Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF OCHSNER MEDICAL CENTER FOR THE PERIOD JANUARY 1, 2011, THROUGH SEPTEMBER 30, 2012

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

Brian P. Ritchie
Assistant Inspector General
for Audit Services

December 2014
A-06-13-00042

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

Ochsner Medical Center did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated overpayments of at least $1.6 million over almost 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 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 Ochsner Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. 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 813-bed acute-care facility located in New Orleans, Louisiana. Medicare paid the Hospital approximately $259 million for 25,765 inpatient and 233,684 outpatient claims for services provided to beneficiaries during the period January 1, 2011, through September 30, 2012 (audit period), based on CMS's National Claims History data.

Our audit covered $10,133,506 in Medicare payments to the Hospital for 1,078 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 158 claims with payments totaling $2,397,344. These 158 claims had dates of service in the audit period and consisted of 76 inpatient and 82 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 107 of the 158 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 51 claims, resulting in overpayments of $396,247 for the audit period. Specifically, 26 inpatient claims had billing errors resulting in overpayments of $287,776, and 25 outpatient claims had billing errors resulting in overpayments of $108,471.

These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $1,650,592 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare program $1,650,592 in estimated overpayments for claims that it incorrectly billed and

- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital generally agreed that 33 of the 51 claims reflect billing errors and disagreed with our determinations on the remaining 18 claims.

Specifically, the Hospital disagreed that it had incorrectly billed 15 claims as inpatient and 3 claims with the incorrect diagnosis code. Although the Hospital disagreed with our determinations on the 18 claims, it stated that it will resubmit all 51 claims to its Medicare Administrative Contractor using the codes and classifications we recommended and seek Medicare Part B reimbursement for the services provided.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid.

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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 other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 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

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

BACKGROUND

The Medicare Program

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

CMS contracts with Medicare 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, 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 claims billed with high-severity-level DRG codes,
- inpatient claims paid in excess of charges,
- inpatient short stays,
- outpatient claims with payments greater than $25,000,
- outpatient surgeries billed with units greater than one, and
- inpatient and outpatient manufacturer credits for replaced medical devices.

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. 100-04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Ochsner Medical Center

The Hospital is an 813-bed acute-care facility located in New Orleans, Louisiana. Medicare paid the Hospital approximately $259 million for 25,765 inpatient and 233,684 outpatient

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

claims for services provided to beneficiaries during the period January 1, 2011, through September 30, 2012 (audit period), based on CMS's National Claims History (NCH) data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $10,133,506 in Medicare payments to the Hospital for 1,078 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 158 claims with payments totaling $2,397,344. These 158 claims had dates of service in the audit period and consisted of 76 inpatient and 82 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 70 inpatient claims to an independent contractor for focused medical review to determine whether the services met medical necessity and coding requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

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

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

FINDINGS

The Hospital complied with Medicare billing requirements for 107 of the 158 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 51 claims, resulting in overpayments of $396,247 for the audit period. Specifically, 26 inpatient claims had billing errors resulting in overpayments of $287,776, and 25 outpatient claims had billing errors resulting in overpayments of $108,471. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $1,650,592 for the audit period. See Appendix B for our sample design and methodology, Appendix C for our sample results and estimates, and Appendix D for the results of our review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 26 of the 76 sampled inpatient claims, which resulted in overpayments of $287,776.

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 17 of the 76 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Hospital officials stated that the Hospital had billed 2 of the 17 claims incorrectly because of human error. The Hospital did not provide a cause for the remaining 15 errors because it did not agree that it had made these billing errors. Additionally, Hospital officials stated that the Hospital relied on the treating physicians' clinical judgment, external physician advisors, and a screening tool its case management staff used in determining the appropriate level of care it should bill. As a result of these errors, the Hospital received overpayments of $227,791.[2]

Incorrectly Billed Diagnosis-Related Group Codes

Medicare payments may not be made for items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act, § 1862(a)(1)(A)). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 9 of the 76 sampled inpatient claims, the Hospital billed Medicare for incorrect DRG codes. For these claims, the Hospital used an incorrect diagnosis code to determine the DRGs.

