Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

VANDERBILT UNIVERSITY MEDICAL CENTER: AUDIT OF OUTPATIENT OUTLIER PAYMENTS

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Office of Inspector General

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Report in Brief
Date: May 2022
Report No. A-06-20-04003

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Vanderbilt University Medical Center: Audit of Outpatient Outlier Payments

Why OIG Did This Audit

Medicare makes supplemental payments to hospitals, known as outlier payments, which are designed to protect hospitals from significant financial losses resulting from patient-care cases that are extraordinarily costly. Unlike predetermined payment amounts for most Medicare hospital claims, outlier payments are directly influenced by hospital charges. We selected Vanderbilt University Medical Center (VUMC) because outpatient outlier payments increased from $2.7 million in 2017 to $6.2 million in 2018.

Our objective was to determine whether possible billing inconsistencies resulted in improper outpatient outlier payments to VUMC.

How OIG Did This Audit

Our audit covered 2,362 outpatient outlier payments, totaling $6.2 million, to VUMC for services provided from January 1 through December 31, 2018. We selected a stratified random sample of 117 outlier payments totaling $543,684 for review. Because outlier payments are based on total charges, we retrieved the claim detail related to each outlier payment. We submitted the claims related to the 117 outlier payments to VUMC for it to review. We requested that VUMC verify that charges and codes on the claim were correct. Additionally, OIG reviewed outlier claims data for inconsistences and claim support documentation for billing errors.

What OIG Found

VUMC properly billed the claims for 34 of the 117 sampled outlier payments totaling $102,551. However, VUMC did not properly bill the claims related to 81 outlier payments, resulting in improper outlier payments during our audit period. These 81 claims, which had outlier payments totaling $427,644, contained 110 billing errors. The billing errors primarily occurred because VUMC did not have adequately designed controls or billing system capabilities to prevent coding errors, charge errors, and billing for services not covered by Medicare Part B. VUMC billed another two claims with incorrect dates of service that caused the claims to fall outside the scope of this audit (outpatient services longer than 1 day) and so were classified as non-errors.

What OIG Recommends and VUMC Comments

We recommend that the Vanderbilt University Medical Center refund to the Medicare contractor the portion of the $686,500 in estimated outpatient outlier net overpayments for incorrectly billed claims that are within the 4-year reopening period. We also recommend that VUMC improve procedures, provide education, and implement changes to its billing system to ensure that claims billed to Medicare are accurate.

In written comments on our draft report, VUMC concurred with our recommendations and described the corrective actions that it has taken to address them. These actions include, but are not limited to, additional verification processes for pricing of pharmacy items, re-training of outsourced coders, and implementing specific reviews of unlisted procedure coding.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare makes supplemental payments to hospitals, known as outlier payments, which are designed to protect hospitals from significant financial losses resulting from patient-care cases that are extraordinarily costly. Unlike predetermined payment amounts for most Medicare hospital claims, outlier payments are directly influenced by hospital charges.

A prior Office of Inspector General (OIG) report focusing on inpatient outlier payments found that a hospital's high charges, unrelated to cost, led to excessive inpatient outlier payments.[1] Additionally, prior OIG audits focusing on outpatient outlier payments found that billing errors led to increased outlier payments.[2] Therefore, we are performing multiple audits of hospital outpatient outlier payments.

We selected Vanderbilt University Medical Center (VUMC) because outpatient outlier payments increased from $2.7 million in 2017 to $6.2 million in 2018.

OBJECTIVE

Our objective was to determine whether possible billing inconsistencies detected during OAS survey work resulted in improper outpatient outlier payments to VUMC.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with Medicare administrative contractors (MACs) to, among other things, process and pay claims submitted by hospitals.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which was 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

[1] OIG *Medicare Hospital Outlier Payments Warrant Increased Scrutiny*, Nov. 2013, (OEI-06-10-00520).

[2] See Appendix D for related work.

Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.[3] All services and items within an APC group are comparable clinically and require comparable resources. In this respect, some services, such as anesthesia, supplies, certain drugs, and use of recovery and observation rooms (packaged services) are included in APCs and are not paid separately.

