

Department of Health and Human Services

OFFICE OF  
INSPECTOR GENERAL

**MEDICARE COMPLIANCE REVIEW  
OF NEW YORK UNIVERSITY  
LANGONE MEDICAL CENTER  
FOR THE PERIOD JULY 1, 2008,  
THROUGH DECEMBER 31, 2010**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



James P. Edert  
Regional Inspector General

December 2012  
A-02-11-01043

# *Office of Inspector General*

<http://oig.hhs.gov>

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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 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 University Langone Medical Center (the Hospital) is a 1,069-bed acute care hospital located in New York, New York. Based on CMS's National Claims History data, Medicare paid the Hospital approximately \$711 million for 37,389 inpatient and 289,617 outpatient claims for services provided to beneficiaries during the period July 1, 2008, through December 31, 2010.

Our audit covered approximately \$3.5 million in Medicare payments to the Hospital for 305 inpatient and 62 outpatient claims that we identified as potentially at risk for billing errors. These 367 claims had payment dates 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 187 of the 367 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 180 claims, resulting in overpayments totaling \$613,279 during the period July 1, 2008, through December 31, 2010. Specifically, 155 inpatient claims had billing errors resulting in overpayments totaling \$589,018, and 25 outpatient claims had billing errors resulting in overpayments totaling \$24,261. These 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 \$613,279, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **NEW YORK UNIVERSITY LANGONE MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the Hospital agreed with part of our first recommendation and described actions that it has taken to address our second recommendation. The Hospital disagreed with 101 of the 129 inpatient short stay claims questioned in our draft report. Specifically, the Hospital stated that, based on the clinical indications demonstrated by the patient and supported by the documentation in the medical record, the physician determination for admission was justified and medically necessary for each of the claims. The Hospital's comments appear in their entirety as the Appendix.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid for all but one inpatient short stay claim. We utilized both the Medicare contractor medical review staff and an independent medical review contractor to determine whether 93 inpatient short stay claims met medical necessity requirements. Based on the contractors' conclusions, we determined that 92 inpatient short stay claims should have been billed as outpatient or outpatient with observation services. The independent medical review contractor determined that one claim was correctly billed as an inpatient stay. We are no longer questioning eight other inpatient short stay claims due to the age of the claims and have revised our finding and related recommendation accordingly.

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### NEW YORK UNIVERSITY LANGONE MEDICAL CENTER COMMENTS

## 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.

#### **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.<sup>1</sup> 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 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.<sup>2</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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<sup>1</sup> In 2009, SCHIP was formally redesignated as the Children's Health Insurance Program.

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

## **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 psychiatric facility (IPF) emergency department adjustments,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims for blood clotting factor drugs,
- inpatient hospital-acquired conditions and present on admission indicator reporting,
- outpatient claims billed with evaluation and management services,
- outpatient claims billed with modifier -59,
- outpatient doxorubicin hydrochloride, 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.

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 University Langone Medical Center**

New York University Langone Medical Center (the Hospital) is a 1,069-bed acute care hospital located in New York, New York. Based on CMS's National Claims History data, Medicare paid the Hospital approximately \$711 million for 37,389 inpatient and 289,617 outpatient claims 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 \$3,466,115 in Medicare payments to the Hospital for 367 claims that we judgmentally selected as potentially at risk for billing errors. These 367 claims consisted of 305 inpatient and 62 outpatient claims with payment dates 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 evaluated compliance with selected billing requirements and subjected a 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 at the Hospital from November through December 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;
- obtained information on known credits for replacement cardiac medical devices from the device manufacturers 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 367 claims (305 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;
- utilized Medicare contractor medical review staff to determine whether a limited selection of sampled claims met medical necessity requirements;
- 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;
- utilized an outside independent contractor to determine whether questioned inpatient short stay claims met medical necessity requirements; 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 requirements for billing inpatient and outpatient services for 187 of the 367 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 180 claims,<sup>3</sup> resulting in overpayments totaling \$613,279 during the period July 1, 2008, through December 31, 2010. Specifically, 155 inpatient claims had billing errors resulting in overpayments totaling \$589,018, and 25 outpatient claims had billing errors resulting in overpayments totaling \$24,261. These 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.

