Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF UNIVERSITY OF MINNESOTA MEDICAL CENTER FOR 2012 AND 2013

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Office of Inspector General

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EXECUTIVE SUMMARY

University of Minnesota Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated overpayments of at least $3.2 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 analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2013, Medicare paid hospitals $156 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether University of Minnesota Medical Center (the Hospital) 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. For inpatient rehabilitation services, CMS pays 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. For hospital outpatient services, CMS pays on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is an 885-bed acute care teaching hospital located in Minneapolis, Minnesota. Medicare paid the Hospital approximately $376 million for 12,864 inpatient and 262,335 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

Our audit covered $24,360,864 in Medicare payments to the Hospital for 3,351 claims that were potentially at risk for billing errors. We selected a stratified random sample of 255 claims with payments totaling $2,370,592 for review. These 255 claims had dates of service in CY 2012 or CY 2013 and consisted of 75 inpatient and 180 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 125 of the 255 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 130 claims, resulting in overpayments of $565,286 for

CYs 2012 and 2013 (audit period). Specifically, 29 inpatient claims had billing errors, resulting in overpayments of $261,886, and 101 outpatient claims had billing errors, resulting in overpayments of $303,400. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $3,266,841 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor $3,266,841 (of which $565,286 was overpayments identified in our sample) in estimated overpayments for incorrectly billed services, and

- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF MINNESOTA MEDICAL CENTER COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital generally agreed with our first recommendation and discussed steps it had taken or planned to take regarding our second recommendation.

After considering the Hospital's comments, we continue to recommend that the Hospital refund to the Medicare contractor $3,266,841 in estimated overpayments and strengthen controls to ensure full compliance with Medicare requirements.

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WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2013, Medicare paid hospitals $156 billion, which represents 45 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether University of Minnesota Medical Center (the Hospital) 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 (MAC) 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 (IRF) 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 92 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 rehabilitation claims,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient dental claims,
- outpatient claims billed with modifier -59,
- outpatient claims billed for Doxorubicin Hydrochloride, and
- outpatient claims billed for Herceptin.

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).

University of Minnesota Medical Center

The Hospital, which is part of Fairview Health Services, is an 885-bed acute care teaching hospital located in Minneapolis, Minnesota. Medicare paid the Hospital approximately $376 million for 12,864 inpatient and 262,335 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $24,360,864 in Medicare payments to the Hospital for 3,351 claims that were potentially at risk for billing errors. We selected a stratified random sample of 255 claims with payments totaling $2,370,592 for review. These 255 claims had dates of service in CY 2012 or CY 2013 and consisted of 75 inpatient and 180 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 120 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 submitted by the Hospital for Medicare reimbursement.

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

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

FINDINGS

The Hospital complied with Medicare billing requirements for 125 of the 255 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 130 claims, resulting in overpayments of $565,286 for CYs 2012 and 2013 (audit period). Specifically, 29 inpatient claims had billing errors, resulting in overpayments of $261,886, and 101 outpatient claims had billing errors, resulting in overpayments of $303,400. These errors occurred primarily because the Hospital did not have

adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

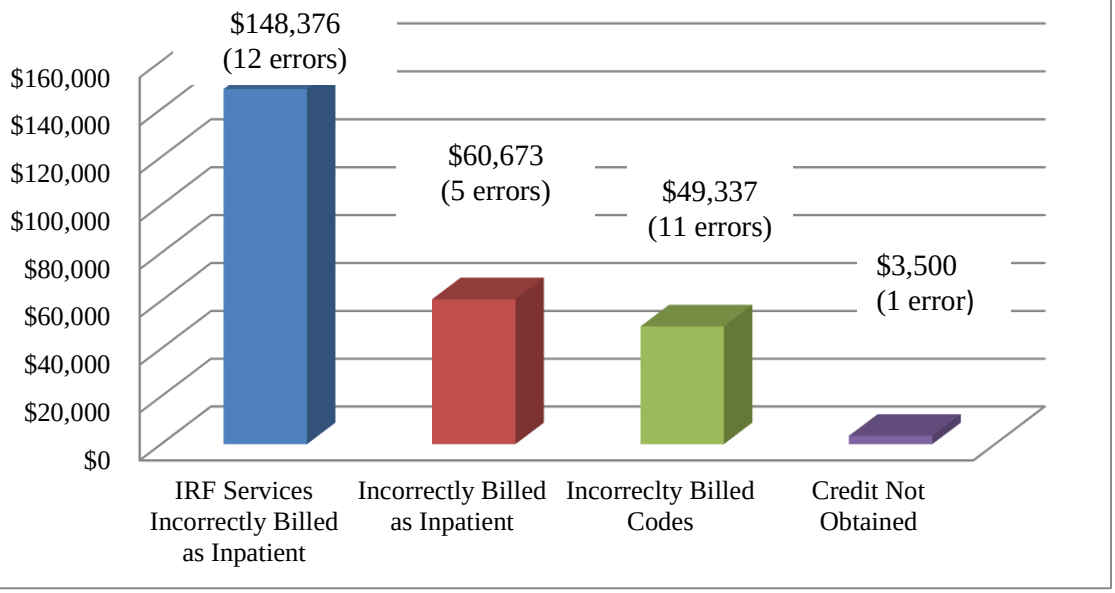
On the basis of our sample results, we estimated that the Hospital received overpayments totaling at least $3,266,841 for the audit period.

See Appendix B for our sample design and 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 Hospital incorrectly billed Medicare for 29 of 75 sampled inpatient claims, which resulted in overpayments of $261,886 as shown in Figure 1.

Figure 1: Inpatient Billing Errors



Inpatient Rehabilitation Facility Services Incorrectly Billed as Inpatient

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act, § 1862(a)(1)(A)).

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, § 110-110.1).

In addition, the *Medicare Benefit Policy Manual* states that in order 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 12[2] of the 75 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation. The Hospital did not provide a cause for the errors because it continues to support the medical necessity of these claims.

As a result of these errors, the Hospital received overpayments of $148,376.[3]

Incorrectly Billed as Inpatient

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act, § 1862(a)(1)(A)).

The *Medicare Benefit Policy Manual* states:

> An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

[2] One of the 12 claims partially met Medicare coverage requirements for acute inpatient rehabilitation. The guidance that CMS has given providers about this particular issue (when an IRF patient needs to remain in the IRF for the few days past the date at which they have completed their course of IRF treatment) is to record the remaining days as "non-covered" using occurrence code 76. Occurrence code 76 indicates to the Pricer to ignore the charges for those days, and not factor them in to any outlier calculations.

[3] The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status). We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor prior to the issuance of our draft report.

> The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark. . . . (T)he decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.
>
> Factors to be considered when making the decision to admit include such things as: The severity of the signs and symptoms exhibited by the patient; the medical predictability of something adverse happening to the patient; the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and the availability of diagnostic procedures at the time when and at the location where the patient presents (Pub. No. 100-02, chapter 1, § 10).

For 5 of the 75 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services. The Hospital did not provide a cause for the errors identified because it disagreed with our findings.

As a result of these errors, the Hospital received overpayments of $60,673.[4]

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 11[5] of the 75 sampled claims, the Hospital billed Medicare with either incorrect DRG or CMG codes. The Hospital stated that 7 of the incorrectly billed DRG codes occurred primarily due to human error.

As a result of these errors, the Hospital received overpayments of $49,337.

[4] The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor prior to the issuance of our draft report.

[5] Of the 11 incorrectly billed codes, 9 were DRG and 2 were CMG codes.

Manufacturer Credit for Replaced Medical Device Not Obtained

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 credit equal to 50 percent or more of the device cost (42 CFR § 412.89).

Federal regulations state, "All payments to providers of services must be based on the reasonable cost of services …" (42 CFR § 413.9). The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements 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/manufacturer 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).

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).

