

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF NORTHSORE
UNIVERSITY
HEALTHSYSTEM
FOR 2013 AND 2014**

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Office of Inspector General

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EXECUTIVE SUMMARY

NorthShore University HealthSystem did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated overpayments of at least \$4.1 million over 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2014, Medicare paid hospitals \$159 billion, which represents 46 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 NorthShore University HealthSystem (NorthShore) complied with Medicare requirements for billing inpatient and outpatient services on selected types of 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 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. CMS pays inpatient rehabilitation services at a predetermined rate according to the distinct case-mix group (CMG). The CMG is based on the beneficiary's clinical characteristics and expected resource needs. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Under section 1128J(d) of the Social Security Act and 42 CFR Part 401 Subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments. (42 CFR 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

NorthShore is a 789-bed acute care teaching health system comprising Evanston, Glenbrook, Highland Park, and Skokie Hospitals located in or near Evanston, Illinois. Our audit covered claims billed under the provider number used for Evanston, Glenbrook, and Highland Park Hospitals (the Hospitals). Medicare paid the Hospitals approximately \$567 million for 32,577 inpatient and 1,059,931 outpatient claims for services provided to beneficiaries during CYs 2013 and 2014.

Our audit covered \$24,616,746 in Medicare payments to the Hospitals for 2,728 claims that were potentially at risk for billing errors. These claims consisted of inpatient and outpatient claims paid to the Hospitals for services provided to Medicare beneficiaries during CYs 2013 and 2014 (audit period). We selected a stratified random sample of 190 claims with payments totaling \$2,030,823 for review. These 190 claims had dates of service during the audit period and consisted of 89 inpatient and 101 outpatient claims.

WHAT WE FOUND

The Hospitals complied with Medicare billing requirements for 97 of the 190 inpatient and outpatient claims we reviewed. However, the Hospitals did not fully comply with Medicare billing requirements for the remaining 93 claims, resulting in overpayments of \$624,638 for the audit period. Specifically, 46 inpatient claims had billing errors, resulting in overpayments of \$496,366, and 47 outpatient claims had billing errors, resulting in overpayments of \$128,272. These errors occurred primarily because the Hospitals did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospitals received overpayments of at least \$4,110,073 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospitals:

- refund to the Medicare contractor \$4,110,073 (of which \$624,638 was overpayments identified in our sample) in estimated overpayments for incorrectly billed services;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

NORTSHORE UNIVERSITY HEALTHSYSTEM COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital generally disagreed with our findings and recommendations and described corrective actions that it has taken in response to our third recommendation.

After considering the Hospital's comments, we continue to recommend that the Hospital refund to the Medicare contractor \$4,110,073 in estimated overpayments and strengthen controls to ensure full compliance with Medicare requirements.

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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 data analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2014, Medicare paid hospitals \$159 billion, which represents 46 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 NorthShore University HealthSystem (NorthShore) complied with Medicare requirements for billing inpatient and outpatient services on selected types of 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 administrative contractors (MACs) 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 Inpatient Rehabilitation Prospective Payment System

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for inpatient rehabilitation facilities. CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the payment system, CMS established a Federal

prospective payment rate for each of the distinct case-mix groups (CMG). The assignment to a CMG is based on the beneficiary's clinical characteristics and expected resource needs. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

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.¹ 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 at other hospitals identified these types of claims at risk for noncompliance:

- inpatient claims billed with high-severity-level DRG codes,
- inpatient rehabilitation,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient observation claims with outlier payments,
- outpatient claims for Intensity Modulated Radiation Therapy (IMRT),
- outpatient claims for Herceptin, and
- outpatient dental claims.

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 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 Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

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

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).

Under section 1128J(d) of the Social Security Act and 42 CFR Part 401 Subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments. (42 CFR 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

NorthShore University HealthSystem

NorthShore is a 789-bed acute care teaching health system comprising Evanston, Glenbrook, Highland Park, and Skokie Hospitals located in or near Evanston, Illinois. Our audit covered claims billed under the provider number used for Evanston, Glenbrook, and Highland Park Hospitals (the Hospitals). Medicare paid the Hospitals approximately \$567 million for 32,577 inpatient and 1,059,931 outpatient claims for services provided to beneficiaries during CYs 2013 and 2014.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$24,616,746 in Medicare payments to the Hospitals for 2,728 claims that were potentially at risk for billing errors. These claims consisted of inpatient and outpatient claims paid to the Hospitals for services provided to Medicare beneficiaries during CYs 2013 or 2014 (audit period). We selected a stratified random sample of 190 claims with payments totaling \$2,030,823 for review. These 190 claims had dates of service during the audit period and consisted of 89 inpatient and 101 outpatient claims.

We focused our review on the risk areas that we identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 129 claims to focused medical review to determine whether the services met medical necessity and coding requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims that the Hospitals submitted 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 audit scope and methodology.

