

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW
OF UNIVERSITY OF KENTUCKY
HEALTHCARE FOR 2011 AND 2012**

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



**Lori S. Pilcher
Regional Inspector General
for Audit Services**

**June 2015
A-04-13-08026**

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

The University of Kentucky HealthCare did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of approximately \$209,000 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 represents 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.

The objective of this review was to determine whether University of Kentucky HealthCare (the Hospital) 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 Hospital is an acute care hospital located in Lexington, Kentucky. It consists of two acute care facilities: Albert B. Chandler Hospital, a 718-bed hospital, and University of Kentucky Good Samaritan Hospital, a 224-bed hospital. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$343 million for 18,318 inpatient and 141,120 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 (audit period).

Our audit covered \$3,071,797 in Medicare payments to the Hospital for 232 claims that we selected as potentially at risk for billing errors. These claims consisted of 136 inpatient and 96 outpatient claims that had dates of service during the audit period.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 154 of the 232 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 78 claims, resulting in overpayments of \$208,504. Specifically, 51 inpatient claims had billing errors resulting in overpayments of \$190,513, and 27

outpatient claims had billing errors resulting in overpayments of \$17,991. These overpayment amounts include some claims outside of the 3-year recovery period.

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.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare program \$113,441, consisting of \$108,796 in overpayments for the incorrectly billed inpatient claims and \$4,645 in overpayments for the incorrectly billed outpatient claims that are within the 3-year recovery period,
- work with the contractor to return overpayments outside of the 3-year recovery period in accordance with the 60-day repayment rule, and
- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF KENTUCKY HEALTHCARE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital did not agree with our finding that claims were incorrectly billed as inpatient. 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. The Hospital indicated that it would exercise the right to appeal any claims that are eventually denied. The Hospital offered no comments regarding our three recommendations.

After reviewing the Hospital's comments, we maintain that all of our findings and the associated recommendations remain valid. We obtained independent medical review to determine whether the inpatient claims with which the Hospital disagreed met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. On the basis of the contractor's conclusions, we continue to assert that the Hospital 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 represents 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

The objective of this review was to determine whether the University of Kentucky HealthCare (the Hospital) 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. 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, 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 short stays,
- inpatient paid in excess of charges,
- inpatient claims billed with high severity level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims billed for psychiatric facility (IPF) emergency department adjustments,
- outpatient claims paid in excess of \$25,000,
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day), and
- outpatient claims billed with evaluation and management (E&M) services.

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 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-

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

04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

The University of Kentucky HealthCare

The Hospital is an acute care hospital located in Lexington, Kentucky. It consists of two acute care facilities: Albert B. Chandler Hospital, a 718-bed hospital, and University of Kentucky Good Samaritan Hospital, a 224-bed hospital. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$343 million for 18,318 inpatient and 141,120 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$3,071,797 in Medicare payments to the Hospital for 232 claims that we selected as potentially at risk for billing errors. These claims consisted of 136 inpatient and 96 outpatient claims that had dates of service during the audit period. We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 74 claims to medical and coding review to determine whether the services were medically necessary or coded correctly.

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.

For the details of our audit scope and methodology, see Appendix A.

FINDINGS

The Hospital complied with Medicare billing requirements for 154 of the 232 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 78 claims, resulting in overpayments of \$208,504. Specifically, 51 inpatient claims had billing errors resulting in overpayments of \$190,513, and 27 outpatient claims had billing errors resulting in overpayments of \$17,991. These overpayment amounts include some claims that are outside of the 3-year recovery period.²

² Our audit report represents the results for all claims within our audit period. Section 1870(b) of the Act governs the recovery of excess payments. This section provides that excess payments identified are barred from recovery 3 years after the year in which the original payment was made. In addition, the Hospital is responsible for reporting and returning overpayments they identified to their Medicare administrative contractor. The 2010 Patient Protection and Affordable Care Act requires the reporting and return of Medicare overpayments along with written notice of the reason for the overpayment within 60 days after the overpayment was identified (60-day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

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. For the results of our review by risk area, see Appendix B.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 51 of 136 inpatient claims, which resulted in overpayments of \$190,513.