Only risk areas with errors are listed in the findings and recommendations section below.

### **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 155 of the 305 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$589,018.

#### **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 ....” 42 CFR § 424.13(a) states 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 120 of the 240 sampled claims, the Hospital incorrectly billed Medicare Part A for inpatient claims that should have been billed as outpatient or outpatient with observation services (119 claims) or did not have a valid physician’s order to admit the beneficiary for inpatient care (1 claim). Hospital officials attributed the patient admission errors to inadequate internal controls for monitoring short stays and the lack of physicians’ orders to human error. As a result, the Hospital received overpayments totaling \$556,156.

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<sup>3</sup> This figure does not include eight inpatient short stays that we questioned in our draft report. We removed these claims and their associated dollars from this final report due to the age of the claims.

## **Inpatient Psychiatric Facility Emergency Department Adjustments**

Pursuant to 42 CFR § 412.424(d)(1)(v), CMS adjusts the Federal per diem base rate upward for the first day of a Medicare beneficiary's stay at an IPF to account for costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary used emergency department services. However, the IPF should not receive the additional payment if the beneficiary was discharged from the acute care section of the same hospital. CMS requires that an IPF enter a source of admission code on each claim. The Manual, chapter 3, section 190.6.4.1, states that source of admission code "D" should be reported by IPFs to identify IPF patients who have been transferred to the IPF from the same hospital.<sup>4</sup>

For all 32 claims reviewed, the Hospital did not enter source of admission code "D" for beneficiaries who were admitted to the IPF upon discharge from the acute care section of the same hospital. Hospital officials stated that the errors occurred because source of admission code "D" was not an available option within the Hospital's existing billing system. As a result, the Hospital received overpayments totaling \$3,270.

## **Inpatient Manufacturer Credits for Medical Devices**

Federal regulations (42 CFR § 412.89) require reductions 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 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 bill correctly for a replacement device that was provided with a credit, the hospital must use the combination of condition codes 49 or 50 along with value code "FD."

For 2 of the 10 sampled claims, the Hospital received full credit from the manufacturer for a replaced medical device but did not report the "FD" value code to reduce payment as required. The Hospital officials stated that these errors occurred due to inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result, the Hospital received overpayments totaling \$23,450.

## **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.

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<sup>4</sup> An IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For one of the eight sampled claims, the Hospital billed Medicare separately for a related discharge and readmission within the same day. Hospital officials stated that the error occurred because existing internal controls failed to identify the claim for case management review. As a result, the Hospital received an overpayment totaling \$6,142.

## **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 25 of 62 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$24,261.

### **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).” In addition, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

For 15 of the 34 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes that did not meet criteria for the use of modifier -59. Hospital officials stated these errors occurred primarily because of human error, including the hospital staff’s misinterpretation of Medicare billing requirements for claims with modifier -59. As a result, the Hospital received overpayments totaling \$10,009.

### **Outpatient Evaluation and Management Services Billed with Surgical Services**

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, requires that claims be completed accurately to be processed correctly and promptly.

For 7 of the 13 sampled claims, the Hospital incorrectly billed Medicare for evaluation and management services that were part of the usual preoperative and postoperative care associated with the procedure. Hospital officials stated that the errors occurred because coding staff did not fully understand Medicare billing requirements for evaluation and management services. As a result, the Hospital received overpayments totaling \$448.

### **Outpatient Manufacturer Credits for Medical Devices**

Federal regulations (42 CFR § 419.45) require reductions in the OPSS 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 in the Manual explains how a provider should report no-cost and reduced-cost devices under the OPSS. For services furnished

on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduce 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.

For two of the three sampled claims, the Hospital received a full credit from the manufacturer for a replaced device but did not report the required “FB” modifier or reduce the charges on its claim. Hospital officials stated that these errors occurred due to inadequate controls to identify, obtain, and properly report credits from device manufacturers. As a result, the Hospital received overpayments totaling \$11,726.

