

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF THE  
UNIVERSITY OF IOWA HOSPITAL  
FOR CALENDAR YEARS  
2009 AND 2010**

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



**Patrick J. Cogley  
Regional Inspector General**

**November 2012  
A-07-12-05023**

# *Office of Inspector General*

<https://oig.hhs.gov/>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <https://oig.hhs.gov/>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

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

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.

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.

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 outpatient and inpatient services.

University of Iowa Hospital (the Hospital) has 729 beds and is located in Iowa City, Iowa. Medicare paid the Hospital approximately \$659 million for 515,751 outpatient and 31,110 inpatient 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 \$5,227,498 in Medicare payments to the Hospital for 321 outpatient and 77 inpatient claims that we identified as potentially at risk for billing errors for CYs 2009 and 2010. Of these 398 claims, 395 had dates of service in CYs 2009 and 2010 and the remaining 3 claims, involving replacement medical devices, had dates of service in CYs 2008 and 2011.

### **OBJECTIVE**

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

## **SUMMARY OF FINDINGS**

The Hospital complied with Medicare billing requirements for 124 of the 398 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 274 claims, resulting in overpayments totaling \$826,104 for CYs 2008 through 2011. Specifically, 245 outpatient claims had billing errors, resulting in overpayments totaling \$590,539, and 29 inpatient claims had billing errors, resulting in net overpayments totaling \$235,565. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$826,104, consisting of \$590,539 in overpayments for the 245 incorrectly billed outpatient claims and \$235,565 in net overpayments for the 29 incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations concerning 4 outpatient claims totaling \$24,521 and 29 inpatient claims totaling \$235,565; for these findings, the Hospital described corrective actions that it had taken or planned to take.

However, the Hospital disagreed with our finding regarding 241 outpatient claims totaling \$566,180 that were billed for Lupron (a drug commonly used to treat hormone-dependent cancers) injections. Specifically, the Hospital said that it believed that it accurately billed for Lupron injections based upon CMS guidance at the time of the billing. The Hospital agreed with our finding regarding the four claims billed for Lupron injections for which it could provide no documentation that the drug had been administered.

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

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the Hospital's comments, we maintain that our findings and recommendations remain valid. Specifically, we maintain that the Hospital billed 237 Lupron claims incorrectly because it assigned incorrect Healthcare Common Procedure Coding System (HCPCS) codes for these claims. Moreover, the Hospital's comments did not provide us with evidence that the correct HCPCS codes were used for any of these claims or that we applied the wrong criteria. For the other four claims, the Hospital agreed that the medical records did not support that this medication had actually been administered. Therefore, we continue to recommend that the Hospital refund \$566,180 related to the 241 claims.

# TABLE OF CONTENTS

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Hospital Outpatient Prospective Payment System .....	1
Hospital Inpatient Prospective Payment System .....	1
Hospital Payments at Risk for Incorrect Billing .....	2
Medicare Requirements for Hospital Claims and Payments .....	2
University of Iowa Hospital.....	3
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	3
Objective.....	3
Scope.....	3
Methodology.....	3
<b>FINDINGS AND RECOMMENDATIONS</b> .....	4
<b>BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS</b> .....	4
Outpatient Claims Billed for Lupron Injections .....	5
Outpatient Manufacturer Credits for Replaced Medical Devices.....	5
Outpatient Claims With Payments Greater Than \$25,000.....	6
Outpatient Claims Paid in Excess of Charges.....	6
<b>BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS</b> .....	6
Inpatient Claims Paid in Excess of Charges .....	7
Inpatient Claims Billed With High Severity Level Diagnosis-Related Group Codes ...	7
Inpatient Manufacturer Credits for Replaced Medical Devices .....	7
Inpatient Post-Acute Transfers to Skilled Nursing Facilities .....	8
Inpatient Psychiatric Facility Transfers .....	8
Inpatient Same Day Discharge and Readmission .....	9
<b>RECOMMENDATIONS</b> .....	9
<b>AUDITEE COMMENTS</b> .....	9
<b>OFFICE OF INSPECTOR GENERAL RESPONSE</b> .....	10
<b>APPENDIX</b>	
<b>AUDITEE COMMENTS</b>	

# 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 and 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 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 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.

