons discussed above. With respect to the ten (10) claims that Hartford Hospital agrees with, it will put control into place and monitor compliance. With respect to the claims that Hartford Hospital disagrees with, once CMS notifies Hartford Hospital that it has changed the rules with respect to billing for canceled surgeries, Hartford Hospital will implement the proper controls to fully comply with such rules.

2. Category B-Inpatient claims paid in excess of charges.

The OIG auditor found ten (10) cases in this category to be in error. Hartford Hospital believes that nine (9) claims in this category are correct and are the subject of the discussion above relating to payment for canceled surgeries. Hartford Hospital has addressed the one case in error by putting in place appropriate controls to correct and monitor. To the extent that CMS notifies Hartford Hospital that it has changed the rules with respect to billing for canceled surgeries, Hartford Hospital will implement the proper controls to fully comply with such rules.

3. Category C-Outpatient claims paid in excess of charges.

A limited number of errors were identified and were associated with human error. Corrective action has been implemented to reduce the risk of the same human error reoccurring, including a prospective audit plan to monitor prospective compliance.

4. Category H-Inpatient medical devices and Category G- Outpatient medical devices.

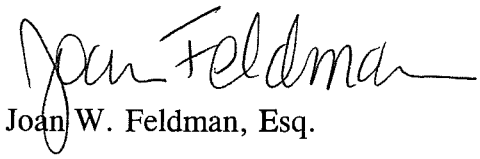
Hartford Hospital has reinforced its processes for physician documentation relating to describing the clinical reasons why the subject device presents unacceptable risk to the patient if it were to be explanted. In addition, to the limited extent that any credits are issued by a particular manufacturer, the Hospital has very strong processes to refund any amounts owed to Medicare.

5. Category I-Outpatient E&M services with modifier 25.

These errors were isolated to one department and corrective action was taken, including a prospective audit plan to monitor prospective compliance.

Hartford Hospital takes its compliance obligations very seriously. With respect to all the claims subject to audit, the Hospital reviewed its relevant internal processes and controls and where necessary, made adjustments to enhance its compliance efforts and processes. We are very grateful for your time and consideration. Please feel free to call me if you have any questions about the Hospital's efforts in this regard or if you require additional information. We look forward to your response.

Sincerely,



Joan W. Feldman, Esq.

JWF:
Cc: Sonal Shah, Vice President and Chief Compliance Officer