Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# MEDICARE COMPLIANCE REVIEW OF SIERRA VIEW MEDICAL CENTER FOR 2012 AND 2013

*Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.*

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

November 2015
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http://oig.hhs.gov

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## OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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## EXECUTIVE SUMMARY

***Sierra View Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately $798,000 over 2 years.***

### WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals $148 billion, which represented 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

Our objective was to determine whether Sierra View Medical Center (the Medical Center) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Medical Center is a 167-bed acute-care facility located in Porterville, California. Medicare paid the Medical Center approximately $65 million for 4,439 inpatient and 46,901 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013.

Our audit covered $850,226 in Medicare payments to the Medical Center for 30 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 28 inpatient and 2 outpatient claims and had dates of service in CY 2012 or CY 2013.

### WHAT WE FOUND

The Medical Center complied with Medicare billing requirements for 5 of the 30 inpatient and outpatient claims we reviewed. However, the Medical Center did not fully comply with Medicare billing requirements for the remaining 25 claims, resulting in overpayments of $798,064 for CYs 2012 and 2013. Specifically, 23 inpatient claims had billing errors, resulting in overpayments of $228,969, and 2 outpatient claims had billing errors, resulting in overpayments of $569,095. These errors occurred primarily because the Medical Center did not

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

## WHAT WE RECOMMEND

We recommend that the Medical Center:

- refund to the Medicare program $798,064, consisting of $228,969 in overpayments for the incorrectly billed inpatient claims and $569,095 in overpayments for the incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

## MEDICAL CENTER COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Medical Center agreed with our findings for five claims (three inpatient and two outpatient claims) and described actions that it had taken to address those findings. However, the Medical Center disagreed with our findings for 20 claims that we identified as incorrectly billed as inpatient and provided an explanation of its position for each claim. The Medical Center stated that because of the beneficiaries' medical histories, many of the beneficiaries needed continuous monitoring, and it would not have been reasonable to monitor patients in a less intensive setting, such as observation. In addition, the Medical Center stated that our independent medical reviewer relied on a retrospective analysis of the clinical data and that CMS instructed contractors to review the reasonableness of each inpatient admission decision on the basis of information known to the physician at the time of admission. The Medical Center did not explicitly address our recommendations.

After reviewing the Medical Center's comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether claims met medical necessity requirements. The contractor examined all the medical records and documentation submitted and carefully considered this information to determine whether the Medical Center billed the inpatient claims according to Medicare requirements. On the basis of the contractor's conclusions, we determined that the Medical Center should have billed the inpatient claims as outpatient or outpatient with observation services.

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# INTRODUCTION

## WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals $148 billion, which represented 43 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 Sierra View Medical Center (the Medical Center) complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

## BACKGROUND

### The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

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

### Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). The rates vary according to the diagnosis-related group (DRG) to which a beneficiary’s stay is assigned and the severity level of the patient’s diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary’s stay.

### Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000. 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

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

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 short stays and

- outpatient claims for injectable drugs.

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 Social Security Act (the Act) § 1862(a)(1)(A)). In addition, payments may not be made to any provider of services or other person without information necessary to determine the amount due to the provider (the Act § 1833(e)).

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

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

### Sierra View Medical Center

The Medical Center is a 167-bed acute-care facility located in Porterville, California. Medicare paid the Medical Center approximately $65 million for 4,439 inpatient and 46,901 outpatient claims for services provided to beneficiaries during CYs 2012 and 2013.[2]

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[2] These data came from CMS's National Claims History file.

## HOW WE CONDUCTED THIS REVIEW

Our audit covered $850,226 in Medicare payments to the Medical Center for 30 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 28 inpatient and 2 outpatient claims and had dates of service in CY 2012 or CY 2013.[3] 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 subjected all 30 claims to focused medical review to determine whether the services were medically necessary and met coding requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Medical Center for Medicare reimbursement.

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

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

# FINDINGS

The Medical Center complied with Medicare billing requirements for 5 of the 30 inpatient and outpatient claims we reviewed. However, the Medical Center did not fully comply with Medicare billing requirements for the remaining 25 claims, resulting in overpayments of $798,064 for CYs 2012 and 2013. Specifically, 23 inpatient claims had billing errors, resulting in overpayments of $228,969, and 2 outpatient claims had billing errors, resulting in overpayments of $569,095. These errors occurred primarily because the Medical Center did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

## BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Medical Center incorrectly billed Medicare for 23 of 28 selected inpatient claims, which resulted in overpayments of $228,969.

