

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF  
INTERMOUNTAIN MEDICAL CENTER  
FOR CALENDAR YEARS  
2009 AND 2010**

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



**Patrick J. Cogley  
Regional Inspector General**

**October 2012  
A-07-12-01108**

# *Office of Inspector General*

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, payment in full to the hospital for inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

The Intermountain Medical Center (the Hospital) has 420 beds and is located in Murray, Utah. Medicare paid the Hospital approximately \$181 million for 16,994 inpatient and 89,304 outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$2,504,726 in Medicare payments to the Hospital for 165 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 62 inpatient and 103 outpatient claims with dates of service in CYs 2009 and 2010 (2 of these 165 claims involved replacement medical devices and had dates of service in CY 2011).

### **OBJECTIVE**

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

## **SUMMARY OF FINDINGS**

The Hospital complied with Medicare billing requirements for 99 of the 165 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 66 claims, resulting in net overpayments totaling \$198,141 for CYs 2009 through 2011. Specifically, 13 inpatient claims had billing errors that resulted in overpayments totaling \$109,016, and 53 outpatient claims had billing errors that resulted in net overpayments totaling \$89,125. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims or did not fully understand the Medicare billing requirements.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$198,141, consisting of \$109,016 in overpayments for the 13 incorrectly billed inpatient claims and \$89,125 in net overpayments for the 53 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital concurred with both of our recommendations. The Hospital stated that it has refunded the overpayments and described corrective actions that it has taken to ensure compliance with Medicare requirements.

The Hospital's comments appear in their entirety as the Appendix.

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# INTRODUCTION

## BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

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

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. For beneficiary stays incurring extraordinarily high costs, section 1886(d)(5)(A) of the Act provides for additional payments (called outlier payments) to Medicare-participating hospitals.

### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>1</sup> The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the 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>2</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements.

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

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

OIG identified these types of payments to hospitals using computer matching, data mining, and analysis of claims. Examples of the types of claims at risk for noncompliance included the following:

- inpatient claims paid in excess of charges,
- inpatient transfers,
- inpatient claims billed with high severity level DRGs,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed for Lupron injections,
- outpatient claims paid in excess of charges,
- outpatient claims billed with modifiers, and
- outpatient claims billed with Doxorubicin Hydrochloride.

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

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

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

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and services that “... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

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

### **Intermountain Medical Center**

The Intermountain Medical Center (the Hospital) has 420 beds and is located in Murray, Utah. Medicare paid the Hospital approximately \$181 million for 16,994 inpatient and 89,304

outpatient claims for services provided to Medicare beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

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

### **Scope**

Our audit covered \$2,504,726 in Medicare payments to the Hospital for 165 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 62 inpatient and 103 outpatient claims with dates of service in CYs 2009 and 2010. Two of the 165 claims (involving replacement medical devices) had dates of service in CY 2011.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and did not include a focused medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital during March 2012.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with CMS and Medicare contractor officials to gain an understanding of Medicare requirements for billing inpatient and outpatient claims;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;

- obtained information on known credits for replacement cardiac medical devices from selected device manufacturers for CYs 2009 through 2011;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 165 claims (62 inpatient and 103 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- 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 on June 1, 2012.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATIONS**

The Hospital complied with Medicare billing requirements for 99 of the 165 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 66 claims, resulting in net overpayments totaling \$198,141 for CYs 2009 through 2011. Specifically, 13 inpatient claims had billing errors that resulted in overpayments totaling \$109,016, and 53 outpatient claims had billing errors that resulted in net overpayments totaling \$89,125. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims or did not fully understand the Medicare billing requirements.

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

The Hospital incorrectly billed Medicare for 13 of the 62 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$109,016.

## **Inpatient Claims Paid in Excess of Charges**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and services that "... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." The Manual, chapter 3, section 10, states: "The hospital may bill only for services provided." In addition, the Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For 3 out of 11 sampled claims, the Hospital incorrectly billed Medicare for claims in which the payments exceeded the charges. Specifically, for the three claims, the Hospital billed Medicare with incorrect diagnosis codes that resulted in the assignment of incorrect DRG codes. The Hospital attributed these errors to human error and to the fact that its existing quality control system did not identify every error. As a result of these errors, the Hospital received overpayments totaling \$41,717.