For example, for one claim, the hospital used the diagnosis code for pneumonia. A clinic visit note on the date of admission indicated a possible diagnosis of aspiration pneumonia, but pneumonia was ruled out during the hospital stay.

Hospital officials stated that the Hospital had billed six of the nine claims incorrectly because of human error. The Hospital did not provide a cause for the remaining three errors because it did not agree that it had made the billing errors. As a result of these errors, the Hospital received overpayments of $59,985.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 25 of the 82 sampled outpatient claims, which resulted in overpayments of $108,471.

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

Incorrectly Billed Cochlear Implants

The *Medicare National Coverage Determination Manual* states that cochlear implants are covered for individuals who demonstrate limited benefit from amplification and meet other selection guidelines. Limited benefit from amplification is defined by hearing test scores equal to or less than 40 percent correct (Pub. No. 100-03, chapter 1, § 50.3). Additionally, 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)).

For 2 of the 82 sampled outpatient claims, the Hospital billed Medicare for cochlear implants that did not meet Medicare coverage requirements:

- For one claim, a patient scored 42 percent correct on a hearing test. The Hospital billed for a cochlear implant. Hospital officials stated that the Hospital had relied on the treating physician's medical judgment that the procedure was medically necessary.

- For another claim, the medical records did not contain hearing test documentation. Hospital officials stated that the hearing test had been performed but that the test documentation was not scanned into the medical record because of human error or technical scanning errors.

As a result, the Hospital received overpayments of $56,203.

Incorrectly Billed Number of Units

The Manual states: "The definition of service units … is the number of times the service or procedure being reported was performed" (chapter 4, § 20.4).

For 21 of the 82 sampled outpatient claims, the Hospital submitted claims to Medicare with the incorrect number of units of surgical procedures. Hospital officials stated that the Hospital had incorrectly billed the claims because of human error. As a result, the Hospital received overpayments of $30,577.

Incorrectly Billed Outpatient Services With Modifier -50

The Manual states that modifier -50 is used to bill for bilateral surgical procedures performed during the same operating session as a single line item on a claim (chapter 4, § 20.6.2).

For 1 of the 82 sampled outpatient claims, the Hospital billed an ear surgery with modifier -50. However, the medical record indicated that surgery was performed on only one ear. Hospital officials stated that the Hospital had incorrectly billed the claim because of human error. As a result, the Hospital received an overpayment of $12,844.

Incorrectly Billed Duplicate Service

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 the 82 sampled outpatient claims, the Hospital billed for services that it had billed previously. Hospital officials stated that the Hospital had incorrectly billed the claim because of human error. As a result of this error, the Hospital received an overpayment of $8,847.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $1,650,592 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program $1,650,592 in estimated overpayments for claims that it incorrectly billed and

- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital generally agreed that 33 of the 51 claims reflect billing errors and disagreed with our determinations on the remaining 18 claims, stating that they were billed appropriately.

Specifically, the Hospital disagreed that it had incorrectly billed 15 claims as inpatient for beneficiary stays that should have been billed as outpatient or outpatient with observation services, and it disagreed that it had billed for incorrect diagnosis codes on three claims.

Although the Hospital disagreed with our determinations on the 18 claims, it stated that it will submit revised claims to its Medicare Administrative Contractor using the codes and classifications we recommended and seek Medicare Part B reimbursement for the services provided.

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

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $10,133,506 in Medicare payments to the Hospital for 1,078 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 158 claims with payments totaling $2,397,344. These 158 claims consisted of 76 inpatient and 82 outpatient claims and had dates of service in 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 submitted 70 inpatient claims to an independent contractor for focused medical review to determine whether the services met medical necessity and coding requirements.

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

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

We conducted our fieldwork from September 2013 through August 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 NCH file for the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 158 claims (76 inpatient and 82 outpatient) totaling $2,397,344 for detailed review (Appendix B);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;

- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;

- used an independent medical review contractor to determine whether 70 sampled claims met medical necessity and coding requirements;

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

- calculated the correct payments for those claims requiring adjustment;

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

- discussed the results of our review with Hospital officials.