FINDINGS

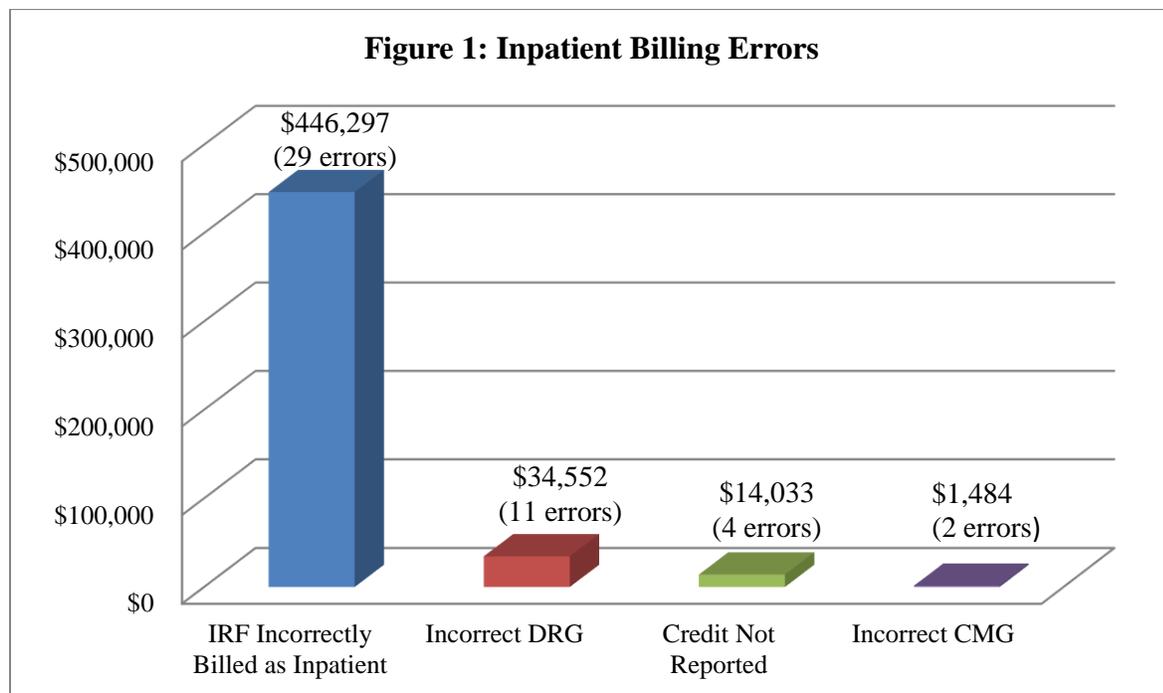
The Hospitals complied with Medicare billing requirements for 97 of the 190 inpatient and outpatient claims we reviewed. However, the Hospitals did not fully comply with Medicare billing requirements for the remaining 93 claims, resulting in overpayments of \$624,638 for the audit period. Specifically, 46 inpatient claims had billing errors, resulting in overpayments of \$496,366, and 47² outpatient claims had billing errors, resulting in overpayments of \$128,272. These errors occurred primarily because the Hospitals did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospitals received overpayments totaling at least \$4,110,073 for the audit period.

See Appendix B for our statistical sampling methodology, Appendix C for our sample results and estimates, and Appendix D for the results of our review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospitals incorrectly billed Medicare for 46 of 89 sampled inpatient claims, which resulted in net overpayments of \$496,366 as shown in Figure 1.



² Of the 47 outpatient claims, 8 had errors with no monetary effect.

Inpatient Rehabilitation Facility Services Incorrectly Billed as Inpatient

Medicare may not pay 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)).

The *Medicare Benefit Policy Manual* states that the IRF benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care (Pub. No. 100-02, chapter 1, § 110).

In addition, the *Medicare Benefit Policy Manual* states that for IRF care to be considered reasonable and necessary, the documentation in the patient’s IRF medical record must demonstrate a reasonable expectation that, at the time of admission to the IRF, the patient (1) required the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally required an intensive rehabilitation therapy program; (3) actively participated in, and benefited significantly from, the intensive rehabilitation therapy program; (4) required physician supervision by a rehabilitation physician; and (5) required an intensive and coordinated interdisciplinary approach to providing rehabilitation (Pub. No. 100-02, chapter 1, § 110.2).

Furthermore, the *Medicare Benefit Policy Manual* states that a primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient’s IRF medical record must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs (Pub. No. 100-02, chapter 1, § 110.2.2).

For 29 of the 89 sampled inpatient claims, the Hospitals incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation services. The Hospitals did not provide a cause for the errors because officials continue to contend that these claims met Medicare requirements.

As a result of these errors, the Hospitals received overpayments totaling \$446,297.³

Incorrectly Billed Diagnosis-Related-Group Codes

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(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).

³ The Hospitals may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status). Until the Hospitals bill these Medicare Part B services and the MAC adjudicates them, we do not have enough information to determine the effect on the overpayment amount. The Hospitals should contact their MAC for rebilling instructions.

For 11 of the 89 sampled claims, the Hospitals billed Medicare for an incorrect DRG code. The Hospitals did not provide a cause for the errors because officials continue to contend that the DRG codes for these claims were correct.

As a result of these errors, the Hospitals received overpayments of \$34,552.⁴

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require a reduction in the IPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives a partial credit equal to or greater than 50 percent of the device cost (42 CFR § 412.89).

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).

For 4 of the 89 sampled claims, the Hospitals received but failed to report a credit for a replaced device received under the terms of the manufacturer’s warranty. Hospitals officials stated that these errors occurred because of inconsistent or untimely communication between the manufacturer and the hospital regarding available device credits.

As a result of these errors, the Hospitals received overpayments of \$14,033.

Incorrectly Billed Group Codes

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(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).