### Incorrectly Billed as Inpatient

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

For 22 of 28 selected inpatient claims, the Medical Center incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. For 2 of the 28 claims, the Medical Center stated that the errors were the result of a physician not

[3] The 28 inpatient claims had dates of service in CY 2012 or in CY 2013 before October 1, 2013.

documenting the intended observation status until 3 days after discharge and the result of a clerical error. For the remaining 20 claims, the Medical Center did not offer a cause for the errors and stated that it believed these claims were billed appropriately. As a result of the 22 errors, the Medical Center received overpayments of $225,785.[4]

### Incorrect Diagnosis-Related Group

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 Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 1 of 28 selected inpatient claims, the Medical Center billed Medicare with the incorrect DRG. For this claim, to determine the DRG, the Medical Center used a diagnosis code that was incorrect or unsupported by the medical record. The Medical Center stated that the coder did not follow the Medical Center's coding guidelines related to the selection of the principal diagnosis code. As a result of this error, the Medical Center received an overpayment of $3,184.

## BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Medical Center incorrectly billed Medicare for both of the two selected outpatient claims, which resulted in overpayments of $569,095.

### Incorrect Healthcare Common Procedure Coding System Code

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act § 1833(e)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For two of two selected outpatient claims, the Medical Center submitted claims to Medicare with the incorrect HCPCS code. Specifically, the Medical Center billed J0178 (aflibercept, a drug used in the treatment of wet macular degeneration) when it should have billed C9296 (ziv-aflibercept, a drug used in the treatment of metastatic colorectal cancer). The Medical Center stated that these errors occurred because its system was configured to select the incorrect HCPCS code. As a result of these errors, the Medical Center received overpayments of $569,095.

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[4] The Medical Center 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 before issuance of our report.

## RECOMMENDATIONS

We recommend that the Medical Center:

- refund to the Medicare program $798,064, consisting of $228,969 in overpayments for the incorrectly billed inpatient claims and $569,095 in overpayments for the incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

## MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

### MEDICAL CENTER COMMENTS

In written comments on our draft report, the Medical Center agreed with our findings for five claims (three inpatient and two outpatient claims) and described actions that it had taken to address those findings. However, the Medical Center disagreed with our findings for 20 claims that we identified as incorrectly billed as inpatient. The Medical Center did not explicitly address our recommendations.

In its comments, the Medical Center addressed each of the 20 inpatient claims and included the reasons for its disagreement with our findings. The following summarizes the Medical Center's position:

- Because of their medical histories, many beneficiaries needed continuous monitoring, and it would not have been reasonable to monitor patients in a less intensive setting, such as observation. The Medical Center stated that observation is not appropriate for continuous monitoring.

- OIG's independent reviewer relied on a retrospective analysis of the clinical data.

- CMS instructed contractors to review the reasonableness of each inpatient admission decision on the basis of information known to the physician at the time of admission.

The Medical Center's comments are included in their entirety as Appendix C.

### OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Medical Center's comments, we maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether claims met medical necessity requirements. The contractor examined all the medical records and documentation submitted and carefully considered this information to determine whether the Medical Center billed the inpatient claims according to Medicare requirements. Each claim that was found to be improperly billed was reviewed by two clinicians (one of whom was a physician), who confirmed our finding. On the basis of the contractor's conclusions, we

determined that the Medical Center should have billed the inpatient claims as outpatient or outpatient with observation services.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered $850,226 in Medicare payments to the Medical Center for 30 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 28 inpatient and 2 outpatient claims and had dates of service in CY 2012 or CY 2013.[5]

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 subjected all 30 claims to focused medical review to determine whether the services were medically necessary and met coding requirements.

We limited our review of the Medical Center'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 CMS's 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 Medical Center for Medicare reimbursement.

We conducted our audit from October 2014 to June 2015. Our fieldwork included contacting the Medical Center in Porterville, California.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Medical Center's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2012 and 2013;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 30 claims (28 inpatient and 2 outpatient claims) for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;

[5] The 28 inpatient claims had dates of service in CY 2012 or in CY 2013 before October 1, 2013.