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

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during the period January 1, 2011, through September 30, 2012 (audit period).

SAMPLING FRAME

According to CMS's NCH data, Medicare paid the Hospital $259,369,917 for 25,765 inpatient and 233,684 outpatient claims for services provided to beneficiaries during the audit period.

We obtained from NCH a database of claims for the audit period data totaling $176,783,247 for 14,616 inpatient and 39,078 outpatient claims in 28 high-risk areas. From the 28 high-risk areas, we selected 7 that consisted of 12,445 claims totaling $102,881,951 for further review.

We performed data analysis of the claims within each of the seven risk areas. For risk areas three and four (see chart, next page), we removed claims with payment amounts of less than $3,000. For risk area two, we removed claims with payment amounts of less than $10,000 over the charged amount.

We then removed the following:

- $0 paid claims,
- claims that were under review by the Recovery Audit Contractor, and
- duplicated claims within individual risk areas.

For duplicated inpatient claims, we assigned each claim that appeared in multiple risk areas to just one area based on the following hierarchy: Manufacturer Credits for Replaced Medical Devices, Claims Paid in Excess of Charges, Claims Billed With High-Severity-Level DRG Codes, and Short Stays. For duplicated outpatient claims, we used the following hierarchy: Manufacturer Credits for Replaced Medical Devices, Claims With Payments Greater Than $25,000, and Surgeries Billed With Units Greater Than One. This resulted in a sampling frame of 1,078 unique Medicare claims in 7 risk areas totaling $10,133,506.

Risk Area	Number of Claims	Amount of Payments
1. Inpatient Manufacturer Credits for Replaced Medical Devices	6	$207,175
2. Inpatient Claims Paid in Excess of Charges	5	265,488
3. Inpatient Claims Billed With High-Severity-Level DRG Codes	226	2,003,794
4. Inpatient Short Stays	734	5,588,410
5. Outpatient Manufacturer Credits for Replaced Medical Devices	15	219,726
6. Outpatient Claims With Payments Greater Than $25,000	55	1,620,247
7. Outpatient Surgeries Billed With Units Greater Than One	37	228,666
Total	**1,078**	**$10,133,506**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into seven strata based on the risk area.

SAMPLE SIZE

We selected 158 sample claims for review as follows:

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Manufacturer Credits for Replaced Medical Devices	6	6
2	Inpatient Claims Paid in Excess of Charges	5	5
3	Inpatient Claims Billed With High-Severity-Level DRG Codes	226	35
4	Inpatient Short Stays	734	30
5	Outpatient Manufacturer Credits for Replaced Medical Devices	15	15
6	Outpatient Claims With Payments Greater Than $25,000	55	30
7	Outpatient Surgeries Billed With Units Greater Than One	37	37
	Total	**1,078**	**158**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata 3, 4, and 6. After generating the random numbers for these strata, we selected the corresponding frame items. We selected all claims in strata 1, 2, 5, and 7.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate our estimates. We used the lower-limit of the 90-percent confidence interval to estimate the amount of improper payments in our sampling frame that were paid to the Hospital for claims in the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	6	$207,175	6	$207,175	0	$0
2	5	265,488	5	265,488	3	99,845
3	226	2,003,794	35	327,562	14	111,504
4	734	5,588,410	30	281,692	9	76,427
5	15	219,726	15	219,726	1	8,847
6	55	1,620,247	30	865,196	3	69,047
7	37	228,666	37	230,505	21	30,577
Total	**1,078**	**$10,133,506**	**158**	**$2,397,344**	**51**	**$396,247**

ESTIMATES

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

Point estimate	$2,729,190
Lower limit	$1,650,592[3]
Upper limit	$3,876,835

[3] In accordance with OAS policy, we did not use the results from Stratum 6 in calculating the estimated overpayments. Instead, we added the actual overpayment from Stratum 6 ($69,047) to the lower limit ($1,581,545), which resulted in an adjusted lower limit of $1,650,592.