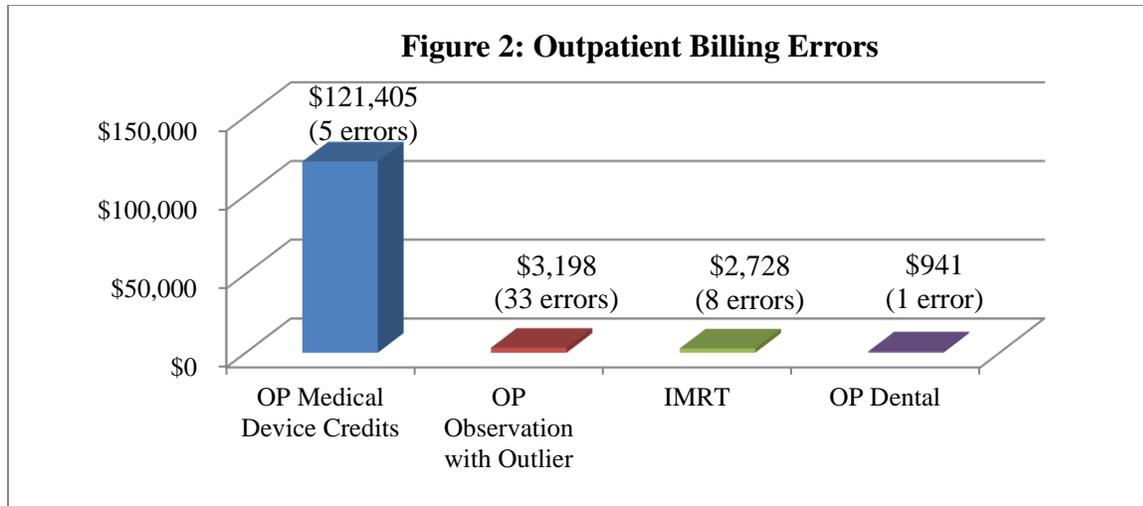
For 2 of the 89 sampled claims, the Hospitals billed Medicare for an incorrect CMG code. Hospitals did not provide a cause for the errors because officials continue to contend that the DRG codes for these claims were correct.

As a result of these errors, the Hospitals received overpayments of \$1,484.

⁴ The Hospitals may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status). Until the Hospitals bill these Medicare Part B services and the MAC adjudicates them, we do not have enough information to determine the effect on the overpayment amount. The Hospitals should contact their MAC for rebilling instructions.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospitals incorrectly billed Medicare for 47 of 101 sampled outpatient claims, which resulted in net overpayments of \$128,272 as shown in Figure 2 below.



Manufacturer Credits for Replaced Medical Devices Not Obtained and Reported

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(a)).

Federal regulations state: “All payments to providers of services must be based on the reasonable cost of services ...” (42 CFR § 413.9). The *CMS Provider Reimbursement Manual (PRM)* reinforces this requirement in additional detail (Pub. No. 15-1). 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 I, § 2102.1).

The PRM further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties (part I, § 2103.A). The PRM provides the following example: “Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacture for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment” (part I, § 2103.C.4).

For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduced charges on an outpatient 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.⁵

For 5 of the 101 sampled claims, the Hospitals did not obtain a credit for a replaced device for which a credit was available under the terms of the manufacturer's warranty. Hospital officials stated that these errors occurred because of inconsistent or untimely communication between the manufacturer and the Hospitals regarding available device credits.

As a result of these errors, the Hospitals received overpayments of \$121,405.

Incorrectly Billed Observation Services and Unsupported Charges Resulting in Incorrect Outlier Payments

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

The Manual states: “Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services” (chapter 4, § 290.1). In addition, the Manual states:

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order.... Observation time ends when all medically necessary services related to observation care are completed. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4 to 6 hours), which should be billed as recovery room services (chapter 4, § 290.2.2).

For 33⁶ of the 101 sampled claims, the Hospitals incorrectly billed Medicare for services that were not supported in the medical record.⁷ Specifically, the Hospitals included observation time for services that were part of another Part B service, including postoperative monitoring or standard recovery care (22 errors), for time the patients remained in the hospital after treatment was finished (18 errors), or for observation services that did not have timely orders in the medical records (8 errors). The Hospitals did not provide a cause for the errors because officials continue to contend that the medical record supported these claims.

⁵ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPTS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3). 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.

⁶ The total errors exceed 33 because some of the claims contained more than one type of error.

⁷ Of the 33 outpatient claims, 8 had errors with no monetary effect.

As a result of these errors, the Hospitals received overpayments of \$3,198.

Intensity Modulated Radiation Therapy Services Did Not Fully Meet Medicare Coverage Criteria as Billed

The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). In addition, chapter 4, section 200.3.2 of the Manual requires that certain services should not be billed when they are performed as part of developing an IMRT plan.

For 8 of the 101 sampled outpatient claims, the Hospitals incorrectly billed Medicare for IMRT services. The Hospitals did not provide a cause for the errors because it continues to contend that it correctly billed these claims.

As a result of these errors, the Hospitals received overpayments of \$2,728.

Incorrectly Billed Claims for Outpatient Dental Services

Medicare generally does not cover hospital outpatient dental services. Under the general exclusion provisions of the Act, items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth (e.g., preparation of the mouth for dentures) are not covered (§ 1862(a)(12)).

For hospital outpatient dental services to be covered, they must be performed as incident to and as an integral part of a procedure or service covered by Medicare. For example, Medicare covers extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw, but a tooth extraction performed because of tooth decay is not covered (*Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, section 150).