---

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

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

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

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. Examples of the types of claims at risk for noncompliance included the following:

- outpatient claims billed for lupron injections,
- outpatient and inpatient manufacturer credits for replaced medical devices,
- outpatient claims with payments greater than \$25,000,
- outpatient and inpatient claims paid in excess of charges,
- inpatient claims billed with high severity level DRG codes,
- inpatient post-acute transfers to skilled nursing facilities (SNF),
- inpatient psychiatric facility (IPF) transfers, and
- inpatient same day discharge and readmission.

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 outpatient and inpatient 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 3, section 10, of the Manual states that the hospital may bill only for services provided. In addition, chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

## **University of Iowa Hospital**

University of Iowa Hospital (the Hospital) has 729 beds and is located in Iowa City, Iowa. Medicare paid the Hospital approximately \$659 million for 515,751 outpatient and 31,110 inpatient 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 outpatient and inpatient services on selected claims.

### **Scope**

Our audit covered \$5,227,498 in Medicare payments to the Hospital for 321 outpatient and 77 inpatient claims that we judgmentally selected as potentially at risk for billing errors. Of these 398 claims, 395 had dates of service in CYs 2009 and 2010 and the remaining 3 claims, involving replacement medical devices, had dates of service in CYs 2008 and 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 outpatient and inpatient 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 November 2011 to May 2012.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient and inpatient 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 the device manufacturers for CYs 2008 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 398 claims (321 outpatient and 77 inpatient) 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 and/or coded claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- shared the results of our review with Hospital officials on May 21, 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 124 of the 398 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 274 claims, resulting in overpayments totaling \$826,104 for CYs 2008 through 2011. Specifically, 245 outpatient claims had billing errors, resulting in overpayments totaling \$590,539, and 29 inpatient claims had billing errors, resulting in net overpayments totaling \$235,565. These errors occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

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

The Hospital incorrectly billed Medicare for 245 of the 321 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$590,539.

## **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 11.25 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 237 claims, the Hospital incorrectly submitted claims using the HCPCS code J1950 instead of the correct HCPCS code (J9217) and billed with either 8 or 6 service units when the correct amount should have been 4 or 3, respectively. For the other four claims, the medical records did not support that this medication had actually been administered. The Hospital stated that these errors occurred because they did not know of any CMS guidance on the use of the national drug code to apply HCPCS codes. As a result of these errors, the Hospital received overpayments totaling \$566,180.

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

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

CMS guidance in Transmittal 1103, dated November 3, 2006, and 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 two 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 claims. These overpayments occurred because the Hospital did not have adequate controls to report the appropriate modifiers and charges to reflect credits received from manufacturers. As a result of these errors, the Hospital received overpayments totaling \$17,177.

### **Outpatient Claims With Payments Greater Than \$25,000**

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

For 1 out of 17 sampled claims, the Hospital submitted the claim to Medicare with an incorrect HCPCS code. The Hospital stated that it had initially, and erroneously, used HCPCS code 61886 (connection to two or more electrode arrays) on the claim and then corrected the claim by changing the HCPCS code to 61885 (connection to a single electrode array). However, the Hospital’s business office mistakenly deleted the corrected claim. As a result of this error, the Hospital received an overpayment of \$4,637.

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

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

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 ....”

For the claim we sampled, the Hospital submitted the claim to Medicare with incorrect units of service. Specifically, the claim was billed with 400 units of service when the correct amount should have been 40. The Hospital stated that although a programming adjustment was made to detect this type of error and other accounts were corrected, this claim was not. As a result of this error, the Hospital received an overpayment of \$2,707.