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Inpatient Claims Billed With High-Severity-Level DRG Codes	35*	327,562	14	111,504
Inpatient Claims Paid in Excess of Charges	5*	265,488	3	99,845
Inpatient Short Stays	30*	281,692	9	76,427
Inpatient Manufacturer Credits for Replaced Medical Devices	6	$207,175	0	$0
Inpatient Totals	**76**	**$1,081,917**	**26**	**$287,776**
Outpatient				
Outpatient Claims With Payments Greater Than $25,000	30	865,196	3	69,047
Outpatient Surgeries Billed With Units Greater Than One	37	230,505	21	30,577
Outpatient Manufacturer Credits for Replaced Medical Devices	15	$219,726	1	8,847
Outpatient Totals	**82**	**$1,315,427**	**25**	**$108,471**
Inpatient and Outpatient Totals	**158**	**$2,397,344**	**51**	**$396,247**

* We submitted these claims to an independent contractor for focused medical review to determine whether the services met medical necessity and coding requirements.

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at 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.

APPENDIX E: HOSPITAL COMMENTS

November 21, 2014

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, Texas 75242

Re: Report Number A-06-13-00042
Response of Ochsner Medical Center

Dear Ms. Wheeler:

Ochsner Medical Center ("Ochsner") is in receipt of the draft report provided by the U.S. Department of Health and Human Services, Office of Inspector General ("OIG") dated October 22, 2014, entitled *Medicare Compliance Review of Ochsner Medical Center for the Period January 1, 2011 Through September 30, 2012 (Report Number A-06-13-00042)*. We appreciate the opportunity to review and respond to OIG's draft report and to illustrate Ochsner's strong internal controls, continual process optimization and overall commitment to compliance.

BACKGROUND

Ochsner is proud of our long history of providing high quality, compassionate care to our patients, their families and our community. As a result of that long-standing culture of providing quality patient care, we are equally dedicated to cultivating and maintaining our culture of compliance. Ochsner is committed to complying with the regulations and standards governing Federal health care programs, and we continually strive to strengthen and optimize our internal controls and processes to ensure that we are working proactively to minimize and mitigate the risk of inadvertent errors. As outlined below, where opportunities for improvement are identified, Ochsner implements plans of correction, including revising claims in error, strengthening internal controls, providing additional education and improving workflow efficiencies.

Ochsner Medical Center
1514 Jefferson Highway • New Orleans, LA 70121 • ochsner.org

RECOMMENDATIONS, FINDINGS AND COMMENTS

OIG Recommendations

We recommend that the Hospital:

- refund to the Medicare program $1,650,592 in estimated overpayments for claims that it incorrectly billed and

- strengthen controls to ensure full compliance with Medicare requirements.

Ochsner Comments

Ochsner is committed to submitting accurate claims to the Medicare program, and we will continue to focus our efforts on reviewing and optimizing our processes impacting claims submissions, including auditing, monitoring, continued and focused education and workflow analysis.

We reviewed OIG's draft findings in detail. With respect to the 51 claims that OIG deemed to be billed in error, we generally agree that 33 of these claims reflect billing errors, but we respectfully contend that the remaining 18 claims were billed appropriately. Notwithstanding the latter disagreement, Ochsner has made the decision to re-submit to its Medicare Administrative Contractor ("MAC") all of the 51 claims, using the codes/classifications recommended by OIG. After the completion of this re-billing process, Ochsner will pay to Medicare the difference between $1,650,592 (OIG's estimated overpayment amount) and the amount Ochsner refunds to its MAC through the re-billing process. Until that re-billing process is completed, and depending on its results, Ochsner will not have identified or quantified any overpayments associated with these 51 claims. Please note that nothing herein should be deemed an admission by Ochsner of any regulatory violation.

