

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF THE HOSPITAL OF  
THE UNIVERSITY OF  
PENNSYLVANIA FOR CALENDAR  
YEARS 2008 THROUGH 2011**

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**Stephen Virbitsky  
Regional Inspector General**

**July 2013  
A-03-12-06104**

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## EXECUTIVE SUMMARY

*The Hospital of the University of Pennsylvania did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in net overpayments of \$538,000 over 4 years.*

### WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether the Hospital of the University of Pennsylvania (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient 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, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is a private 784-bed acute-care teaching hospital located in Philadelphia, Pennsylvania. The Hospital is part of the University of Pennsylvania Health System. Medicare paid the Hospital approximately \$913.2 million for 33,051 inpatient and 543,593 outpatient claims for services provided to beneficiaries during CYs 2008 through 2011 based on CMS's National Claims History data.

Our audit covered \$3,961,324 in Medicare payments to the Hospital for 208 claims that we judgmentally selected as potentially at risk for billing errors, consisting of 158 inpatient and 50 outpatient claims.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 154 of the 208 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 54 claims, resulting in net overpayments of \$537,876 for CYs 2008 through 2011. Specifically, 30 inpatient claims had billing errors resulting in net overpayments of \$279,041, and 24 outpatient claims had billing errors resulting in net overpayments of \$258,835. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

## **WHAT WE RECOMMEND**

We recommend that the Hospital:

- refund to the Medicare contractor \$537,876, consisting of \$279,041 in net overpayments for 30 incorrectly billed inpatient claims and \$258,835 in net overpayments for 24 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital generally agreed with our findings and provided information on actions that it had taken to address our recommendations.

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## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2011, Medicare paid hospitals \$151 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

### **OBJECTIVE**

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

### **BACKGROUND**

#### **The Medicare Program**

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. 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.

#### **Hospital Inpatient Prospective Payment System**

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). 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, intended to be 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), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. 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.<sup>1</sup> All services and items within an APC group are comparable clinically and require comparable resources.

### **Hospital Claims at Risk for Incorrect Billing**

Our previous work identified these types of hospital claims at risk for noncompliance:

- inpatient claims billed with high severity level DRG codes,
- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims paid in excess of charges,
- outpatient claims billed during inpatient stays,
- outpatient dental services,
- outpatient intensity modulated radiation therapy planning services, and
- outpatient claims billed with modifier -59.

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.” We reviewed these risk areas as part of this review.

### **Medicare Requirements for Hospital Claims and Payments**

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” (the Social Security Act (the Act), § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)).

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

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

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<sup>1</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

## **Hospital of the University of Pennsylvania**

The Hospital, which is part of the University of Pennsylvania Health System, is a private 784-bed acute-care teaching hospital located in Philadelphia, Pennsylvania. Medicare paid the Hospital approximately \$913.2 million for 33,051 inpatient and 543,593 outpatient claims for services provided to beneficiaries during CYs 2008 through 2011 based on CMS's National Claims History data.

### **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$3,961,324 in Medicare payments to the Hospital for 208 claims that we judgmentally selected as potentially at risk for billing errors. These 208 claims consisted of 158 inpatient and 50 outpatient claims with dates of service in CYs 2008 through 2011 (audit period). We focused our review on the risk areas that we had identified as a result of previous 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. 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 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 objectives.

See Appendix A for the details of our scope and methodology.

### **FINDINGS**

The Hospital complied with Medicare billing requirements for 154 of the 208 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 54 claims, resulting in net overpayments of \$537,876 for the audit period. Specifically, 30 inpatient claims had billing errors resulting in net overpayments of \$279,041, and 24 outpatient claims had billing errors resulting in net overpayments of \$258,835. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

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

The Hospital incorrectly billed Medicare for 30 of 158 selected inpatient claims, which resulted in net overpayments of \$279,041.