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

The Hospital incorrectly billed Medicare for 29 of the 77 sampled inpatient claims that we reviewed. These errors resulted in net overpayments totaling \$235,565.

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

Section 1862(a)(1)(A) of the Act states that no Medicare payment may 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 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

For 8 out of 18 sampled claims, the Hospital incorrectly billed Medicare for claims in which the payments exceeded the charges. Specifically, for the eight claims, the Hospital submitted the claims to Medicare with incorrectly coded DRG codes. In each of these eight claims, either the principal or secondary diagnosis was incorrect or not supported in the medical records. The Hospital stated these errors occurred because coding is a technical and interpretative science, which may result in differences of opinion as to the most appropriate code. As a result of these errors, the Hospital received overpayments totaling \$166,355.

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

Section 1862(a)(1)(A) of the Act states that no Medicare payment may 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 Manual, chapter 3, section 10, states: "The hospital may bill only for services provided." In addition, 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 17 sampled claims, the Hospital submitted the claim to Medicare with incorrectly coded DRG codes. For each of these three claims, the principal diagnosis, secondary diagnosis, or procedure code was incorrect or not supported in the medical records. The Hospital stated that these errors occurred because of coder misinterpretation of coding guidelines or human error. As a result of these errors, the Hospital received overpayments totaling \$41,293.

### **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 correctly bill 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 six out of eight sampled claims, the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claim with the appropriate condition and value codes to reduce payment as required. These overpayments occurred because the Hospital did not have adequate controls to report the appropriate condition and value codes in order to

accurately reflect credits it had received from manufacturers. As a result of these errors, the Hospital received overpayments totaling \$27,231.

### **Inpatient Post-Acute Transfers to Skilled Nursing Facilities**

Section 1862(a)(1)(A) of the Act states that no Medicare payment may 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 § 412.4(c)) state that a discharge of a hospital inpatient is considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to a SNF or to home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge. 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 the claim we sampled, the Hospital incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. The Hospital should have coded the discharge status as a transfer to a SNF. However, the Hospital incorrectly coded the discharge status to home; thus, the Hospital should have received the per diem payment instead of the full DRG payment. The Hospital stated that it had secured a vendor to review correct discharge disposition but that this claim was an oversight that had slipped through both its own and the vendor's internal auditing processes. As a result of this error, the Hospital received an overpayment of \$3,079.

### **Inpatient Psychiatric Facility Transfers**

Pursuant to 42 CFR § 412.424, CMS increases the Federal per diem rate for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary used emergency department services. However, the IPF should not receive the additional payment if the beneficiary was discharged from the acute-care section of the same hospital.

The Manual, chapter 3, section 190.6.4.1, states that source-of-admission code "D" is reported by an IPF to identify patients who have been transferred to the IPF from the same hospital. The IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 10 out of 23 sampled claims, the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to the IPF upon discharge from the Hospital's acute-care section. The Hospital stated that these errors occurred because there was some confusion among coding staff about the proper use of the "D" source-of-admission code. As a result of these errors, the Hospital received overpayments totaling \$735.

## **Inpatient Same Day Discharge and Readmission**

The Manual, chapter 3, section 40.2.5, states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For the claim we sampled, the Hospital billed Medicare incorrectly for a clinically related discharge and readmission that occurred on the same day. The Hospital stated that this error occurred because the patient was admitted to the Hospital with a certain diagnosis, was discharged, and then returned through the emergency department with a different diagnosis than the one rendered during the earlier admission. The different diagnoses led the Hospital's personnel to conclude, incorrectly, that the two admissions were clinically unrelated. However, because the two admissions were related, the combined and correctly coded claim qualified for a higher-paying DRG reimbursement. Accordingly, the Hospital received an underpayment totaling \$3,128.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$826,104, consisting of \$590,539 in overpayments for the 245 incorrectly billed outpatient claims and \$235,565 in net overpayments for the 29 incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **AUDITEE COMMENTS**

In written comments on our draft report, the Hospital generally concurred with our findings and recommendations concerning 4 outpatient claims totaling \$24,521 and 29 inpatient claims totaling \$235,565; for these findings, the Hospital described corrective actions that it had taken or planned to take.