- requested that the Medical Center conduct its own review of the selected claims to determine whether the services were billed correctly;

- reviewed the itemized bills and medical record documentation provided by the Medical Center to support the selected claims;

- reviewed the Medical Center's procedures for assigning HCPCS codes and submitting Medicare claims;

- used an independent medical review contractor to determine whether 28 selected inpatient claims met medical necessity and coding requirements and 2 selected outpatient claims met coding requirements;

- discussed the incorrectly billed claims with Medical Center personnel to determine the underlying causes of noncompliance with Medicare requirements;

- calculated the correct payments for those claims requiring adjustments; and

- discussed the results of our review with Medical Center officials.

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

## APPENDIX B: RESULTS OF REVIEW BY RISK AREA

| Risk Area | Selected Claims | Value of Selected Claims | Claims With Over-payments | Value of Overpayments |
|---|---|---|---|---|
| **Inpatient** | | | | |
| Short Stays | 28 | $274,924 | 23 | $228,969 |
| **Inpatient Totals** | **28** | **$274,924** | **23** | **$228,969** |
| | | | | |
| **Outpatient** | | | | |
| Claims for Injectable Drugs | 2 | $575,302 | 2 | $569,095 |
| **Outpatient Totals** | **2** | **$575,302** | **2** | **$569,095** |
| | | | | |
| **Inpatient and Outpatient Totals** | **30** | **$850,226** | **25** | **$798,064** |

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

# APPENDIX C: MEDICAL CENTER COMMENTS

**SIERRA VIEW MEDICAL CENTER**

**465 West Putnam, Porterville, CA 93257**

**559-784-1100**

September 22, 2015

Lori A. Ahlstrand,
Regional Inspector General for Audit Services

Re: A-09-14-02039

Sent via email

Dear Ms. Ahlstrand,

This letter is in response to the OIG Report number A-09-14-02039 sent to us on August 24, 2015. As stated in earlier replies, we agree with your findings in 10 of the 30 cases reviewed (five of which had no issues) and disagree with your findings for 20 of the cases. We have addressed all 30 of the cases in this letter. Where we were in agreement, and where applicable, we have included the steps that we have taken or plan to take to prevent reoccurrence of the errors. For the 20 cases in dispute we have included a detailed explanation of our position. I would like to take this opportunity to thank you for your helpfulness and courtesy throughout the review process.

**REGARDING BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS:**

**OIG# 1 and 2.** We agree that we were overpaid twice as a result of an incorrect HCPCS code applied to the drug ziv-aflibercept. The employee in charge of our charge master incorrectly used the code for the drug aflibercept. The payment received was much more that we would have expected for the drug which resulted in a 'negative' contractual adjustment. Both the payments and adjustments were electronically posted to the accounts resulting in a zero balance on the accounts. ***As soon as the error was noted during the review process we corrected our charge master. We have instituted two new practices to prevent this from happening in the future. First, anytime a new drug is added to the charge master the pharmacy double checks the HCPCS code entered in the charge master to ensure that it is correct. As an additional safeguard, a report is run daily showing any 'negative' contractual adjustments that were posted. When***

***found, they are researched to ensure that the funds are rightfully ours. If they are not ours, the claims are reprocessed correctly. We performed an audit of all incidents of billing for this drug from inception through the date we made the correction and found no other over payments.***

**REGARDING BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS:**

We both agree that there were no issues with five of the twenty-eight of the inpatient claims reviewed (**OIG # 4, 10, 18, 19, 30**).

We agree with your finding that two of the claims were incorrectly admitted and billed as inpatients. The facts of the first claim are as follows (**OIG# 6**):

The process in place at that time of the patient's stay was for HIM to put the account on hold and add a comment (prepared text) "INPATIENT CRITERIA NOT MET, BILL AS PART B". The biller would see the account was on hold and the reason for the hold and then that would go to their queue to bill as Part B. However, this account was already on hold for something else, specifically a 72-hour hold. Three months later the hold was removed but the biller did not associate the hold with the comment from HIM because the actual hold was for the 72-hour overlap and not for the "Bill as Part B" message. In other words, this was a clerical error. ***We have since changed our process. Case Management now contacts the Patient Accounting department directly to place claims on hold and to rebill as Part B.***

Here are the facts of the second case (**OIG# 7**):

This patient presented to the emergency room with anemia. The admission was reviewed and approved as inpatient. Upon receipt of the Medicare Compliance Review listing all accounts were reviewed. Findings were that the MD H&P stated that the patient was sent over for a blood transfusion as a short stay. The H&P was not available upon initial review and in fact was not supplied by the physician until long after the claim was submitted.