Outpatient Outlier Payments

Section 1833(t)(5) of the Social Security Act (the Act) provides that a payment adjustment (outlier payment) will be made for covered services for which costs exceed a given threshold. OPPS provides outlier payments to hospitals to help mitigate the financial risk associated with high-cost and complex procedures, when a very costly service could present a hospital with significant financial loss.

CMS's *Provider Reimbursement Manual* (PRM) defines charges as the regular rates established by the hospital for services rendered to both beneficiaries and to other paying patients.[4] Generally, charges do not affect the current APC payment amounts. However, the total charges for the packaged services are used to calculate outlier payments.

A service or group of services becomes eligible for outlier payments when the cost of the service or group of services estimated using the hospital's most recent overall cost-to-charge ratio separately exceeds each relevant threshold. The current hospital outlier payment is calculated on a service basis using both fixed-dollar and multiple thresholds to determine outlier eligibility.[5]

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."[6] In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.[7]

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

[4] PRM-part 1, Pub. No. 15-1, § 2202.4.

[5] 42 CFR § 419.43(d).

[6] The Act § 1862(a)(1)(A).

[7] 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.[8]

The CMS *Medicare Claims Processing Manual* (the Manual) requires claims to be completed accurately so that Medicare contractors may process them correctly and promptly.[9] Under the hospital OPPS, Medicare payment is based on predetermined amounts for designated services identified by HCPCS codes.[10]

Medicare Requirements for Providers To Identify and Return Overpayments

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[11]

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.[12]

Hospital Charge Structure

The PRM states that each facility should have an established charge structure that is applied uniformly to each patient as services are furnished to the patient and that is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether the charges are allowable for use in apportioning costs under the program.[13]

[8] 42 CFR § 424.5(a)(6).

[9] Pub. No. 100-04, chapter 1, § 80.3.2.2.

[10] 42 CFR § 419.2(a).

[11] The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

[12] 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); PRM—part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

[13] PRM-part 1, Pub. No. 15-1, §§ 2203 and 2202.4.

National Correct Coding Initiative and Procedure-to-Procedure Claim Processing Edits

To promote correct coding by providers and to prevent Medicare payments for improperly coded services, CMS developed the National Correct Coding Initiative (NCCI). MAC contractors implemented NCCI edits within their claim processing systems for dates of service on or after January 1, 1996.[14]

The NCCI edits include procedure-to-procedure edits that define pairs of HCPCS codes and current procedural terminology (CPT) codes (i.e., code pairs) that generally should not be reported together for the same beneficiary on the same date of service.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 2,362 outpatient outlier payments, totaling $6.2 million, to VUMC for services rendered January 1 through December 31, 2018 (audit period).[15] We selected a stratified random sample of 117 outlier payments totaling $543,684 for review. Because outlier payments are based on total charges, we retrieved the claim detail related to each outlier payment. We submitted the claims related to the 117 outlier payments to VUMC for it to review. We requested that VUMC verify that charges and codes on the claim were correct. Additionally, OIG reviewed outlier claims data for inconsistences and claim support documentation for billing errors.

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 A contains the details of our audit scope and methodology.

FINDINGS

VUMC properly billed the claims for 34 of the 117 sampled outlier payments totaling $102,551. However, VUMC did not properly bill the claims related to 81 outlier payments, resulting in improper outlier payments during our audit period. These 81 claims, which had outlier payments totaling $427,644, contained 110 billing errors. The billing errors primarily occurred because VUMC did not have adequately designed controls or billing system capabilities to

[14] An edit is programming within the standard claim processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, takes action on the claims by either paying them in full, paying them in part, denying payment for them, or suspending them for manual review.

[15] The audit period encompassed the most current data available at the time we initiated our audit.

prevent charge errors, coding errors, and billing for services not covered by Medicare Part B. Another 2 claims were billed with incorrect dates of service, which caused the claims to fall outside the scope of this audit (outpatient services longer than 1 day) and so were classified as non-errors.

VUMC has amended 47 claims based on our audit findings, which lowered the outlier payments by $172,466.[16] On the basis of our sample results, we estimated that VUMC received improper outlier payments of at least $686,500 during our audit period. Appendix B contains the details of our statistical sampling methodology, and Appendix C contains the sample results and estimates.