##### **Incorrectly Billed Diagnosis-Related Group Codes**

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” (the Act, §1862(a)(1)(A)). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 11 of the 158 selected claims, the Hospital billed Medicare for incorrect DRG codes. Hospital officials attributed this to human error. As a result of these errors, the Hospital received net overpayments of \$133,419. The Hospital received overpayments of \$142,022 (10 claims) and was underpaid \$8,603 (1 claim).

### **Incorrectly Billed as Inpatient**

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” (the Act, §1862(a)(1)(A)).

For 8 of the 158 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Hospital officials stated that the errors occurred because Hospital utilization review staff applied inappropriate criteria in its review of the claims. As a result of these errors, the Hospital received overpayments of \$82,702.<sup>2</sup>

### **Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained**

Federal regulations 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 device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). Federal regulations state, “All payments to providers of services must be based on the reasonable cost of services ...” (42 CFR § 413.9). The Manual states that to bill correctly 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” (chapter 3, § 100.8). The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements in additional detail.<sup>3</sup>

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<sup>2</sup> The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. 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 Medicare administrative contractor prior to the issuance of our report.

<sup>3</sup> The PRM 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.” (part 1, § 2102.1). Section 2103 further defines prudent buyer principles and 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 or payments 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 10 of the 158 selected claims, the Hospital did not obtain credits for replaced medical devices for which credits were available under the terms of the manufacturers' warranties. One of the 10 claims also included a second replaced medical device. The Hospital received a reportable credit from the manufacturer for the second device but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required. Hospital officials stated that the errors occurred because the Hospital had inadequate controls to identify, obtain, and properly report credits from medical device manufacturers. As a result of these errors, the Hospital received overpayments of \$59,920.

### **Incorrectly Billed as a Separate Inpatient Stay**

The Manual (chapter 3, § 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 the 158 selected claims, the Hospital billed Medicare separately for a related discharge and readmission within the same day. Hospital officials stated that the error occurred because Hospital utilization review staff applied inappropriate criteria in its review of the claims. As a result of this error, the Hospital received an overpayment of \$3,000.

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

The Hospital incorrectly billed Medicare for 24 of 50 selected outpatient claims, which resulted in net overpayments of \$258,835.

#### **Services Not Performed**

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2). Further, the Manual requires hospitals to include the HCPCS codes for the radiolabeled product and all related nuclear medicine procedures on the same claim, regardless of the dates the procedures were performed (chapter 4, § 200.8).

For 7 of the 50 selected claims, Hospital personnel stated that the Hospital billed Medicare for services that were not performed.

- For five claims (\$143,457 overpayment), the Hospital incorrectly billed for a radiolabeled product (HCPCS code A9545) that was not administered. The Hospital billed five nuclear medicine procedures separately from the claims that included the radiolabeled products administered, but incorrectly added HCPCS code A9545 to each of the five claims. These errors occurred because billing staff incorrectly interpreted the Medicare requirement for billing nuclear medicine procedures.

- For one claim (\$4,298 overpayment), the Hospital billed two HCPCS codes (33224 and 33225) for the insertion of a medical device when only one HCPCS code (33224) was appropriate. The billing was attributed to human error.
- For the remaining claim (\$244 overpayment), the Hospital billed for two cardiac procedures that were already billed on a separate claim for a previous date of service. This error occurred because the procedure report for the cardiac procedures was misfiled with the medical records for a subsequent date of service.

As a result of these errors, the Hospital received overpayments of \$147,999.

### **Manufacturer Credits for Replaced Medical Devices Not Reported or Obtained**

Federal regulations 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 (42 CFR § 419.45). 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.<sup>4</sup> As described on page 4 of this report, the PRM, part 1, chapter 21, reinforces these requirements in additional detail.

For 8 of the 50 selected claims, the Hospital did not obtain credits for replaced medical devices for which credits were available under the terms of the manufacturers’ warranties. One of the eight claims also included a second replaced medical device. The Hospital received a reportable credit from a manufacturer for the second device but did not properly report the “FB” modifier and reduced charges on its claim. Hospital officials stated that the errors occurred because the Hospital had inadequate controls to identify, obtain, and properly report credits from medical device manufacturers. As a result of these errors, the Hospital received overpayments of \$88,095.