However, the Hospital disagreed with our finding regarding 241 outpatient claims totaling \$566,180 that were billed for Lupron injections. Specifically, the Hospital said that it believed that it accurately billed for Lupron injections based upon CMS guidance at the time of the billing. The Hospital stated that there was no "official" guidance from either CMS or the Medicare contractor for the correct usages of HCPCS codes J9217 and J1950. The Hospital also said that "many of the claims that were reviewed in this audit were audited previously in another OIG [Office of Inspector General] review, when no billing errors were found or reported."

The Hospital agreed with our finding regarding the four claims billed for Lupron injections for which it could provide no documentation that the drug had been administered.

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

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the Hospital's comments, we maintain that our findings and recommendations remain valid. Specifically, we maintain that the Hospital's use of HCPCS code J1950 billed using 3.75 mg per service unit for prostatic cancer patients was improper, given that the correct code is J9217 with 7.5mg per service unit. We note, too, that in 1989, the FDA approved the 7.5mg Lupron dose for prostatic cancer, and in 2001 it approved the 3.75 mg dose specifically for disorders relating to the uterus. Further, the Manual, chapter 17, section 90.2, requires that effective January 1, 2009, hospitals use the correct HCPCS code and ensure that the reported units of service of the reported HCPCS code be consistent with the quantity of the drug used in the care of the patient.

Although the Hospital mentioned in its comments that some of these claims were reviewed by the OIG in previous audits with no billing errors identified, audits have different objectives and scopes. We continue to assert, as part of addressing the objective of this audit, that the Hospital billed 237 Lupron claims incorrectly because it assigned incorrect HCPCS codes for these claims. Moreover, the Hospital's comments did not provide us with evidence that the correct HCPCS codes were used for any of these claims or that we applied the wrong criteria. For the other four claims, the Hospital agreed that the medical records did not support that this medication had actually been administered. Therefore, we continue to recommend that the Hospital refund \$566,180 related to the 241 claims.

# **APPENDIX**

## APPENDIX: AUDITEE COMMENTS



University of Iowa Health Care

*Joint Office for Compliance*

200 Hawkins Drive, 1346 JCP  
Iowa City, Iowa 52242-1009  
319.384-5897 Tel  
319.356-3862 Fax  
www.uihealthcare.org

October 29, 2012

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  
ATTN: Mr. Patrick J. Cogley  
Regional Inspector General for Audit Services

RE: Report Number: A-07-12-05023 entitled, "*Medicare Compliance Review of the University of Iowa Hospital for Calendar Years 2009 and 2010*"

Dear Mr. Cogley:

On behalf of University of Iowa Health Care, I am providing comments to the report entitled, "*Medicare Compliance Review of the University of Iowa Hospital for Calendar Years 2009 and 2010*." University of Iowa Health Care is committed to providing patient-focused health care available to every person in an environment devoted to innovative care, excellent service, and exceptional outcomes. We are committed to continued compliance with Medicare program regulations. We appreciate the opportunity to provide this response to the draft Office of Inspector General (OIG) report.

The objective of the audit was to determine whether University of Iowa Health Care complied with Medicare requirements for billing outpatient and inpatient services on selected claims. The draft audit states that the Hospital complied with Medicare billing requirements for 124 of the 398 outpatient and inpatient claims reviewed. However the auditors found that the Hospital did not fully comply with Medicare billing requirements for the remaining 274 claims, resulting in overpayments totaling \$826,104 for CYs 2008 – 2011. It was specifically noted that 245 outpatient claims had billing errors, resulting in overpayments totaling \$590,539, and 29 inpatient claims had billing errors, resulting in net overpayments totaling \$235,565.

Following are the auditors' recommendations and our responses.