For 1 of the 101 sampled claims, the Hospitals billed Medicare for a hospital dental service that did not meet Medicare coverage criteria. Hospital officials stated that this error was an isolated incident that occurred when the dental clinic was closed and the patient was treated in the emergency room.

As a result of this error, the Hospitals received an overpayment of \$941.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospitals received overpayments of at least \$4,110,073 for the audit period.

RECOMMENDATIONS

We recommend that the Hospitals:

- refund to the Medicare contractor \$4,110,073 (of which \$624,638 was overpayments identified in our sample) in estimated overpayments for incorrectly billed services;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having being made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

NORTHSHORE UNIVERSITY HEALTHSYSTEM COMMENTS

In written comments on our draft report, the Hospitals generally disagreed with our findings and recommendations and described corrective actions that they have taken in response to our third recommendation.

The Hospitals agreed that 35 of the 93 claims identified in our draft report were improperly billed and said that they plan to reprocess the claims and refund Medicare. The Hospitals disagreed with our determination that they did not correctly bill the remaining 58 claims. For 39 inpatient claims, the Hospitals maintained that the inpatient admissions were appropriate and met Medicare criteria. For 19 outpatient claims, the Hospitals stated that the medical record and documentation appropriately support the services provided. Finally, the Hospitals disagreed with the reasonableness and validity of our overall statistical estimation.

The Hospitals' comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

In response to the Hospitals' comments, we maintain that all of our findings and the associated recommendations are valid. For 58 of the 58 contested claims, we subjected these claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Each claim that was denied was reviewed by two clinicians, including a physician. We stand by those determinations. The Hospital is within its rights to appeal the recommended disallowances through the Medicare appeals process.

Regarding the Hospitals' objections to our statistical sampling and extrapolation methodology, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.⁸ We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software to apply the correct formulas for the extrapolation.

⁸ See *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enter., LLC, v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$24,616,746 in Medicare payments to the Hospitals for 2,728 claims that were potentially at risk for billing errors. These claims consisted of inpatient and outpatient claims paid to the Hospitals for services provided to Medicare beneficiaries during the audit period. We selected a stratified random sample of 190 claims with payments totaling \$2,030,823 for review. These 190 claims had dates of service in CYs 2013 or 2014 (audit period) and consisted of 89 inpatient and 101 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 129 claims to focused medical review to determine whether the services met medical necessity and coding requirements.

We limited our review of the Hospitals' 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 that the Hospitals submitted for Medicare reimbursement.

We conducted our fieldwork from August 2015 through July 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospitals' 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 analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 190 claims (89 inpatient and 101 outpatient) totaling \$2,030,823 for detailed review (Appendix B and C);

- 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 that the Hospitals provided to support the sampled claims;
- requested that the Hospitals conduct their own review of the sampled claims to determine whether they billed the services correctly;
- reviewed the Hospitals’ procedures for submitting Medicare claims;
- used an independent medical review contractor to determine whether 129 sampled claims met medical necessity and coding requirements;
- discussed the incorrectly billed claims with the Hospitals’ personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample review to calculate the estimated Medicare overpayments to the Hospitals (Appendix C); and
- discussed the results of our review with the Hospitals’ 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: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population contained inpatient and outpatient claims paid to the Hospitals for services provided to Medicare beneficiaries during the audit period.

SAMPLING FRAME

Medicare paid the Hospitals \$567,454,300 for 32,577 inpatient and 1,059,931 outpatient claims for services provided to beneficiaries during CYs 2013 and 2014 based on CMS's National Claims History data.

We downloaded a database of claims from the National Claims History database totaling \$360,750,127 for 15,773 inpatient and 239,686 outpatient claims in 31 risk areas. From these 31 areas, we selected 8 consisting of 10,945 claims totaling \$135,957,114 for further review.

We performed data analysis of the claims within each of the eight risk areas. For risk area two, we removed claims with payment amounts less than or equal to \$1,000. For risk area three, we removed claims with claim lines that were billed with less than 10 units of HCPCS G0378 (observation hours).

We then removed the following:

- all \$0 paid claims,
- all claims under review by the Recovery Audit Contractor, and
- all duplicated claims within individual risk areas.

We assigned each claim that appeared in multiple risk areas to just one category based on the following hierarchy: Inpatient MCC/CC, Inpatient Rehabilitation, Outpatient Observation with Outlier Payment Amounts, Outpatient IMRT Planning Services, Inpatient Manufacturer Credits for Replaced Medical Devices, Outpatient Manufacturer Credits for Replaced Medical Devices, Outpatient Herceptin, and then Outpatient Dental. This assignment hierarchy resulted in a sample frame of 2,728 unique Medicare claims in 8 risk areas totaling \$24,616,746 from which we drew our sample (Table 1).

Table 1: Risk Areas

Risk Area	Number of Claims	Amount of Payments
Inpatient Claims Billed With High-Severity-Level DRG Codes	604	\$6,317,182
Inpatient Rehabilitation	368	6,388,313
Outpatient Observation Claims with Outlier Payments	1,439	10,412,084
Outpatient Intensity Modulated Radiation Therapy	287	984,658
Inpatient Manufacturer Credits for Replaced Medical Devices	9	294,312
Outpatient Manufacturer Credits for Replaced Medical Devices	5	166,685
Outpatient Herceptin	14	52,088
Outpatient Dental	2	1,424
Total	2,728	\$24,616,746

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into eight strata based on the risk area.