MEDICARE REQUIREMENTS

No payment may be made under Part A or Part B for any expenses incurred 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.[17]

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider.[18] Claims must be completed accurately so that Medicare contractors may process them correctly and promptly.[19] Providers must use HCPCS codes for most outpatient services.[20]

Medicare does not cover items or services for which neither the beneficiary, nor anyone on his behalf, has an obligation to pay.[21] Federal regulations generally require reductions in OPPS payments for the replacement of certain implanted devices if (1) the device is replaced without cost to the hospital or beneficiary, (2) the hospital receives full credit for the device cost, or (3) the hospital receives a credit equal to 50 percent or more of the device cost.[22] The hospital is required to report a charge of zero or a token charge (e.g., $1.00) for an implanted device that was furnished at no cost to the hospital.[23]

[16] OIG required only claims that were determined to have an error that would impact payment to be amended.

[17] The Act § 1862(a)(1)(A).

[18] The Act § 1833(e).

[19] Pub. No. 100-04, chapter 1, § 80.3.2.2.

[20] The Manual, chapter 23, § 20.3.

[21] The Act § 1862(a)(2).

[22] 42 CFR § 419.45(a).

[23] The Manual, chapter 4, § 61.3.5.

Observation services are a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.[24] Hospitals should not report as observation care services that are part of another Part B service, nor should they bill observation services concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure.[25]

The *NCCI Policy Manual for Medicare Services* states that fluoroscopy is integral to many procedures, including, but not limited to, most spinal, endoscopic, and injection procedures and shall not be reported separately.[26]

An HCPCS modifier was created for hospital claims that is to be reported with every code for outpatient hospital items and services furnished in an off-campus, provider-based department of a hospital. This 2-digit modifier was added to the HCPCS annual file as of January 1, 2015, with the label "PO." Reporting of this new modifier was voluntary for CY 2015, with reporting required beginning on January 1, 2016.[27]

Effective January 1, 2018, hospitals paid under the OPPS that are not excepted from the 340B[28] drug payment policy for calendar year (CY) 2018 are required to report modifier "JG" on the same claim line as the drug HCPCS code to identify a 340B-acquired drug.[29]

Services and procedures that are designated as requiring inpatient care are excluded from payment under the hospital outpatient prospective payment systems.[30]

The costs of all hospital and physician services for pre-transplant evaluations become acquisition costs and are included in the cost report.[31]

[24] The Manual, chapter 4, § 290.1.

[25] 80 Fed. Reg. 70298, 70335 (Nov. 13, 2015); see also, the Manual, chapter 4, § 290.2.2.

[26] *NCCI Policy Manual for Medicare Services*, Jan. 1, 2018, chapter 9, (D)(8).

[27] 79 Fed. Reg. 66770, 66914 (Nov. 10, 2014).

[28] The 340B Program is a Federal discount drug program for eligible entities such as outpatient hospitals.

[29] 82 Fed. Reg. 59216, 59369 (Dec. 14, 2017).

[30] 42 CFR § 419.22.

[31] 42 CFR § 412.100(a) and (b); PRM – part 1, Pub. No. 15-1, chapter 31, § 3101.

VANDERBILT UNIVERSITY MEDICAL CENTER HAD CHARGE ERRORS

Payments to Medicare providers should not be made unless the provider has furnished information necessary for the MAC to determine the amount owed to the provider.[32] Claims must be completed accurately so that Medicare contractors may process them correctly and promptly.[33] Additionally, Medicare does not cover items or services for which neither the beneficiary, nor anyone on the beneficiary's behalf, has an obligation to pay.[34] The hospital is required to report a charge of zero or a token charge for an implanted device that was furnished at no cost to the hospital.[35]

Of the 117 claims reviewed, we identified 9 claims with errors related to charges.

- Six claims contained charges for a drug for which the cost of a case of the drug was input rather than the cost of a vial in a drug pricing calculation, increasing charges by $17,637.

- One claim contained charges for a medical device that was not correctly identified as a no-cost replacement, increasing charges by $19,328.

- One claim contained charges for a medical supply that was not correctly identified as a non-chargeable supply item, increasing charges by $1,147.

- One claim contained charges for a medical supply for which the vendor item number was input instead of the supply item number, increasing charges by $27,722.

For all nine claims with errors, VUMC stated that human error caused the incorrect charges.