### **Incorrectly Billed as Outpatient**

Certain items and nonphysician services furnished to inpatients are covered under Part A and consequently are covered by the inpatient prospective payment rate (the Manual, chapter 3, § 10.4).

For 6 of the 50 selected claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays. For four claims, the Hospital provided wound care, radiation, injection, and air transport services to inpatients of other hospitals. Those services should have been included on the other hospitals’ inpatient (Part A) claims to Medicare. For the remaining two claims, the Hospital provided radiation therapy and blood transfusion services to

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<sup>4</sup> CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

inpatients of the Hospital and should have included these services on the Hospital's inpatient claims to Medicare. Hospital officials attributed this to human error in the Hospital's manual process for reviewing outpatient services provided during inpatient stays. As a result of these errors, the Hospital received net overpayments of \$11,165. The Hospital received overpayments of \$11,421 for five claims and was underpaid \$256 for one claim.

### **Noncovered Dental Services**

The Act precludes payment under Part A or Part B for any expense incurred for items or services where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth (the Act, § 1862(a)(12)).

For 2 of the 50 selected claims, the Hospital incorrectly billed Medicare for the treatment or removal of teeth. Hospital officials stated that the errors occurred because Hospital departmental staff misinterpreted coverage eligibility requirements for dental services. As a result of these errors, the Hospital received overpayments of \$10,502.

### **Insufficiently Documented Service and Incorrectly Billed Healthcare Common Procedure Coding System Code**

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 1 of the 50 selected claims, the Hospital billed Medicare for a service that was not supported in the medical record and a separate incorrect HCPCS code. Hospital officials attributed this to human error after the Hospital billing department moved from a paper-based billing process to a paperless one. As a result of these errors, the Hospital received an overpayment of \$1,074.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$537,876, consisting of \$279,041 in net overpayments for 30 incorrectly billed inpatient claims and \$258,835 in net overpayments for 24 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital generally agreed with our findings and provided information on actions that it had taken to address our recommendations. The Hospital's comments are included in their entirety as Appendix C.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered \$3,961,324 in Medicare payments to the Hospital for 208 claims that we judgmentally selected as potentially at risk for billing errors. These 208 claims consisted of 158 inpatient and 50 outpatient claims with dates of service in CYs 2008 through 2011 (audit period).

We focused our review on the risk areas that we had identified as a result of previous 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 areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established 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 May 2012 through April 2013.

### **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 audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 208 claims (158 inpatient and 50 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;
- reviewed the medical record documentation provided by the Hospital to support the selected claims;

- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for 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 objectives.

**APPENDIX B: RESULTS OF REVIEW BY RISK AREA**

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Underpayments/Overpayments</b>	<b>Value of Net Overpayments</b>
<b>Inpatient</b>				
Claims Billed with High Severity Level Diagnosis-Related Group Codes	33	\$828,853	12	\$149,445
Short Stays	71	608,279	6	60,445
Manufacturer Credits for Replaced Medical Devices	50	1,801,722	10	59,920
Same-Day Discharges and Readmissions	4	272,161	2	9,231
<b>Inpatient Totals</b>	<b>158</b>	<b>\$3,511,015</b>	<b>30</b>	<b>\$279,041</b>
<b>Outpatient</b>				
Claims Paid in Excess of Charges	5	\$144,513	5	\$143,457
Manufacturer Credits for Replaced Medical Devices	14	206,731	9	92,393
Claims Billed During Inpatient Stays	7	16,140	6	11,165
Dental Services	3	13,101	2	10,502
Intensity Modulated Radiation Therapy Planning Services	3	23,273	1	1,074
Claims Billed with Modifier -59	18	46,551	1	244
<b>Outpatient Totals</b>	<b>50</b>	<b>\$450,309</b>	<b>24</b>	<b>\$258,835</b>
<b>Inpatient and Outpatient Totals</b>	<b>208</b>	<b>\$3,961,324</b>	<b>54</b>	<b>\$537,876</b>