SAMPLE SIZE

We selected 190 claims for review as follows:

Table 2: Claims by Stratum

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Claims Billed With High-Severity-Level DRG Codes	604	40
2	Inpatient Rehabilitation	368	40
3	Outpatient Observation Claims with Outlier Payments	1,439	40
4	Outpatient Intensity Modulated Radiation Therapy	287	40
5	Inpatient Manufacturer Credits for Replaced Medical Devices	9	9
6	Outpatient Manufacturer Credits for Replaced Medical Devices	5	5
7	Outpatient Herceptin	14	14
8	Outpatient Dental	2	2
	Total	2,728	190

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata one through four. After generating the random numbers for these strata, we selected the corresponding frame items. We selected all claims in strata five through eight.

ESTIMATION METHODOLOGY

We used the 2eOAS statistical software to estimate the total amount of overpayments paid to the Hospitals during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Net Over-payments in Sample
1	604	\$6,317,182	40	\$418,162	11	\$34,552
2	368	6,388,313	40	681,922	31	447,781
3	1,439	10,412,084	40	279,536	33**	3,198
4	287	984,658	40	136,695	8	2,728
5*	9	294,312	9	294,312	4	14,033
6*	5	166,685	5	166,685	5	121,405
7*	14	52,088	14	52,088	0	0
8*	2	1,424	2	1,424	1	941
Total	2,728	\$24,616,746	190	\$2,030,824	93	\$624,638

*We reviewed all claims in this stratum.

**Of these 33 incorrectly billed claims, 8 had no monetary effect.

ESTIMATES

**Table 4: Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval**

Point Estimate	\$ 4,912,305
Lower Limit	4,110,073
Upper Limit	5,714,538

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Table 5: Sample Results by Risk Area

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Under/Over-payments	Value of Net Over-payments
Inpatient				
Claims Billed With High-Severity-Level Diagnosis-Related Group Codes	40*	\$6,317,182	11	\$34,552
Rehabilitation	40*	6,388,313	31	447,781
Manufacturer Credits for Replaced Medical Devices	9	294,312	4	14,033
Inpatient Totals	89	\$12,999,807	46	\$496,366
Outpatient				
Observation Claims with Outlier Payments	40*	\$10,412,084	33	\$3,198
Intensity Modulated Radiation Therapy	40**	984,658	8	2,728
Herceptin	14	52,088	0	0
Manufacturer Credits for Replaced Medical Devices	5	166,685	5	121,405
Dental	2	1,424	1	941
Outpatient Totals	101	\$11,616,939	47	\$128,272
Inpatient and Outpatient Totals	190	\$24,616,746	93	\$624,638

* We submitted all of these claims to a focused medical review to determine whether the services met medical necessity and coding requirements.

** We submitted nine of these claims to a focused medical review to determine whether the services met medical necessity and coding requirements.

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 Hospitals. 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 E: NORTHSORE UNIVERSITY HEALTHSYSTEM COMMENTS



Harry L. Jones, Jr.
Chief Compliance Officer

Office of Corporate
Compliance 1301
Central Street, Suite 140
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November 10, 2016

Report Number: A-05-15-00044

Sheri L. Fulcher, Regional Inspector General for Audit Services
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

Dear Ms. Fulcher:

NorthShore University HealthSystem appreciates the opportunity to review and respond to the OIG Draft Report #A-05-15-00044 sent to us on October 14, 2016.

NorthShore University HealthSystem is a comprehensive, fully integrated healthcare delivery system serving the Chicagoland region. The system includes four hospitals: Evanston, Glenbrook, Highland Park and Skokie. NorthShore employs approximately 10,000 individuals which include 900 employed physicians who are a part of the NorthShore Medical Group, a multispecialty group practice with 132 office locations. NorthShore also has 2,100 affiliated physicians. As the principal teaching affiliate for the University Of Chicago Pritzker School Of Medicine, NorthShore is dedicated to excellence in medical education and research. Combined with NorthShore's established reputation for advanced information technology and its strong clinical environment, this affiliation represents exciting advancements in patient care for the Chicagoland area. We take compliance with CMS Medicare Program requirements for coverage and payment seriously and have performed a detailed review of the audit findings, correlating medical record documentation, and supporting materials through our internal audit, coding and clinical documentation compliance programs. In addition we have utilized external clinical experts to review the OIG's findings related to inpatient rehabilitation services. The following is our response to the OIG Draft Report findings and recommendations.

According to the Draft Report, the OIG reviewed 190 paid claims (89 inpatient and 101 outpatient claims); the report describes a stratified sampling and estimation approach where the 190 claims were composed of 8 strata (1 through 8). For strata 1 - 4 random samples of 40 claims each were used, for a total of 160 paid claims. For the remaining strata 5 - 8 judgmental samples and certainty strata were used, for a total of 30 paid claims. It is noted that only statistically valid random samples can be used for extrapolation of overpayment that is objective and statistically valid. Furthermore, the Draft Report asserts that NorthShore complied with Medicare billing requirements for 97 of the claims, and did not comply with Medicare requirements for 93 paid claims. According to the OIG's Draft Report, not all of the 93 claims with billing errors had a financial impact. Only 84 of the 93 paid claims had an overpayment (8 cases were changes with no associated payment impact) and 1 claim had an underpayment. We respectfully disagree with the OIG's findings for 58 of the 93 paid claims.