## **Inpatient Transfers**

Federal regulations (42 CFR § 412.4(b)) state that a discharge of a hospital inpatient is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge. A discharge of a hospital inpatient is also considered to be a transfer when (1) the patient's discharge is assigned to one of the qualifying DRGs, (2) the discharge is to home under a written plan of care for the provision of home health services from a home health agency, and (3) those services begin within 3 days after the date of discharge (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For three out of six sampled transfer claims, the Hospital incorrectly billed Medicare discharges that should have been billed as transfers. For one of these claims, the Hospital coded the discharge status as "patient discharged to a skilled nursing facility" instead of "patient transferred to another acute care hospital." For another one of these claims, the Hospital coded the discharge status as "patient discharged to home" instead of "patient discharged to home under a written plan of care for the provision of home health services." The Hospital attributed these errors to human error and stated that its existing quality control system did not identify every error.

For the remaining claim that was in error, the Hospital coded the discharge status as "patient left against medical advice" instead of "patient discharged to home under a written plan of care for the provision of home health services." The Hospital stated that this error occurred because of a transmission error that occurred when the Hospital submitted the claim to the Medicare contractor. Specifically, the Hospital said that it entered the discharge status correctly in its computerized system and added that it did not understand how the Medicare contractor received the incorrect discharge status.

As a result of these errors, the Hospital received overpayments totaling \$30,384.

### **Inpatient Claims Billed With High Severity Level Diagnosis-Related Group Codes**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and services that "... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." The Manual, chapter 3, section 10, states: "The hospital may bill only for services provided." In addition, the Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For 4 out of 41 sampled claims with high severity level DRG codes, the Hospital billed Medicare with incorrect diagnosis and/or procedure codes that resulted in the assignment of incorrect DRG codes. The Hospital stated that these errors occurred due to human error and because its existing quality control system did not identify every error. As a result of these errors, the Hospital received overpayments totaling \$24,415.

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

Federal regulations (42 CFR § 412.89) require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device. The Manual, chapter 3, section 100.8, states that to bill correctly for a replacement device that was provided with a credit, the hospital must code its Medicare claims with a combination of condition code 49 or 50 along with value code "FD."

For three out of four sampled claims, the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claims with the proper value and condition codes to reduce payments as required. These errors occurred because the Hospital did not have adequate controls to report the appropriate value codes in order to accurately reflect credits it had received from manufacturers. The Hospital attributed the inadequacy of the controls to the complexities of the relevant regulations as well as the many possible recall and warranty scenarios. Specifically, the Hospital stated that warranty contract terms are, in specific circumstances, difficult to interpret and can result in disputes regarding the appropriateness of a credit to the Hospital. As a result of these errors, the Hospital received overpayments totaling \$12,500.

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

The Hospital incorrectly billed Medicare for 53 of the 103 sampled outpatient claims that we reviewed. These errors resulted in net overpayments totaling \$89,125.

## **Outpatient Claims Billed for Lupron Injections**

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” The Manual, chapter 17, section 90.2.A, states: “It is ... of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug ... that was used in the care of the patient.” If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 ....”

The Food and Drug Administration (FDA) identifies and reports drug products with a universally used unique, three-segment number called the national drug code (NDC). Each quarter, CMS provides Medicare contractors with an updated listing that cross-references the NDC to the drug name, billing units, and HCPCS code.

Lupron is a drug commonly used to treat hormone-dependent cancers. The FDA approved Lupron for the treatment of disorders relating to the uterus and for the treatment of prostatic cancer. According to the NDCs in effect during our audit period, Lupron was available for the treatment of: (1) disorders relating to the uterus, in doses of 3.75 mg once a month or 11.5 mg once every 3 months, and was linked to HCPCS code J1950; and (2) prostatic cancer, in doses of 7.5 mg once a month, 22.5 mg once every 3 months, or 30 mg once every 4 months, and was linked to HCPCS code J9217.

For 42 out of 45 sampled claims, the Hospital incorrectly billed Medicare for Lupron injections. For 35 of the 42 claims that were in error, the Hospital billed Medicare using HCPCS code J1950 when its documentation showed that according to administered dosage, the Hospital should have billed Medicare using HCPCS code J9217. For six of the other seven claims that were in error, the Hospital billed Medicare using the correct HCPCS code (J9217) but with the wrong number of units of Lupron administered. For the remaining claim, the Hospital did not have documentation supporting the claim for Lupron. The Hospital stated that these errors occurred primarily due to programming problems in its pharmacy clinical information system. The Hospital stated that it had incorrectly programmed its computerized system to assign HCPCS code J1950 instead of HCPCS code J9217 for prostatic cancer diagnoses. In addition, the Hospital had computerized edits that assigned the wrong number of units of Lupron administered to the HCPCS code J9217. As a result of these errors, the Hospital received overpayments totaling \$86,226.<sup>3</sup>

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

Federal regulations (42 CFR § 419.45) require a reduction in the OPSS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device.