VANDERBILT UNIVERSITY MEDICAL CENTER HAD CODING ERRORS

Payments to Medicare providers should not be made unless the provider has furnished information necessary for the MAC to determine the amount owed to the provider.[36] Claims

[32] The Act § 1833(e).

[33] Pub. No. 100-04, chapter 1, § 80.3.2.2.

[34] The Act § 1862(a)(2).

[35] The Manual, chapter 4, § 61.3.5.

[36] The Act § 1833(e).

must be completed accurately so that Medicare contractors can process them correctly and promptly.[37] Providers must use HCPCS codes for most outpatient services.[38]

Hospitals should not report as observation care services that are part of other Part B services; nor should they bill observation services concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure.[39]

The *NCCI Policy Manual for Medicare Services* states that fluoroscopy is integral to many procedures, including, but not limited to, most spinal, endoscopic, and injection procedures and shall not be reported separately.[40]

The PO modifier is to be reported with every HCPCS code for all outpatient hospital items and services in an excepted, off-campus, provider-based department of a hospital.[41]

Hospitals paid under the OPPS that are not excepted from the 340B drug payment policy for CY 2018 are required to report modifier "JG" on the same claim line as the drug HCPCS code to identify a 340B-acquired drug.[42]

Of the 117 claims reviewed, we identified 71 claims with 93 coding errors.

- Fifty-six claims contained errors for inaccurate coding. When reviewers looked at VUMC claims, they determined that other coding better described the services provided.

- Eight claims did not have the appropriate modifier to identify either services furnished at off-campus, provider-based, outpatient departments or drugs obtained through a discount program.

- Seven claims had separately billed radiology procedures that were included in another service.

- Seven claims had supplies or devices that were billed as routine supplies rather than with specific HCPCS codes.

[37] Pub. No. 100-04, chapter 1, § 80.3.2.2.

[38] The Manual, chapter 23, § 20.3.

[39] 80 Fed. Reg. 70298, 70335 (Nov. 13, 2015); see also the Manual, Pub. No. 100-04, chapter 4, § 290.2.2.

[40] *NCCI Policy Manual for Medicare Services*, January 1, 2018, chapter 9, (D)(8).

[41] The Manual, chapter 4, § 20.6.11.

[42] The Manual, chapter 4, § 20.6.16.

- Five claims had incorrect units related to recovery time, radiology, or cardiac procedures.

- Five claims had the main procedure omitted when the claim was downgraded from inpatient to outpatient.

- Four claims had the incorrect type of bill.[43]

- One claim had separately billed observation hours that were included in another service.

VUMC stated that human and billing system errors caused the inaccurate coding.

VANDERBILT UNIVERSITY MEDICAL CENTER BILLED FOR NON-PART B SERVICES

Payments to Medicare providers should not be made unless the provider has furnished information necessary for the MAC to determine the amount owed to the provider.[44] Furthermore, claims must be completed accurately so that Medicare contractors may process them correctly and promptly.[45]

Services and procedures that are designated as required inpatient care are excluded from payment under the hospital OPPS.[46]

The costs of all hospital and physician services for pre-transplant evaluations become acquisition costs and are included in the cost report.[47]

Of the 117 claims reviewed, we identified 8 claims that did not represent covered Medicare Part B services.

- Seven claims were billed for inpatient-only procedures, which resulted in improper outlier payments of $65,400. VUMC stated that billing system and human error caused the incorrect outpatient claims.

[43] Type of bill is a code required on all CMS-1450 institutional claims. This four-digit alphanumeric code gives three specific pieces of information after a leading zero: the second digit identifies the type of facility, the third digit classifies the type of care, and the fourth digit indicates the sequence of this bill in this particular episode of care.

[44] The Act § 1833(e).

[45] Pub. No. 100-04, chapter 1, § 80.3.2.2

[46] 42 CFR § 419.22.

[47] The Manual, chapter 31, § 3106.

- One claim was billed for organ acquisition-related testing, which resulted in an improper outlier payment of $1,103. VUMC stated that human error caused the incorrect outpatient claim.