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We furthermore disagree with the reasonableness of the overall extrapolation as well as the statistical validity of the overall Point Estimate (\$4,912,305). As such, we also disagree with the validity of the Lower Bound (\$4,110,073) at the 90% confidence level for the Point Estimate that is suggested for recovery. In addition to disagreement on the merits of these 58 claims, NorthShore has concerns with procedural aspects of this audit, including the application and accuracy of the extrapolation.

A statistical extrapolation of overpayment is only as valid and accurate as the individual assessed claims that are incorporated into the estimation. The difference amounts should indicate those amounts that should have been paid if the claim had been billed correctly, based upon the documentation available. In stratum 2 (Inpatient Rehabilitation - which accounted for 71% of the overpayment dollars) any partial overpayments that may be payable were not considered at all and only full overpayments were assessed. This invalidates stratum 2 difference amounts and thereby the Overall Point Estimate.

Most significantly, OIG completely ignores the substantial amount of Part B payment NorthShore would be entitled to receive if the OIG's suggestion that these patients should have been treated at a lower level of care (skilled care) is ultimately determined to be true. Neither the outside medical reviewer nor the OIG questioned that these patients received medically necessary services. The only controversy is whether payment should have been provided under Part A or Part B.

Ignoring the amount of Part B reimbursement corrupts the validity of the extrapolation. In footnote 3 of the Draft Report, OIG acknowledges that the OIG is unable to "determine the effect on the overpayment amount" until the Medicare Part B services are billed by the hospital. (*"Until these Medicare Part B services are billed by the hospital and adjudicated by the Medicare administrative contractor, we do not have enough information to determine the effect on the overpayment amount. The Hospital should contact its MAC for rebilling instructions."*) The fact that OIG admits that the overpayment findings are inaccurate and overstated makes the application of extrapolation using the difference amounts in this stratum particularly troubling. The only certainty is that the OIG's extrapolation is overstated. As this stratum contains 71% of the dollars in question, the Overall Point Estimate and associated upper and lower bounds are tainted.

The issue regarding Part B reimbursements has been raised in other hospital Medicare compliance reviews as well as by the American Hospital Association.¹ It is concerning that OIG has yet to develop a process by which such payments can be accounted for and reflected in the published findings. As the process stands today, it is clear that the published findings are overstated and incomplete. Upon final adjudication of any Part B payments as well as appeals of individual claims, OIG will need to reflect this adjustment and re-calculate the extrapolation and should update the public final report.

Aside from the inaccurate overpayment assessments in stratum 2, there is further concern that the extrapolation is not reasonable because of the extremely low financial error rates (FER), i.e., net overpayment percentages in stratum 3 and 4. The FER in stratum 3 and 4 is 1.1% and 2% respectively.

In corporate integrity agreements (CIAs) the OIG does not require that Independent Review Organizations extrapolate if FERs in samples of 30 or 50 (Discovery Samples) are below 5%.

¹ See November 20, 2014 correspondence from the American Hospital Association to Gloria Jarmon, Deputy Inspector General for Audit Services, Office of Inspector General. See also e.g. Medicare Compliance Review of Northwestern Memorial Hospital for 2011 and 2012; Medicare Compliance Review of New York Presbyterian Hospital for 2011 and 2012; and Medicare Complaint Review of Houston Methodist Hospital for 2012 and 2013.

We believe it is reasonable to remove strata 3 and 4 from the extrapolation as no systemic overpayments are indicated and because NorthShore should not be held to a higher standard than organizations under CIAs.

Finally, at the exit conference NorthShore was assured that the report would identify the areas where no deficiencies were noted. The Draft Report is close to silent on the Herceptin sample (strata 7) other than to identify it as a risk area and an area of investigation with an overall summary of accounts and changes attached in the appendix. The absence of specific recognition of lack of findings by the OIG regarding Herceptin demonstrates a lack of transparency and complete accountability with respect to the audit process.

Below is NorthShore's response to OIG's specific findings in the areas reviewed.

INPATIENT CLAIMS:

Inpatient Rehabilitation Facility Services Incorrectly Billed as Inpatient:

OIG finds that in 29 of the 89 sampled inpatient claims the Hospitals incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation services (associated payment impact \$446,297)(71% of the overpayment dollars). Based upon an independent third-party review of these claims, NorthShore University HealthSystem disagrees with the OIG's determinations for all 29 claims and will appeal each of them. For these 29 claims, we will exercise our right to appeal based on our independent third-party reviewer's evaluation of the clinical merits of these cases and documentation to support medical necessity for rehabilitation services in the inpatient setting.

It is significant to note that the OIG's medical reviewer's report notes in all of the 29 sampled claims that the overall plan of care prescribed met the medical necessity requirement of the patient's medical prognosis, the expected intensity of the patient's medical prognosis, the expected intensity, frequency and duration of physical, occupational, speech-language pathology, and/or prosthetic/orthotic therapies. In other words, the services provided were medically necessary. The only issue is whether the services should have been provided in an inpatient or skilled care setting. NorthShore's documentation supports provision of these services in an inpatient setting. Additionally, NorthShore has in place multiple processes to ensure providers are determining and documenting the need for intensive inpatient rehabilitation services based on the complexity of the inpatient's nursing, medical management and rehabilitation needs at the time of admission to the inpatient rehabilitation floor.