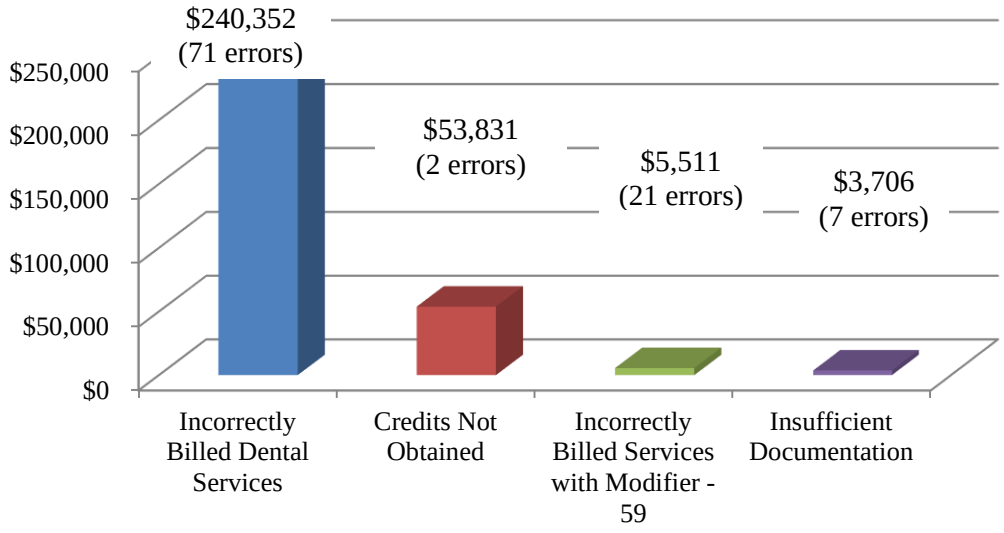
For 1 of the 75 sampled claims, the Hospital did not obtain the credit for the replaced device for which a credit was available under the terms of the manufacturer's warranty. Hospital officials stated that this error occurred due to a lack of standardized processes to properly identify, obtain, and report credits from device manufacturers.

As a result of this error, the Hospital received an overpayment of $3,500.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 101 of 180 sampled outpatient claims, which resulted in overpayments of $303,400 as shown in Figure 2.

Figure 2: Outpatient Billing Errors



Incorrectly Billed 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*, Publication No. 100-02, chapter 15, section 150).

For 71 of the 180 sampled claims, the Hospital billed Medicare for outpatient dental services that did not meet Medicare coverage criteria. The Hospital stated that these errors occurred because of its incorrect procedures to bill Medicare for outpatient dental claims.

As a result of these errors, the Hospital received overpayments of $240,352.

Manufacturer Credits for Replaced Medical Devices Not Obtained

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

For 2 of the 180 sampled claims, the Hospital did not obtain credits for replaced devices for which credits were available under the terms of the manufacturer's warranty. The Hospital stated that these errors occurred due to a lack of standardized processes to properly identify, obtain, and report credits from device manufacturers.

As a result of these errors, the Hospital received overpayments of $53,831.

Incorrectly Billed Outpatient Services with Modifier -59

The Manual states: "The '-59' modifier is used to indicate a distinct procedural service…. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)" (chapter 23, § 20.9.1.1). 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 21 of the 180 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes, appended with modifier -59, which were already included in the payments for other services billed on the same claim or did not require modifier -59. The Hospital stated that 13 of the 21 errors occurred primarily due to a misunderstanding of Medicare billing requirements for claims billed with modifier -59 and to human error.

As a result of these errors, the Hospital received overpayments of $5,511.

Insufficiently Documented Services

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

For 7 of the 180 sampled claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record. The Hospital stated that these errors occurred primarily because of human error.

As a result of these errors, the Hospital received overpayments of $3,706.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $3,266,841 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $3,266,841 (of which $565,286 was overpayments identified in our sample) in estimated overpayments for incorrectly billed services, and

- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF MINNESOTA MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital generally agreed with our first recommendation and discussed steps it had taken or planned to take regarding our second recommendation.