### **Outpatient Claims Billed for Doxorubicin Hydrochloride**

The Manual, chapter 4, section 20.4, states: “The definition of service units ... is the number of times the service or procedure being reported was performed.” The Manual, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

For 1 of the 12 sampled claims, the Hospital incorrectly billed Medicare with an incorrect number of units of doxorubicin hydrochloride. Hospital officials stated that the error occurred because of human error. As a result, the Hospital received an overpayment totaling \$2,078.

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$613,279, and
- strengthen controls to ensure full compliance with Medicare requirements.

### **NEW YORK UNIVERSITY LANGONE MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the Hospital agreed with part of our first recommendation and described actions that it has taken to address our second recommendation. The Hospital disagreed with 101 of the 129 inpatient short stay claims questioned in our draft report. Specifically, the Hospital stated that, based on the clinical indications demonstrated by the patient and supported by the documentation in the medical record, the physician determination for admission was justified and medically necessary for each of the claims. The Hospital’s comments appear in their entirety as the Appendix.

After reviewing the Hospital’s comments, we maintain that our findings and recommendations are valid for all but one inpatient short stay claim. We utilized both the Medicare contractor medical review staff and an independent medical review contractor to determine whether 93 inpatient short stay claims met medical necessity requirements. Based on the contractors’ conclusions, we determined that 92 inpatient short stay claims should have been billed as outpatient or outpatient with observation services. The independent medical review contractor determined that one claim was correctly billed as an inpatient stay. We are no longer

questioning eight other inpatient short stay claims due to the age of the claims and have revised our finding and related recommendation accordingly.

# **APPENDIX**

**APPENDIX: NEW YORK UNIVERSITY LANGONE MEDICAL CENTER COMMENTS**



**Nancy Dean, JD, MPA, CHC, CHRC**  
Vice President  
Compliance, Privacy & Internal Audit

June 14, 2012

Mr. James P. Edert  
Regional Inspector General for Audit Services  
Office of Inspector General  
Office of Audit Services, Region II  
Jacob K. Javits Federal Building  
26 Federal Plaza, Room 3900  
New York, New York 10278

**RE: Report Number: A-02-11-01043**

Dear Mr. Edert:

We are in receipt of the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled Medicare Compliance Review of New York University Langone Medical Center for the period July 1, 2008 through December 31, 2010.

The Medicare Compliance Review sampled 367 claims across a variety of inpatient and outpatient areas. The audit concluded that 189 of the 367 claims were billed incorrectly, resulting in overpayments of \$653,969. The recommendations contained in the report include:

- refunding the Medicare contractor \$653,969 and
- strengthening controls to ensure full compliance with Medicare requirements.

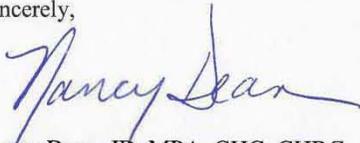
NYU Langone Medical Center takes the OIG findings and recommendations very seriously, concurs with findings of error on 88 of the 189 claims, and will make a refund of \$179,038 related to these claim errors. NYU Langone Medical Center does not agree with the OIG findings on 101 inpatient short stay claims worth \$474,931. Based on the clinical indications demonstrated by the patient and supported by the documentation in the medical record we believe the physician determination for admission is justified and medically necessary and we will exercise our rights to have a claim re-determination conducted by our Medicare Administrative Contractor, National Government Services. Therefore, we will appeal these claims with National Government services.

NYU Langone Medical Center has reviewed the claims errors and has implemented various processes and systems to prevent these errors from occurring in the future. All of the corrective measures will be monitored on an ongoing basis to ensure that the Hospital remains in compliance with Medicare billing requirements.

We are committed to ensuring we are compliant with Medicare billing rules and regulations. We will continue to educate our staff and conduct auditing and monitoring activities to strengthen and improve our internal controls.

Please contact me if you need any additional information.

Sincerely,

A handwritten signature in blue ink that reads "Nancy Dean". The signature is fluid and cursive, with a long horizontal stroke at the end.

Nancy Dean, JD, MPA, CHC, CHRC  
Vice President Compliance, Privacy & Internal Audit