VANDERBILT UNIVERSITY MEDICAL CENTER'S POLICIES AND PROCEDURES DID NOT ALWAYS ENSURE COMPLIANCE WITH FEDERAL REQUIREMENTS

Payments to Medicare providers should not be made unless the provider has furnished information necessary for the MAC to determine the amount owed to the provider.[48] Furthermore, claims must be completed accurately so that Medicare contractors may process them correctly and promptly.[49]

VUMC did not have adequately designed controls or billing system capabilities in place to ensure that claims billed to Medicare were accurate. In addition, some existing controls were not implemented. We identified billing errors on 81 of the 117 claims in our sample. We noted that 25 claims had more than one error, for a total of 110 billing errors. Inaccurate claims caused underpayments and overpayments, including improper outlier payments.

RECOMMENDATIONS

We recommend that Vanderbilt University Medical Center:

- refund to the Medicare contractor the portion of the $686,500[50] in estimated outpatient outlier net overpayments for incorrectly billed claims that are within the 4-year reopening period;[51]

[48] The Act § 1833(e).

[49] Pub. No. 100-04, chapter 1, § 80.3.2.2.

[50] $172,466 has already been recovered.

[51] OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

- based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule[52] and identify any of those returned overpayments as having been made in accordance with this recommendation;

- improve procedures and provide education to staff to ensure that claims billed to Medicare are accurate; and

- implement changes to its billing system to ensure that claims billed to Medicare are accurate.

VANDERBILT UNIVERSITY MEDICAL CENTER COMMENTS

In written comments on our draft report, VUMC concurred with our recommendations and described the corrective actions that it has taken to address them. These actions include, but are not limited to, additional verification processes for pricing of pharmacy items, re-training of outsourced coders, and implementing specific reviews of unlisted procedure coding.

VUMC's comments appear in their entirety as Appendix E.

[52] This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based on the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 2,362 outpatient outlier payments, totaling $6,168,546, to VUMC for services rendered during our audit period (January 1 through December 31, 2018). The claims data were obtained from the CMS National Claims History file on the OIG Data Warehouse. We included claims for which a payment was made from the Medicare trust fund, claims for outpatient services less than or equal to 1 day, claims for which the outlier payment was more than $1,000, claims that were not processed by Medicare contractor Cahaba, and claims not under review or previously reviewed by the Recovery Audit Contractor (RAC). We selected a stratified random sample of 117 outlier payments to review.

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we reviewed responses to our questionnaire, hospital policies and procedures, and results from our sample and pricing analyses to determine whether VUMC had adequately designed controls or billing system capabilities in place to ensure that claims billed to Medicare were accurate.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- obtained outpatient claims with outpatient outlier payment from the National Claims History file;
- created a sampling frame of 2,362 outpatient outlier payments, totaling $6,168,546, to VUMC for services rendered during our audit period;
- selected a stratified random sample of 117 outpatient outlier payments from the sampling frame;
- reviewed codes and charges on the claims related to our 117 selected outlier payments to look for possible errors;
- sent the claims with questions on possible billing errors related to our 117 selected outlier payments to VUMC;
- requested that VUMC review the documentation supporting these claims to verify that an outlier payment should have been made;

- reviewed documentation obtained from VUMC to determine whether billing errors contributed to outlier payments;

- requested that VUMC send the corrected claims to the Medicare contractor for rebilling;

- used the results of the sample to estimate the improper outpatient outlier payments to VUMC; and

- discussed the results of our audit with VUMC.

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 2,362 outpatient outlier payments, totaling $6,168,546, to VUMC for services rendered during our audit period (January 1 through December 31, 2018). We included claims for which a payment was made from the Medicare trust fund, claims for outpatient services less than or equal to 1 day, claims for which the outlier payment was more than $1,000, claims that were not processed by Medicare contractor Cahaba, and claims not under review or previously reviewed by the RAC.

SAMPLE UNIT

The sample unit was an outpatient outlier payment.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. The sampling frame was divided into four strata based on outlier payment amounts.