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 16 of the 136 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. The Hospital disputes 15 of the 16 claim errors, indicating that it does not believe there are errors with the admissions because the admissions met criteria or were reviewed and approved by a Utilization Review Physician Advisor. Nevertheless, the medical records did not support the medical necessity for the inpatient admissions and, consequently, did not justify the billings. As a result of these errors, the Hospital received overpayments of \$149,948.³

Incorrectly Billed Diagnosis-Related-Group Codes

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 12 of 136 inpatient claims, the Hospital billed Medicare for incorrect DRGs. For these claims, the Hospital used a diagnosis code that was incorrect or unsupported by the medical record. The Hospital did not dispute these errors and provided no explanation for why these errors occurred. As a result of these errors, the Hospital received overpayments of \$35,417.

Incorrectly Billed Discharge Status Code

Federal regulations (42 CFR § 412.4(c) and (f)) state that a discharge of a hospital inpatient is considered to be a transfer when the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to a home under a written plan of care for the provision of home

³ 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 contractor prior to the issuance of our report.

health services from a home health agency and those services begin within 3 days after the date of discharge. A hospital that transfers an inpatient under the above circumstance is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting.

For 1 of 136 inpatient claims, the Hospital billed Medicare for a patient discharge that should have been billed as a transfer. For this claim, the Hospital should have coded the discharge status as a transfer to home under a written plan of care for the provision of home health services. However, the Hospital incorrectly coded the discharge status as to home, thus the Hospital should have received the per diem payment instead of the full DRG payment. The Hospital did not dispute this error and provided no explanation for why it occurred. As a result, the Hospital received an overpayment of \$1,816.

Incorrectly Billed Source-of-Admission Code

CMS increases the Federal per diem rate for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary used emergency department services; however, the IPF should not receive the additional payment if the beneficiary was discharged from the acute care section of the same hospital (42 CFR § 412.424 and the Manual, chapter 3, § 190.6.4). The Manual also states that IPFs report source-of-admission code "D" to identify patients who have been transferred to the IPF from the same hospital (chapter 3, § 190.6.4.1). An IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 22 of 136 inpatient claims, the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to its IPF upon discharge from its acute care section. The Hospital stated that the errors occurred because the Hospital's information system was not appropriately loaded with source-of-admission code "D" that would have allowed staff to identify patients admitted to psychiatric service from the acute care section of the hospital. As a result, the Hospital received overpayments of \$3,332.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 27 of the 96 outpatient claims, which resulted in overpayments of \$17,991.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 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 12 of the 96 outpatient claims, the Hospital submitted the claims to Medicare with incorrect HCPCS codes. The Hospital stated these errors occurred because neither the Hospital's edit tool

nor the coding compliance staff caught these errors. As a result of these errors, the Hospital received overpayments of \$16,948.

Incorrectly Billed Evaluation and Management 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 15 of 96 outpatient claims, the Hospital incorrectly billed Medicare for E&M services that were insufficiently documented in the medical records or should not have been billed with another procedure type. For example, E&M code 99213 with modifier 25 should not be billed on the same day as Chemotherapy Administration code 96413, according to the National Correct Coding Initiative edits. The Hospital stated that these errors occurred because neither the Hospital's edit tool nor the coding compliance staff caught these errors. As a result of these errors, the Hospital received overpayments of \$1,043.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$113,441, consisting of \$108,796 in overpayments for the incorrectly billed inpatient claims and \$4,645 in overpayments for the incorrectly billed outpatient claims that are within the 3-year recovery period,
- work with the contractor to return overpayments outside of the 3-year recovery period in accordance with the 60-day repayment rule, and
- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF KENTUCKY HEALTHCARE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

University of Kentucky Healthcare Comments

In written comments on our draft report, the Hospital did not agree with our finding that claims incorrectly billed as inpatient. 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. The Hospital indicated that it would exercise the right to appeal any claims that are eventually denied.