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

## APPENDIX C: HOSPITAL COMMENTS



Office of Billing Compliance

University of Pennsylvania Health System

**Robert F. Bacon, MHA**  
Associate Vice President and  
Billing Compliance Officer

June 19, 2013

**VIA UPS**

Stephen Virbitsky  
Regional Inspector General for Audit Services  
U S Department of Health & Human Services  
Office of the Inspector General  
Public Ledger Building, Suite 316  
150 South Independence Mall West  
Philadelphia, PA 19106-3499

**Re:** Report Number A-03-12-06104  
Hospital of the University of Pennsylvania (HUP)

Dear Mr. Virbitsky:

I am writing on behalf of the Hospital of the University of Pennsylvania (HUP) in response to your draft report dated May 23, 2013.

The University of Pennsylvania Health System (UPHS) is strongly committed to compliance with all applicable regulations. We understand the Office of the Inspector General's (OIG) important role in ensuring compliance with billing regulations, and greatly appreciate the opportunity to respond to your draft report.

As noted in the draft report and reiterated in *Appendix A: Audit Scope and Methodology*, the government's sample was not randomly drawn, but instead "used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk" ...and "judgmentally selected 208 claims for detailed review". We have reviewed in detail the draft findings and generally agree that 54 of 208 claims selected for review reflected inadvertent billing errors. Pursuant to instructions from your staff, UPHS has filed adjustment claims with Medicare for all 54 claims identified and provided copies of the same to your office.

The following represents a brief discussion regarding identified errors and the related corrective action which has already been initiated by UPHS:

### **1. Incorrectly Billed Diagnosis Related Group Codes**

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- a. These errors were principally attributable to incorrect selection of principal and/or secondary diagnosis codes by the coding staff when applying the ICD-9-CM coding guidelines and conventions.
- b. UPHS has conducted an additional, special education session for the coding staff on sequencing of principal and secondary diagnosis codes as specified in the ICD-9-CM Official Guidelines for Coding and Reporting. Coding staff were informed to refer any case requiring clarification regarding DRG assignment to the coding supervisor prior to billing.

## **2. Incorrectly Billed As Inpatient**

- a. These errors were principally attributable to incorrect application of InterQual criteria set by the Clinical Resource Coordinator (utilization review RN) as part of the utilization review process.
- b. UPHS has conducted additional training sessions for the Clinical Resource Coordinators on selection and use of InterQual Criteria to determine correct level of care. Staff were reminded that cases not meeting InterQual criteria must be referred for secondary review to the HUP physician advisor and/or an external physician advisor company retained by UPHS.

## **3. Manufacturers Credits for Replaced Medical Devices Not Reported or Obtained**

- a. These errors were attributable to inadequate controls to identify, obtain, and properly report credits from device manufacturers.
- b. UPHS conducted a series of interdepartmental meetings to include the clinical departments, Patient Accounting, Finance, Purchasing and Compliance to heighten awareness and develop effective controls for tracking and managing device credits. UPHS implemented the following action:
  - i. A new process including a log for all device retrievals that immediately sends devices back to manufacturers for device interrogation and determination of credit amounts.
  - ii. Developed a monthly reconciliation process with the manufacturers.

## **4. Outpatient Claims Paid in Excess of Charges**

- a. These errors were principally attributable to unique requirements with respect to billing nuclear medicine procedures resulting in data entry errors related to pharmaceuticals.
- b. UPHS conducted a focused education session for the staff involved with these services. More importantly, the staff were reminded that no services can be added to a claim without proof of documentation.

Stephen Virbitsky  
June 19, 2013  
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We appreciate the opportunity to respond to the draft audit report from the OIG, and believe that our subsequent remediation efforts will greatly reduce the likelihood of similar problems in the future.

If you have any questions or require additional information, please do not hesitate to contact me.

Respectfully submitted,

/Robert F. Bacon/

Pc: Diane Corrigan  
Keith Kasper