Stratum #	Dollar Range of Frame Units	Number of	Sample	Dollar Value of
1	≥ $1,000.79 and ≤ $2,238.06	1,233	34	$2,029,695.40
2	≥ $2,238.21 and ≤ $3,614.31	746	33	2,068,081.06
3	≥ $3,616.80 and ≤ $9,921.67	366	33	1,854,896.80
4	≥ $10,003.62 and ≤ $18,700.05	17	17	215,872.26
TOTAL		**2,362**	**117**	**$6,168,545.52**

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the frame. After the statistical specialist generated the random numbers for strata 1, 2, and 3, we selected the corresponding sample units. We selected all sample units from stratum 4.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate the amount of improper outpatient outlier payments that did not meet applicable Medicare billing requirements. We calculated a point estimate and a two-sided 90-percent confidence interval for this estimate.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size	Frame Value	Sample Size	Sample Value	Number of Improper Outlier Payments*	Net Value of Improper Outlier Payments in Sample
1	1,233	$2,029,695	34	$56,888	9	$7,370
2	746	2,068,081	33	91,309	15	9,799
3	366	1,854,897	33	179,615	11	39,047
4	17	215,872	17	215,872	10	116,250
Total†	**2,362**	**$6,168,546**	**117**	**$543,684**	**45**	**$172,466**

ESTIMATES

Estimated Value of Improper Outpatient Outlier Payments in the Sampling Frame
(*Limits Calculated for a 90-Percent Confidence Interval)*

Point estimate	$1,038,108
Lower limit	686,500
Upper limit	1,389,715

APPENDIX D: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Baylor Scott & White—College Station: Audit of Outpatient Outlier Payments	A-06-18-04003	9/3/2020
CHI St. Vincent Infirmary: Audit of Outpatient Outlier Payments	A-06-16-01002	2/25/2020
Review of Medicare Outpatient Prospective Payment System Outlier Payments Made to Rush-Presbyterian-St. Luke's Medical Center Chicago, Illinois	A-05-03-00033	7/31/2003
Review of Outlier Payments Made to Eastern Maine Medical Center Under the Outpatient Prospective Payment System for the Period August 1, 2000 Through June 30, 2001	A-01-02-00507	1/15/2003

APPENDIX E: VANDERBILT UNIVERSITY MEDICAL CENTER COMMENTS

Vanderbilt University Medical Center
Office of Compliance and Corporate Integrity

May 2, 2022

Patricia Wheeler
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: Comments on Draft Report for Audit No. A-06-20-040003

Dear Ms. Wheeler,

Vanderbilt University Medical Center ("VUMC") appreciates the opportunity to provide this letter in response to the draft findings of the Department of Health and Human Services Office of Inspector General ("OIG") for Audit No. A-06-20-040003.

At VUMC, we hold ourselves to the highest legal and compliance standards and are fully dedicated to carrying out a comprehensive and thorough compliance program. VUMC is one of the largest academic medical centers in the Southeast and the Nashville region's only Level 1 trauma center. Annually, VUMC performs over 70,000 surgical cases, including many of the most complex variety, and provides more than 2.4 million ambulatory visits. We are proud of the quality services we provide, and we are committed to continuing to improve upon what we already believe to be a robust compliance framework.

We understand this audit was conducted as part of a series of audits performed by OIG in recent years focused on outpatient outlier payments. In particular, OIG selected VUMC because our outpatient outlier payments increased between 2017 and 2018.[1] This letter responds to OIG's findings and recommendations in the draft report. First, however, we would like to express our appreciation to OIG's Office of Audit Services for your guidance, communication, and transparency throughout the course of this audit. We are especially grateful to OIG for allowing VUMC a short pause in our audit response to deal with the early impacts of the COVID-19 public health emergency in 2020.

[1] VUMC cannot verify that the amounts cited in the "Why We Did This Audit" section of the draft report reflect all outpatient outlier payments made to VUMC in the relevant years. Rather, we understand that OIG's audit scope excluded certain outpatient outlier payments.

I. RESPONSE TO FINDINGS

A. Charge Errors

Out of the 117 claims reviewed, OIG identified 9 claims with errors related to charges. VUMC concurs with this finding.

These 9 claims resulted from human errors. VUMC has undertaken corrective action to address these errors. Six of these instances relate to a single pricing file update error in the VUMC billing system in 2018. This error impacted a single medication and generally did not result in incorrect payments. VUMC has implemented additional verification processes to improve accurate pricing of pharmacy items.