**Outpatient Claims Billed for Lupron Injections:**

The audit stated that for 237 claims, we submitted claims using the HCPCS code J1950 instead of the HCPCS code J9217, and that we billed with either 8 or 6 service units when the correct amount should have been 4 or 3, respectively. The audit asserts that our use of J1950 was incorrect. In 4 other claims, we did not have the documentation to support that the medication was actually administered. The auditors stated that the errors occurred "because they did not know of any CMS guidance on the use of the national drug code to apply HCPCS codes." As a result of these errors, the hospital received alleged overpayments totaling \$566,018.

Office of Audit Services, Region VII  
Report Number: A-07-12-05023  
October 29, 2012  
Page 2

We disagree in principle with this finding. We believe we billed Lupron accurately based upon Medicare guidance at the time of billing. For the dates of service in question, there was no "official" guidance for using HCPCS codes J9217 vs. J1950, either from CMS or our local contractor, Wisconsin Physician Services (WPS). Additionally, many of the claims that were reviewed in this audit were audited previously in another OIG review, when no billing errors were found or reported.

The auditor suggested that in the absence of National Coverage Decisions or Local Coverage Decisions, we should have used the package insert or the FDA label as a billing guide. We do not use such information to apply HCPCS codes, because the HIPAA Transactions and Code Sets rules do not approve of the use of this information for this purpose. Given that our billing was previously reviewed by the OIG and no errors were found, we believed we were billing the Lupron injections correctly. In May, 2010, Lupron billing instructions were published by our local contractor. We thereafter complied with the unit instructions as described beginning with the policy's effective date.

We disagree in principle that we incorrectly billed Lupron injections. We used billing guidance that was available at the time that the services were provided, and were confident of our processes based upon previous OIG audits. We agree that we should repay Medicare for the 4 claims for which we could find no documentation of the drug administration, for a total of \$11,738.36.

**Our Response to Recommendations:**

We have conducted or implemented the following measure: A comprehensive review of all Lupron injection billing from the year 2008 through the present.

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

We agree with the audit findings that the Hospital received overpayments totaling \$17,177.

**Our Response to Recommendations:**

1. Education was provided to procurement services and coders on the correct use of the FB and FC modifiers.
2. We now have additional "stops" in the billing process that all claims with a nominal charge, for example, \$1.01, will be manually reviewed. This claim edit assists us in identifying implants or devices that may have reduced cost.
3. We believe it is important to note that it is sometimes months or even years after an implant or device has been returned to the company or manufacturer before the facility is made aware of the percent of the credit that the facility will receive. In our conversations with the OIG auditor, we were made aware of a website that is available to them that helps them identify manufacturer credits, which is apparently not available to healthcare providers. Access to such information would be invaluable for providers to assist in determining device and implant credits.

**Outpatient Claims With Payments Greater Than \$25,000:**

We agree with the audit findings that the Hospital received a single overpayment of \$4,637.

Office of Audit Services, Region VII  
Report Number: A-07-12-05023  
October 29, 2012  
Page 3

**Our Response to Recommendations:**

Claims edits have been implemented for outpatient and inpatient claims paid in excess of charges, allowing manual review of each claim.

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

We agree with the audit findings that the Hospital received a single overpayment of \$2,707.

**Our Response to Recommendations:**

Since this drug has two separate HCPCS codes and accurate assignment depends if used for ESRD or NON-ESRD purposes, we have programming in place to look at diagnosis codes. We made a programming adjustment and went back and corrected all accounts with an error. This one patient did not appear on the list. However, we later sent in an adjustment claim to change the units from 400 to 40 units. This single claim appears to have been in the readjustment process when it appeared on this audit. We continue to have programming in place to manually review claims for ESRD and NON-ESRD drugs.

**Billing Errors Associated with Inpatient Claims:**

We agree with the audit findings that the Hospital received net overpayments totaling \$235,565.