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<sup>3</sup> The Hospital indicated that there may be some allowable costs for related drug administration services.

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPPS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and to reduce the charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device.

For one out of four sampled claims, the Hospital received a full credit for a replaced medical device but did not report the “FB” modifier or reduced charges on its claim. This error occurred because the Hospital did not have adequate controls to report the appropriate modifiers or reduce charges on its claims. The Hospital attributed the inadequacy of the controls to the complexities of the relevant regulations as well as the many possible recall and warranty scenarios. Specifically, the Hospital stated that warranty contract terms are, in specific circumstances, difficult to interpret and can result in disputes regarding the appropriateness of a credit to the Hospital. As a result of this error, the Hospital received overpayments totaling \$4,514.

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

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and services that “... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” Federal regulations (42 CFR § 410.32) state that diagnostic tests must be ordered by the physician who is treating the beneficiary. Tests not ordered by the physician are considered not reasonable or necessary. Additionally, the Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For 10 out of 36 sampled claims, the Hospital incorrectly billed Medicare for claims in which the payments exceeded the charges. These errors included six claims with the wrong HCPCS code and two claims that lacked sufficient documentation to indicate that the diagnostic services were ordered by a physician. The errors also included two claims for which the Hospital did not have documentation supporting the HCPCS code billed and one claim that lacked the required modifiers reflecting the work performed for bilateral procedures. (One of the claims had two errors.) The Hospital stated that these errors occurred due to human error and because its existing quality control system did not identify every error. As a result of these errors, the Hospital received net underpayments totaling \$1,615.

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$198,141, consisting of \$109,016 in overpayments for the 13 incorrectly billed inpatient claims and \$89,125 in net overpayments for the 53 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

### **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital concurred with both of our recommendations. The Hospital stated that it has refunded the overpayments and described corrective actions that it has taken to ensure compliance with Medicare requirements.

The Hospital's comments appear in their entirety as the Appendix.

# **APPENDIX**

## APPENDIX: AUDITEE COMMENTS



36 South State Street  
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801.442.2000

July 30, 2012

Mr. Patrick J. Cogley  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Audit Services, Region VII  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

Re: Report Number: A-07-12-01108

Dear Mr. Cogley:

This letter is in response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled *Medicare Compliance Review of Intermountain Medical Center for Calendar Years 2009 and 2010*, dated July 25, 2012.

The Office of Inspector General audit covered \$2,504,726 in Medicare payments for the 165 claims (62 inpatient and 103 outpatient claims). We understand that these claims were judgmentally selected by the OIG as potentially at risk for billing errors. As a result of the detailed review, the OIG identified 66 claims with billing errors, totaling \$198,141 in net overpayments for CYs 2009 through 2011.

Intermountain Medical Center has reviewed the findings and concurs with the recommendations noted in the draft report. The OIG recommendations and Intermountain Medical Center's statements of concurrence are set forth below:

1. The OIG recommends Intermountain Medical Center *refund to the Medicare contractor \$198,141, consisting of \$109,016 in overpayments for the 13 incorrectly billed inpatient claims and \$89,125 in net overpayments for the 53 incorrectly billed outpatient claims.*

Intermountain Medical Center concurs with the recommendation and has refunded the \$198,141 in overpayments.

2. The OIG recommends Intermountain Medical Center *strengthen controls to ensure full compliance with Medicare requirements.*

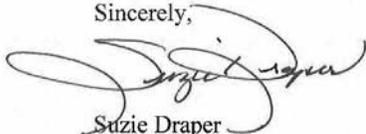
Intermountain Medical Center takes the OIG audit findings and recommendations seriously as we continually strive to be compliant in all coding and billing requirements. We continue to further develop our internal controls, which includes providing additional education to coding and billing staff and creating additional edits as part of our own internal corrective action plans. Similar to the OIG Medicare Compliance Audit, we audit on specific high risk

areas. We also engage in less focused, random audits with the goal to routinely review a sample of claims across all coders in order to better ensure ongoing quality and accuracy.

Intermountain Medical Center appreciates the opportunity to respond to the findings of this OIG audit. Intermountain Medical Center's goal is to ensure our inpatient and outpatient claims are submitted timely and accurately and are in compliance with Medicare regulations and guidance through continued improvement of internal controls.

If you like additional information on the specific corrective actions that have been completed or are in progress for each issue, please contact me at 801.442.1502.

Sincerely,

A handwritten signature in black ink, appearing to read "Suzie Draper", written in a cursive style.

Suzie Draper  
Vice President of Business Ethics and Compliance  
Intermountain Healthcare