This Claim did not meet internal re-review criteria in place at that time. The information from the doctor that caused us to re-evaluate the claim was extremely untimely. ***We now flag claims for re-review anytime additional information is received – regardless of the amount of time that has passed since the claim was billed.***

We agree that one case was billed using an incorrect DRG (**OIG# 26**). The medical center employees highly trained experienced medical coders. In spite of their qualifications errors may occur. ***As a result we contract a firm called Health Care Cost Solutions to perform quarterly coding audits on Inpatient, Surgical Day Care and Emergency Room Medicare accounts. The results of the audits are***

***reviewed and education provided to the coding staff based on the findings. If it is noted that a coder falls out of the standards during the audit, a larger sample of the coder's claims are pulled, reviewed and rebilled if necessary. The coder also receives additional remedial training in the area of weakness noted. We also utilize 3M 360 Encompass product which includes guidance in the proper selection of MS-DRG's as well as APR-DRG grouping.***

Of the twenty remaining inpatient cases reviewed, we respectfully disagree with the Department's findings that these cases were incorrectly admitted and billed as inpatients. Here is our explanation and a case by case explanation.

Medicare guidelines in effect on the date of admission for each of these patients state the following;

**20.6 - Outpatient Observation Services**
**(Rev. 107, Issued: 05-22-09, Effective: 07-01-09, Implementation: 07-06-09)**
**A. Outpatient Observation Services Defined**
Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Observation services are not appropriate:

- As a substitute for an inpatient admission;
- For continuous monitoring;
- For medically stable patient who need diagnostic testing or outpatient procedures (e.g., blood transfusion, chemotherapy, dialysis) that are routinely provided in an outpatient setting;
- For patient's awaiting nursing home placement;
- To be used as a convenience to the patient, his or her family the hospital or staff;
- For routine "stop" between the emergency department and an inpatient admission.

**Medicare Benefit Policy Manual Chapter 1, Inpatient Hospital Services**

**Rev.1, 10-01-03**
**A3-3101,HO210**

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.

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, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the 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.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

**Minor Surgery or Other Treatment** - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered **outpatients** for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

**Renal Dialysis** - Renal dialysis treatments are usually covered only as outpatient services but may under certain circumstances be covered as inpatient services depending on the patient's condition. Patients staying at home, who are ambulatory, whose conditions are stable and who come to the hospital for routine chronic dialysis treatments, and not for a diagnostic workup or a change in therapy, are considered outpatients. On the other hand, patients undergoing short-term dialysis until their kidneys recover from an acute illness (acute dialysis), or persons with borderline renal failure who develop acute renal failure every time they have an illness and require dialysis (episodic dialysis) are usually inpatients. A patient may begin dialysis as an inpatient and then progress to an outpatient status.

Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.

**Based on Medicare guidelines the remaining 20 cases in question are, in our opinion, appropriate inpatient admissions. Our rebuttals follow:**

**OIG# 3**

***Based on the patient's history uncertain outcome and continuous need for monitoring and care an inpatient hospitalization was appropriate. This patient met InterQual criteria a nationally recognized third party screening tool that was properly applied by qualified staff. CMS instructed contractors to follow longstanding guidance to review the reasonableness of the inpatient admission decision based on the information known to the physician at the time of admission. This guidance was readily available to competent reviewers at the time of the proposed denial. (CMS guidance: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/ReviewingHospitalClaimsforAdmissionFINAL.pdf Published 11/27/13, accessed 6/10/15)***

**OIG# 5**

*Due to the patient extensive medical comorbidities it would not have been reasonable to monitor the patient in a less intensive setting such as observation as observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