**Our Response to Recommendations:**

1. We provided education to coders on reporting the correct admission and discharge dispositions, including intra-facility psychiatric transfers and discharges to SNFs or other facilities. We continue to routinely monitor these intra-facility transfers.
2. Education was provided to Financial Services on claim submission of inpatient same day discharge and readmission.
3. The Health Information Management (HIM) department performs daily random and focused MS-DRG reviews. These random reviews include Medicare claims, and particularly, high-risk MS-DRG cases, including those with single complications and comorbidities (CCs, high-weighted MS-DRGs and frequently targeted MS-DRG cases as determined by outside auditors such as CERT and RAC reviews). These records are pre-bill, and the auditors communicate any findings to the coding staff so corrections can be made.
4. The Joint Office for Compliance (JOC) also reviews inpatient records and communicates findings to the HIM department for follow-up education with coding staff and improvements in documentation.
5. As noted in our earlier response, coding is a technical and interpretative science, which may result in differences of opinion on the "best" code. Additionally, coding interpretative processes change over time. For example, in 2008 and 2009, coders understood that if a diagnosis was documented by the physician, they should code it. Under today's guidance, coders are cautioned to be more careful in selecting the diagnoses, particularly CCs and MCCs. Currently, even if the

Office of Audit Services, Region VII  
Report Number: A-07-12-05023  
October 29, 2012  
Page 4

CC or MCC is mentioned in the documentation, if the condition is not followed through the patient's hospital course, or otherwise well-documented, the coder would not assign the code.

6. The HIM department has increased auditing staff in order to increase the number of records that can be reviewed. HIM is utilizing more physician queries when there is unclear documentation in the health record.
7. It is sometimes difficult to ascertain the correct patient discharge disposition. Even though the documentation may indicate that a patient had home health referral services or plans to enter a skilled nursing facility, for example, these statuses can change once the patient leaves the hospital. We have also discovered that sometimes the patient discharge disposition we have entered is correct, but for some reason the follow-up entity did not submit a claim for services to Medicare; thus there is no claim evidence for Medicare that a transfer even occurred. On occasion, we will make follow-up calls to the entity we thought was accepting the patients, or we have called WPS, our Medicare Contractor, to ask if their files show a patient transfer.

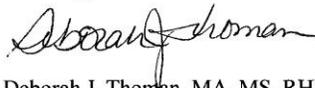
Generally speaking, our documentation accurately describes the patient's discharge disposition, including physician progress notes, nursing notes, social worker notes, and utilization review notes. We will continue to reinforce the importance of assigning the correct discharge disposition. We have emphasized that if the documentation is unclear, or otherwise lacking in sufficient detail, that we will ascertain the patient's discharge disposition by calling the referring agency or the payer. We have also utilized vendor services to enhance this process, and will continue to do so as needed.

8. We have instituted a process whereby claims of patients who discharged and were readmitted within 72 hours are manually reviewed.

The University of Iowa Hospitals and Clinics takes its obligation to bill correctly very seriously and has taken several steps to strengthen internal processes to ensure compliance with Medicare requirements. We will continue to conduct various reviews and audits to regularly monitor coding and billing. As noted, we disagree with the OIG findings related to billing for Lupron injections, particularly in light of the fact that a previous OIG audit of many of these claims did not identify any billing errors.

In closing, we wish to note the professionalism of the OIG audit team throughout this process and thank you for the opportunity to provide comment.

Sincerely,



Deborah J. Thomán, MA, MS, RHIA, CHP  
Assistant Vice President for Compliance and Accreditation  
University of Iowa Privacy Officer  
University of Iowa Health Care  
200 Hawkins Drive, 1346 JCP  
Iowa City, IA. 52242

Office of Audit Services, Region VII  
Report Number: A-07-12-05023  
October 29, 2012  
Page 5

cc: Jean Robillard, M.D., Vice President for Medical Affairs, University of Iowa  
Mr. Ken Kates, Associate Vice President, UI Health Care; and Chief Executive Officer, UIHC  
Mr. Ken Fisher, Vice President for Finance, UI Health Care; and Chief Financial Officer, UIHC