The Hospital agreed that 102 of the 130 claims identified in our draft report were improperly billed and plans on reprocessing the claims and refunding Medicare. The Hospital disagreed with our determination that it did not correctly bill 28 claims and stated that it intends to appeal the denial of these claims. For 20 inpatient claims, the hospital maintained that the inpatient admissions were appropriate and met medical necessity as evidenced by the medical record and guidance from the physician advisor. For eight outpatient claims, the hospital stated that the modifier 59 was used appropriately to designate distinctly separate services.

Finally, the Hospital stated that because statistical sampling may be subject to errors in methodology or application, it reserved the right to challenge our stratified sample once appeals are completed.

OFFICE OF INSPECTOR GENERAL RESPONSE

In response to the Hospital's comments, we maintain that all of our findings and the associated recommendations are valid. For the 28 contested claims, we subjected these claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Each case that was denied was reviewed by two clinicians, including a physician. We stand by those determinations.

The Hospital maintains its appeal rights. In those instances where the Hospital disagrees with the results, the Hospital should first contest these disallowances with the CMS action official, and finally, the last recourse is the appeals process.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $24,360,864 in Medicare payments to the Hospital for 3,351 claims that were potentially at risk for billing errors. We selected a stratified random sample of 255 claims with payments totaling $2,370,592 for review. These 255 claims had dates of service in CY 2012 or CY 2013 and consisted of 75 inpatient and 180 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 120 claims to focused medical review to determine whether the services met medical necessity and coding requirements.

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

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

We conducted our fieldwork from August 2014 through July 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 255 claims (75 inpatient and 180 outpatient) totaling $2,370,592 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 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;

- reviewed the Hospital's procedures for submitting Medicare claims;

- used an independent medical review contractor to determine whether 120 sampled claims met medical necessity and coding requirements;

- 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;

- used the results of the sample review to calculate the estimated Medicare overpayments to the Hospital (Appendix C); and

- discussed the results of our review with Hospital officials.

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

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

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

Medicare paid the Hospital $376,369,640 for 12,864 inpatient and 262,335 outpatient claims for services provided to beneficiaries during the audit period based on CMS's National Claims History data.

We downloaded claims from the National Claims History database totaling $239,984,373 for 7,112 inpatient and 78,356 outpatient claims in 31 risk areas. From these 31 areas, we selected 8 consisting of 25,784 claims totaling $115,450,647 for further review.

We performed data analysis of the claims within each of the eight risk areas. For risk area one, we removed claims with payment amounts less than $3,000. For risk area three, we removed claims with claim lines containing modifier -59 with payment amounts less than $100.

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 high risk categories to just one category based on the following hierarchy: Inpatient MCC/CC, Inpatient Rehabilitation, Outpatient Claims Billed with Modifier -59, Dental Services, J9001 Codes, Inpatient Medical Devices, Outpatient Medical Devices, and then Outpatient Herceptin. This resulted in a sample frame of 3,351 unique Medicare claims totaling $24,360,864.

Risk Area	Number of Claims	Amount of Payments
Inpatient Claims Billed With High-Severity-Level DRG Codes	575	$9,411,289
Inpatient Rehabilitation Facility	491	8,839,331
Outpatient Claims Billed with Modifier -59	2,150	5,413,648
Outpatient Dental Service Claims	82	297,468
Outpatient Claims Billed for Doxorubicin Hydrochloride	38	116,095
Inpatient Manufacturer Credits for Replaced Medical Devices	5	138,052
Outpatient Manufacturer Credits for Replaced Medical Devices	7	124,331
Outpatient Claims Billed for Herceptin	3	20,650
Total	**3,351**	**$24,360,864**

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 255 claims for review as follows:

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Claims Billed With High-Severity-Level DRG Codes	575	40
2	Inpatient Rehabilitation Facility	491	30
3	Outpatient Claims Billed with Modifier -59	2,150	50
4	Outpatient Dental Service Claims	82	82
5	Outpatient Claims Billed for Doxorubicin Hydrochloride	38	38
6	Inpatient Manufacturer Credits for Replaced Medical Devices	5	5
7	Outpatient Manufacturer Credits for Replaced Medical Devices	7	7
8	Outpatient Claims Billed for Herceptin	3	3
	Total	**3,351**	**255**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General/Office of Audit Services (OIG/OAS) statistical software, RAT-STATS.