Enhanced Controls and Action Taken:

While the Hospital will appeal these determinations, NorthShore has reinforced its annual internal and external audits to evaluate appropriateness and supportive documentation of services provided in the inpatient rehabilitation setting. Additionally, NorthShore has provided physician, provider and staff education regarding regulatory requirements and documentation standards.

Incorrectly Billed Diagnosis-Related Group Codes:

OIG finds that for 11 of the 89 inpatient claims, the Hospitals billed Medicare for an incorrect DRG (associated payment impact \$34,552). NorthShore disagrees with OIG’s assertion that 10 of the 11 inpatient claims resulted in Medicare being billed for an incorrect DRG.

NorthShore will appeal these 10 denials because the OIG inappropriately applied official coding guidelines and did not follow industry standards or best practices in assessment of code assignment. For example, in the documentation provided by the OIG related to coding determinations, on at least one occasion the case was reviewed by a physician and not a certified coding professional. This practice is contrary to recognized industry standards.

NorthShore has policies, procedures and processes in place and training is provided to keep coders up to date regarding coding and billing requirements and related regulatory updates. Reports summarizing case mix trends are reviewed quarterly by the management team to assess patterns and trends and to adjust focus areas for review, as needed.

Additionally, it should be noted, the OIG’s Draft Report footnotes that NorthShore may be able to bill under Medicare Part B. However, this is incorrect as the opportunity to bill under Part B is not available for this stratum.

Enhanced Controls and Action Taken:

1. Implemented required clinical validity checks for specified diagnoses by the coders;
2. Increased physician involvement in developing internal guidelines for reporting certain conditions;
3. Updated clinical guidelines with physician support to improve clinical documentation;
4. Provided ongoing, updated continued education regarding clinical validity, official coding guidelines and regulatory updates. Ongoing physician, coder and staff education regarding clinical diagnoses, clinical validity and appropriate DRG assignment;
5. Investigating purchase of a systemic method for identifying cases for second and third quality review (software solution); and
6. Ongoing validation audits of claims are conducted to ensure internal controls remain effective.

Manufacturer Credits for Replaced Medical Devices Not Reported

NorthShore will not appeal any of OIG’s four findings in this category (associated payment impact \$14,033). During the time period under review, communication processes from the device manufacturers regarding device credits existed but were not consistent or timely.

Enhanced Controls and Action Taken:

1. Our management team met with the manufacturers to set clear expectations regarding timely communication and reporting mechanisms;
2. Our internal policies and procedures have been updated to ensure adequate communication between the respective NorthShore departments, including Cardiology, Purchasing and Patient Billing so that device credits are received and billed appropriately to Medicare.

1. Our policies have also been further updated, refined and disseminated to reflect current requirements related to partial and full device credits;
2. Based on our internal review findings, an additional retrospective review of all similarly affected inpatient medical device claims from 2013 – 2015 were reviewed and refund amounts were reported and returned; finally
3. Ongoing validation audits are conducted of claims to ensure internal controls remain effective.

Incorrectly Billed Group Codes (CMG Codes)

NorthShore will not appeal either of OIG’s two findings in this category (associated payment impact \$1,484).

Enhanced Controls and Action Taken:

1. Implemented required clinical validity checks for specified diagnoses by the coders;
2. Increased physician involvement in developing internal guidelines for reporting certain conditions;
3. Provided ongoing, updated continued education regarding clinical validity, official coding guidelines and regulatory updates. Additional ongoing physician and coder education regarding appropriate case mix group assignment; and
4. Ongoing validation audits of claims are conducted to ensure internal controls remain effective.

OUTPATIENT CLAIMS:

Manufacturer Credits for Replaced Medical Devices Not Obtained and Reported

NorthShore will not appeal any of the five findings in this category (associated payment impact \$121,405)

Enhanced Controls and Action Taken:

1. Our management team met with the manufacturers to set clear expectations regarding timely communication and reporting mechanisms;
2. Our internal policies and procedures have been updated to ensure adequate communication between the respective NorthShore departments, including Cardiology, Purchasing and Patient Billing so that device credits are received and billed appropriately to Medicare. Our policies have also been further updated, refined and disseminated to reflect current requirements related to partial and full device credits;
3. Based on our internal review, an additional retrospective review of all similarly affected outpatient device claims from 2013 – 2015 was completed. Refund amounts were reported and returned, and
4. Ongoing validation audits are conducted of claims to ensure internal controls remain effective.

Incorrectly Billed Observation Services and Unsupported Charges Resulting in Incorrect Outlier Payments

OIG finds that for 33 of the 101 sampled outpatient claims, the Hospitals incorrectly billed Medicare for services that were not supported in the medical record. It is noted that of the 33 outpatient observation claims with errors, 8 had errors with no monetary effect. Total payment impact for this strata was a reduction in outlier payment of \$3,198).

NorthShore's review revealed that billing system edits could be improved. Additionally, internal processes and communication could be enhanced to ensure observation hours are appropriately reported and billed. Accordingly, NorthShore will not contest 22 of the OIG's findings in this category. NorthShore will appeal the OIG findings of 11 of the sampled claims.