B. Coding Errors

OIG identified 71 claims with 93 coding errors out of the 117 claims reviewed. VUMC concurs with this finding. Having acknowledged that OIG's findings regarding coding errors in the audit are accurate, VUMC notes that many of these coding errors impacted neither VUMC's charge amounts nor correct payment by Medicare. Multiple others of these errors resulted in underpayments to VUMC.

One factor that contributed to these errors was VUMC's onboarding of an outsourced coding vendor during the audit period. VUMC and the coding vendor worked prior to, during, and subsequent to this audit to ensure appropriate accuracy and specificity of CPT coding. VUMC continues to maintain policies and quality assurance activities governing this coding, and VUMC has adapted these steps based on the findings of this audit, including re-training of our outsourced coders, implementing specific reviews of unlisted procedure coding, and adapting quality assurance scoring to better isolate CPT coding issues. In 2021, VUMC migrated its coding platform to more robust software better able to monitor coding usage.

Subsequent audits performed by an independent third-party consultant for time periods occurring after the audit period confirm that VUMC's coding accuracy has improved considerably since the interventions described above and other corrective actions were implemented.

C. Non-Part B Services

OIG concluded that 8 claims did not represent covered Medicare Part B services. VUMC concurs with this finding.

The 7 outpatient claims that included procedures on the Medicare inpatient-only procedures list were incorrectly billed to Part B and should have been billed to Part A as an inpatient service. VUMC reviewed each of these claims to determine the root cause of the errors. VUMC notes that while the claims were not properly payable under Part B, they were medically necessary services that were properly payable by Part A. Had VUMC billed Part A in 2018, the reimbursement received from Part A would have exceeded the amounts VUMC received from Part B, to include any error in outlier payment.

Even prior to this audit, VUMC had begun process improvements to patient status orders and related Utilization Management reviews. VUMC has incorporated these audit findings into our efforts to ensure appropriate patient status and related billing. As established by our independent third-party consultant review findings, VUMC has not discovered further inpatient-only billing errors on outpatient outlier claims.

D. Policies and Procedures

OIG concluded that VUMC did not have adequately designed controls or billing system capabilities in place during the audit period to ensure that claims billed to Medicare were accurate. OIG further found that some controls were not implemented. VUMC concurs with this finding. Importantly, VUMC implemented a replacement integrated electronic health record and billing system in November 2017. Many findings in this audit pertain to charging and workflow processes that were relatively new and in the process of stabilizing. Also, OIG recognized that the errors found in the audit resulted in both underpayments and overpayments to VUMC. VUMC believes its policies, procedures, and processes were robust before this audit occurred. In light of the OIG's audit findings, VUMC continues to improve its policies, procedures, and processes, as described above, to further promote accuracy of our claims billed to Medicare.

II. RESPONSE TO RECOMMENDATIONS

OIG recommends that VUMC:

- refund to the Medicare contractor the portion of the $686,500 in estimated outpatient outlier net overpayments for incorrectly billed claims that are within the 4-year reopening period;

- based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation;

- improve procedures and provide education to staff to ensure that claims billed to Medicare are accurate; and

- implement changes to its billing system to ensure that claims billed to Medicare are accurate.

Where overpayments were identified in this audit, VUMC worked with our Medicare Administrative Contractor, Palmetto GBA, to ensure corrected claims were reprocessed. As OIG notes here, VUMC has successfully refunded $172,466 of the outpatient outlier overpayments through rebilling incorrect claims that were identified during the audit. VUMC will work with CMS and Palmetto GBA to refund the remaining balance of $514,034 in estimated improper outpatient outlier payments for the audit period.

VUMC has undertaken an internal review of outpatient outlier payments received since 2018, including the independent third-party consultant outlier claim reviews described above. VUMC will refund any net overpayments that are identified during these reviews as required under the

60-day rule. VUMC is also implementing internal control enhancements around outlier payments, including regular audits for payment accuracy.

VUMC thanks OIG for the opportunity to provide these comments. We reiterate our appreciation for the professionalism and cooperative spirit of OIG's Office of Audit Services, as well as the helpful information furnished through the audit process. VUMC takes it compliance commitment very seriously. As indicated above, we agree with OIG's findings and recommendations and have undertaken the corrective action described in this letter to improve the accuracy of claims submitted to Medicare.

Sincerely,

/ Robert Mangeot /

Robert Mangeot
Vice President and Chief Compliance Officer, VUMC