METHOD FOR SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software, RAT-STATS to estimate the total amount of overpayments paid to the Hospital during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Over-payments in Sample
1	575	$9,411,289	40	$1,080,800	14	$110,972
2	491	8,839,331	30	483,766	14	147,414
3	2,150	5,413,648	50	109,430	28	9,217
4*	82	297,468	82	297,468	71	240,352
5*	38	116,095	38	116,095	0	0
6*	5	138,052	5	138,052	1	3,500
7*	7	124,331	7	124,331	2	53,831
8*	3	20,650	3	20,650	0	0
Total	**3,351**	**$24,360,864**	**255**	**$2,370,592**	**130**	**$565,286**

*We reviewed all claims in this stratum.

ESTIMATES

Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	$ 4,701,915
Lower Limit	3,266,841
Upper Limit	6,136,989

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Under/ Over-payments	Value of Over-payments
Inpatient				
Inpatient Rehabilitation Facility	30**	$483,766	14	$147,414
Claims Billed With High-Severity-Level Diagnosis-Related Group Codes	40**	1,080,800	14	110,972
Manufacturer Credits for Replaced Medical Devices	5	138,052	1	3,500
Inpatient Totals	**75**	**$1,702,618**	**29**	**$261,886**
Outpatient				
Claims Billed for Dental Services	82	$297,468	71	$240,352
Manufacturer Credits for Replaced Medical Devices	7	124,331	2	53,831
Claims Billed with Modifier -59	50**	109,430	28	9,217
Claims Billed for Doxorubicin Hydrochloride	38	116,095	0	0
Claims Billed for Herceptin	3	20,650	0	0
Outpatient Totals	**180**	**$667,974**	**101**	**$303,400**
Inpatient and Outpatient Totals	**255**	**$2,370,592**	**130**	**$565,286**

** We submitted 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 University of Minnesota Medical Center. 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: UNIVERSITY OF MINNESOTA MEDICAL CENTER COMMENTS

UNIVERSITY OF MINNESOTA
MEDICAL CENTER
FAIRVIEW

2450 Riverside Avenue
Minneapolis, MN 55454
Tel 612-672-6000

University Campus
420 Delaware Street SE
Minneapolis, MN 55455
Tel 612-273-3000

December 16, 2015

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

Ms. Fulcher:

We received your draft report entitled *Medicare Compliance Review of University of Minnesota Medical Center for 2012 and 2013* and appreciate the opportunity to respond. We take compliance with Program requirements seriously and have performed a detailed review of the findings and medical record documentation. The following is our response to the report findings and recommendations.

Rehab Incorrectly Billed as Inpatient

We respectfully disagree with the OIG findings and continue to support the medical necessity for IRF level of care for all cases. We perform ongoing review of admissions, lengths of stay, care delivery, and discharge practices to ensure compliance with appropriate laws and regulations, and stewardship of patient resources in the care delivery process. We believe each case reflects the Medicare Benefits Policy Manual coverage criteria. Each patient's need for intensive inpatient rehab is supported by the documentation in the medical record.

Incorrectly Billed as Inpatient

We respectfully disagree with the OIG findings and believe that these cases met criteria for inpatient care. As stated in the draft report, the decision to admit a patient is a complex medical judgment which must account for a number of factors. Therefore, when a patient at the hospital does not meet InterQual criteria for an ordered status, the record is reviewed by a Physician Advisor with advanced utilization review training. If the Physician Advisor does not feel a patient meets the ordered status, the Physician Advisor discusses the case directly with the provider team to determine if a status change is needed. Therefore, we believe each sampled case was appropriate for inpatient admission, was sufficiently documented in the medical record, and should not be subject to overturn based on clinical results which occur after the complex medical decision was made.