The Hospital offered no comments regarding our three recommendations. The Hospital's comments are included in their entirety as Appendix C.

Office of Inspector General Response

After reviewing the Hospital's comments, we maintain that all of our findings and the associated recommendations remain valid. We obtained independent medical review to determine whether the inpatient claims with which the Hospital disagreed met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. On the basis of the contractor's conclusions, we continue to assert that the Hospital should have billed the inpatient claims as outpatient or outpatient with observation services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$3,071,797 in Medicare payments to the Hospital for 232 claims that we selected as potentially at risk for billing errors. These claims consisted of 136 inpatient and 96 outpatient claims that had dates of service during the audit period.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 74 claims to medical and coding review to determine whether the services were medically necessary or coded correctly.

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 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 Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital from September 2013 to December 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims 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;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected 232 claims (136 inpatient and 96 outpatient claims) with dates of service in CYs 2011 and 2012 for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;

- requested that the Hospital 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 Hospital to support the selected claims;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- used an independent medical review contractor to determine whether 74 selected inpatient claims met medical necessity or 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;
- calculated the overpayments that were within the 3-year claims recovery period; and
- discussed the results of the 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: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Billing Errors	Value of Over-payments
Inpatient				
Short Stays	30	\$290,938	12	\$91,723
Claims Paid in Excess of Charges	30	586,094	5	53,860
Claims Billed With High Severity Level DRG Codes	50	566,077	11	28,498
Manufacturer Credits for Replaced Medical Devices	3	69,420	1	13,100
Claims Billed for Psychiatric Facility Emergency Department Adjustments	23	131,602	22	3,332
Inpatient Totals	136	\$1,644,131	51	\$190,513
Outpatient				
Claims Paid in Excess of \$25,000	46	\$1,303,359	12	\$12,604
Claims Billed With Modifier -59	30	99,961	4	4,719
Claims Billed With Evaluation and Management Services	19	3,255	11	668
Manufacturer Credits for Replaced Medical Devices	1	21,091	0	0
Outpatient Totals	96	\$1,427,666	27	\$17,991
Inpatient and Outpatient Totals	232	\$3,071,797	78	\$208,504

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 Hospital. 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.



May 22, 2015

VIA FEDEX & E-Mail

Ms. Lori S. Pilcher
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Report Number: A-04-13-08026

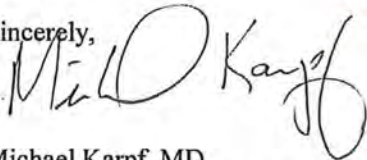
Dear Ms. Pilcher,

University of Kentucky HealthCare has received the U.S Department of Health and Human Services, Office of Inspector General ("OIG") draft report entitled *Medicare Compliance Review of University of Kentucky HealthCare for 2011 and 2012* ("Review"). University of Kentucky HealthCare appreciates the opportunity to provide written comment on the OIG report.

University of Kentucky HealthCare, and the University of Kentucky as a whole, is committed to compliance with all regulations, especially those governing federal health care programs. We have a strong commitment to compliance and an active, effective compliance program that includes appropriate internal controls such as auditing and monitoring. We appreciate the opportunity to have participated in the Review and have carefully considered the recommendations in the letter.

University of Kentucky HealthCare respectfully disagrees with the opinion of the Office of Audit Services regarding the necessity of the inpatient admissions. We maintain that the inpatient admissions were appropriate and met medical necessity as evidenced by the medical record and guidance from the physician advisor. We will exercise the right to appeal any claims that are eventually denied.

Please do not hesitate to contact me at 859-323-3877 or our Chief Compliance Officer, R. Brett Short at (859) 323-8002 or his email at brett.short@uky.edu if you need additional information or have further questions.

Sincerely,


Michael Karpf, MD
Executive Vice President for Health Affairs
UK HealthCare
University of Kentucky

Office of the Executive Vice President for Health Affairs