**OIG# 8**

*Based on the patient's history uncertain outcome and continuous need for monitoring and care an inpatient hospitalization was appropriate. This patient met InterQual criteria a nationally recognized third party screening tool that was properly applied by qualified staff. CMS instructed contractors to follow longstanding guidance to review the reasonableness of the inpatient admission decision based on the information known to the physician at the time of admission. This guidance was readily available to competent reviewers at the time of the proposed denial. (CMS guidance: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/ReviewingHospitalClaimsforAdmissionFINAL.pdf Published 11/27/13. accessed 6/10/15*

**OIG# 9**

*Based on the patient's history uncertain outcome and continuous need for monitoring and care an inpatient hospitalization was appropriate. This patient met InterQual criteria a nationally recognized third party screening tool that was properly applied by qualified staff. CMS instructed contractors to follow longstanding guidance to review the reasonableness of the inpatient admission decision based on the information known to the physician at the time of admission. This guidance was readily available to competent reviewers at the time of the proposed denial. (CMS guidance: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-*

*Review/Downloads/ReviewingHospitalClaimsforAdmissionFINAL.pdf Published 11/27/13. accessed 6/10/15*

**OIG# 11**

*Due to the patient extensive medical comorbidities it would not have been reasonable to monitor the patient in a less intensive setting such as observation as observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

**OIG# 12**

*Due to the patient extensive cardiac history it would not have been reasonable to monitor the patient in a less intensive setting such as observation as observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

**OIG# 13**

*Due to the patient extensive medical comorbidities it would not have been reasonable to monitor the patient in a less intensive setting such as observation as observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

**OIG# 14**

*Due to the patient extensive medical comorbidities it would not have been reasonable to monitor the patient in a less intensive setting such as observation as observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the*

*practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

OIG# 15

*Based on the patient's medical condition and lack of improvement after 24 hours admitting the patient as an inpatient was medically appropriate. But the reviewer impermissibly relies on retrospective analysis of the clinical data. Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.*

OIG# 16

*Due to the patient extensive medical comorbidities it would not have been reasonable to monitor the patient in a less intensive setting such as observation as observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

OIG# 17

*The patient's chest pain was relieved with Vicodin. His chest pain was thought to be from underlying inflammation of the pleura. The patient remained asymptomatic. But the reviewer impermissibly relies on retrospective analysis of the clinical data. Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis,*

*whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.*

OIG# 20

*Due to the patient extensive medical comorbidities it would not have been reasonable to monitor the patient in a less intensive setting such as observation as observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

OIG# 21

*This case meets InterQual criteria and due to the patient extensive medical comorbidities it would not have been reasonable to monitor the patient in a less intensive setting such as observation as observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

OIG# 22

*Based on the patient's medical condition and lack of improvement after 24 hours admitting the patient as an inpatient was medically appropriate. But the reviewer impermissibly relies on retrospective analysis of the clinical data. Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be*

*made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.*

OIG# 23

*Based on the patient's medical condition admitting the patient as an inpatient was medically appropriate. But the reviewer impermissibly relies on retrospective analysis of the clinical data. Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.*

OIG# 24

*Due to the patient extensive medical comorbidities it would not have been reasonable to monitor the patient in a less intensive setting such as observation as observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

OIG# 25

*This case meets InterQual criteria and due to the patient extensive medical comorbidities it would not have been reasonable to monitor the patient in a less intensive setting such as observation as observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

**OIG# 27**

*Based on the patient's medical condition admitting the patient as an inpatient was medically appropriate. But the reviewer impermissibly relies on retrospective analysis of the clinical data. Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.*

**OIG# 28**

*Due to the patient extensive medical comorbidities it would not have been reasonable to monitor the patient in a less intensive setting such as observation. As observation is not appropriate for continuous monitoring. Further, observation is a defined set of services and such a recommendation runs afoul of the SSA prohibition against "supervision or control over the practice of medicine or the manner in which medical services are provided" (SSA sect 1801 found at 41 USC 1395)*

**OIG# 29**

*Based on the patient's medical condition and lack of improvement after 24 hours admitting the patient as an inpatient was medically appropriate. But the reviewer impermissibly relies on retrospective analysis of the clinical data. Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results)*

***which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.***

Once again, if we can be of any further assistance in this process, please do not hesitate to contact me.

Yours truly

Donna J Heffner

Donna J Hefner, CEO Sierra View Medical Center

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