Contrary to the OIG's medical reviewer findings, the medical record did contain a timely order for observation. For the cases being appealed, documentation supports appropriate calculation of observation hours according to regulatory guidelines. Additionally, the medical reviewers may have had difficulty navigating complex documentation in our electronic medical record without our assistance. During review of other categories, the OIG investigator was directed to previously provided documentation to support NorthShore's billing. However, the investigator advised that the medical reviewer had already completed their review and would not be directed to the previously provided supportive records. Accordingly, the OIG investigator encouraged NorthShore to simply appeal the decisions.

Enhanced Controls and Action Taken:

1. Implemented enhanced system billing edits to ensure observation hours are reported appropriately for all observation claims;
2. Targeted additional dedicated resources to systematically review identified claims (based on outpatient outlier status) prior to billing to ensure appropriate units of service and appropriate carve outs of diagnostic/therapeutic services;
3. Updated internal procedures to ensure adequate communication between respective NorthShore departments include Case Management, clinical departments and Patient Billing staff regarding patient status and related billing requirements;
4. Providing ongoing, updated continuing education regarding clinical documentation requirements, regulatory requirements and appropriate reporting of observation services to clinical staff, departments, billing and physicians/providers; and
5. Ongoing validation audits of claims are conducted to ensure internal controls remain effective.

Intensity Modulated Radiation Therapy (IMRT) Services Did Not Fully Meet Medicare Coverage Criteria as Billed

NorthShore disagrees with the OIG's assertion that 8 of the 101 outpatient claims were incorrectly billed to Medicare (associated payment impact \$2,728). Medicare permits certain imaging services to be billed in addition to IMRT planning services when they "are not provided as part of developing the IMRT treatment plan." CMS, MCPM, ch. 4 §200.3.1. The medical records provided demonstrated that NorthShore appropriately billed for these services. Additionally NorthShore believes that its claims were supported by adequate and appropriate documentation.

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Also troubling to OIG's analysis is that only 9 of the 40 sampled claims in this strata were sent for medical review. There was no explanation provided as to why only 9 of the cases were subjected to this review. Without explanation the only interpretation is that it was an arbitrary selection contrary to auditing standards.

Coding guidelines permit certain IMRT services be reported on the same outpatient claim as long as services are performed as part of a separate treatment session. NorthShore's documentation supports a separate treatment session or supports services provided separately from the IMRT treatment plan.

During the OIG's investigation, the investigators had difficulty navigating complex information within our electronic medical record without our assistance. Based upon this difficulty, NorthShore had a resource available to assist the investigators. However, the investigators did not avail themselves of this resource. The OIG investigators were directed to previously provided documentation to support NorthShore's billing. However, the investigator advised that the medical reviewers had already completed their review and would not be directed to the previously provided supportive records. Accordingly, the OIG investigator encouraged NorthShore to simply appeal the decisions. This is not consistent with GAGAS standards; the reviewers must not take short cuts due to time constraints and be fair and objective. The investigators should apply the regulations, standards and allot the time needed to make accurate and complete assessments. If anything, short cuts due to time constraints should not be made in favor of the auditor and disfavor of the auditee.

Enhanced Controls and Action Taken:

NorthShore will appeal all 8 denials inasmuch as the supportive documentation is present. However, as continued and ongoing control enhancement, NorthShore has updated policies and procedures based on recent regulatory changes and provided education to clinical staff, providers and coding/billing staff. Ongoing validation audits are conducted to ensure internal controls remain effective.

INCORRECTLY BILLED CLAIMS FOR OUTPATIENT DENTAL SERVICES

OIG found 1 of the 101 outpatient sampled claims NorthShore billed Medicare for hospital dental services that did not meet Medicare coverage criteria (associated payment impact \$941).

This error was an isolated incident where the dental clinic was closed and the patient was treated in the emergency room.

Enhanced Controls and Action Taken:

1. Implemented a more robust systems edit (technical control) to provide a hard stop which will prevent billing dental services provided in the Emergency Department to Medicare beneficiaries,
2. Provided education to departmental staff and coding/billing staff to ensure dental services provided that do not meet applicable exceptions are not billed to Medicare,
3. Performed a retrospective review of all similarly affected dental claims from 2013 – 2015 with no additional occurrences identified, and
4. Ongoing validation audits of claims are conducted to ensure internal controls remain effective.

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CONCLUSION

NorthShore is committed to its mission to “preserve and improve human life.” This mission will be achieved through the provision of superior clinical care, academic excellence and innovative research. NorthShore respects the mission of OIG to detect and prevent inaccurate billing and reimbursement for Medicare. However, many of OIG’s findings related to its Medicare Compliance Review reflect vague and ambiguous CMS standards for inpatient Part A reimbursement which are then extrapolated in a manner that creates the appearance of abuse, when this is not the case. Further, NorthShore strongly believes that the physician/patient relationship is paramount to the overall health, well-being and successful outcome of the patient. As the face-to-face provider for the patient, the physician is in the best position to understand the severity, intensity and complexity of the patient and to use that knowledge to determine the most appropriate, optimal treatment plan and setting for the patient. This knowledge is not as apparent when reviewing billing from afar. It bears repeating that at no point in its report does the OIG make reference to any service provided as being medically unnecessary or otherwise challenge the quality of care provided by NorthShore.

NorthShore recognizes and takes seriously its obligation to appropriately bill Medicare for services provided. NorthShore continues to improve its internal processes through education, training and ongoing auditing and monitoring through its compliance program to ensure compliant claims submissions.

Sincerely,

/Harry L. Jones, Jr./

Harry L. Jones, Jr.
Chief Compliance Officer
hlj:nb