Incorrectly Billed Group Codes (DRG and CMG)

DRG Codes: We respectfully disagree with the OIG findings for one of the DRG errors identified. All inpatient discharges are reviewed and individually coded by a certified coder and many accounts receive a secondary review by a DRG auditor. Cases in error are reviewed with the individual coders and

continuing education is provided to all staff to ensure that any CC/MCC identified meets the definition of a secondary diagnosis and is appropriate to report. Therefore, we believe the selected claim was accurate.

In addition, two of the cases reported as coding errors in the OIG report were identified as errors due to the surgery order being placed after the surgery was performed. Although we believe the codes were correct, we agree that the rule in place at the time would discount the surgical codes from being placed on the claim. We appreciate that CMS has since changed this ruling to allow for surgical codes to be included if the procedure occurs before the surgery order is placed during the admission.

CMG Codes: We respectfully disagree with the OIG findings. We continue to support the impairment group code assigned in both cases and therefore believe Medicare was billed correctly in both instances. We acknowledge the inconsistency in the assigned etiologic diagnosis codes (PAI field 22). However, the etiologic diagnosis is not linked to payment and therefore did not result in an incorrect payment being received for either case. We do not believe we have any control deficiencies at this time and are confident our CMG assignment was supported by our documentation.

Inpatient Manufacturer Credit Not Obtained

We agree with the OIG findings. A new medical device policy has been created, and work continues to more clearly define each department's role in the communication process when a replacement device occurs. Effective September 5, 2014, the billing process was updated to include an edit to hold for review any replacement claim to ensure that the claim does not include a charge for the replacement device and to ensure that duplicate reimbursement was not received.

Outpatient Dental Services

We agree with the OIG findings. Since these patients had Minnesota Medicaid which does provide dental coverage, a billing process had been created to bill primary insurance before billing secondary insurance. Denials from Medicare' Fiscal Intermediary were expected but apparently did not occur as Noridian (the FI at the time) mistakenly paid for these claims. The billing process did not catch this error by the FI and the claims were accepted by the hospital.

We have reviewed all the Medicare dental claims from September 2013 to September 2014 and those found not in compliance were re-billed. In addition, on July 10, 2014, automated system edits were put in place to hold these claims for review prior to billing.

Outpatient Manufacturer Credits Not Obtained

We agree with the OIG findings. Our response is the same as above for the inpatient manufacturer credits.

Modifier -59

We respectfully disagree with the OIG findings on 8 of the 21 claims as the modifier was used appropriately to designate distinctly separate services the patient received from the hospital. Of the remaining 13 cases, we agree they were coded erroneously as a result of confusing infusion coding and modifier 59 application rules. As the OIG has published many times during the last five years, infusion

coding has a high error rate national and the Deputy Inspector General stated in 2014 that modifier 59 has "controversial interpretations." Nonetheless, we will continue to provide oversight to minimize errors via auditing, workflow adjustments, continuing education, as well as provider education regarding documentation requirements.

Insufficiently Documented Outpatient Services

We agree with the OIG findings. Education on the 59 modifier has been provided to the coding and APC staff. We are also asking all departments to refrain from adding the 59 modifier during their charging process so that only qualified coding and APC staff will add the 59 modifier when appropriate. Quarterly audits of 59 modifier usage will be performed.

Extrapolation Results

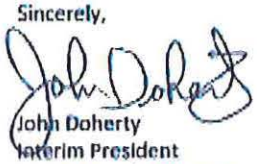
Because statistical sampling may be subject to errors in methodology or application, the hospital reserves the right to challenge the stratified sample used for this review once the specific claim appeals referenced in this response are completed.

Thank you for this opportunity to respond to the OIG's draft report.

For those cases where we agree with the OIG findings, we will be reprocessing the claims and refunding Medicare in the near future if we had not done so already. For those we disagree with, we reserve the right to appeal.

Please feel free to contact me with any further questions.

Sincerely,



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