As discussed previously with OIG and as outlined below, Ochsner implemented many controls during the time period between September 30, 2012 (*i.e.*, the end-date of OIG's review period) and September 6, 2013 (*i.e.*, when OIG began this review). For example, in November 2012, Ochsner implemented a new electronic health record and billing system. As part of that system integration, many enhanced controls, processes and workflows were in place before OIG began its review in September 2013. As discussed previously with OIG and as outlined below, Ochsner has taken this opportunity to further strengthen internal controls designed to reduce the risk of errors with Medicare requirements.

Ochsner continually works to strengthen controls related to compliance with Medicare billing requirements. Accurate claims submission is a primary component of our compliance program. While we may respectfully disagree with a few of the findings identified by OIG, Ochsner

acknowledges the recommendations outlined by OIG, and, as summarized in our responses below, we have already started implementing those recommendations. Ochsner appreciates every opportunity to improve our processes, as well as the opportunity to outline our efforts and respond to the findings in OIG's draft report.

Incorrectly Billed as Inpatient Services

OIG Findings

For 17 of the 76 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. Hospital officials stated that the Hospital had billed 2 of the 17 claims incorrectly because of human error. The Hospital did not provide a cause for the remaining 15 errors because it did not agree that it had made these billing errors. Additionally, Hospital officials stated that the Hospital relied on the treating physicians' clinical judgment, external physician advisors and a screening tool its case management staff used in determining the appropriate level of care it should bill. As a result of these errors, the Hospital received overpayments of $227,791.

Ochsner Comments

Ochsner concurs with OIG's findings on 2 of the 17 identified errors and is submitting revised claims to our MAC seeking Medicare Part B reimbursement for services provided to these 2 patients. Ochsner notes that in both instances the health care services provided were medically necessary, reasonable and appropriate for each patient; however, in both instances, Ochsner agrees that the applicable medical records did not contain sufficient documentation to support bills to Medicare for the patients' treatment in an inpatient setting.

With respect to the remaining 15 OIG identified errors, Ochsner respectfully disagrees with OIG's findings for the reasons outlined below. Nevertheless, Ochsner has submitted revised claims to our MAC seeking Medicare Part B reimbursement for services provided to these 15 patients.

Ochsner notes that OIG did not dispute the necessity of the care provided to our patients. We are confident that Ochsner consistently provides high quality, excellent and medically necessary patient care services, always in the best interest of our patients. Ochsner adamantly supports our physicians' skill, expertise and knowledge in determining the appropriate course of treatment for our patients, and we are pleased that neither the course nor quality of medical treatment for these patients was in question. The internal controls we have implemented around inpatient admissions and level of care assignments exist to assist and support, *not to replace or supersede*, our treating physicians' clinical judgment and complex decision-making in treating our patients.

Ochsner's internal controls governing inpatient admissions and the hospital setting in which patient care is provided includes use of InterQual screening criteria as a guide by our case managers throughout the patient stay to assist in determining the appropriate patient care setting, availability of an external physician advisor for consultation and collaboration, and post-discharge, pre-bill secondary case manager chart review for inpatient stays of 2 days or less.

In treating each of these 15 patients, Ochsner's internal controls as outlined above were followed, did not fail and were not deficient. In fact, the medical records for 14 of these 15 patients contain documented support from an external physician advisor for our Ochsner physician's original inpatient admission order. In each of these 14 cases, Ochsner's medical record contains documentation that two physicians (Ochsner physician and external physician advisor) independently supported the patient's treatment in an inpatient setting based on the patient's medical condition at the time of assessment.

As outlined in the Medicare Benefit Policy Manual, CMS acknowledges the complex medical judgment required for physicians to make admissions determinations:

> "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…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."

Medicare Benefit Policy Manual, Ch. 1, §10. Ochsner relies on the expertise, skill and training of our physicians in making these complex patient care decisions and in determining the appropriate course of treatment for our patients.

As mentioned above, during the time of review, Ochsner had appropriate and effective internal controls and workflow processes in place to provide patient care in the appropriate hospital setting. Ochsner continues to provide ongoing education, training and monitoring for individuals involved in assessing and determining patient level of care. As a result of ongoing process improvement initiatives and with the introduction of the new 2-midnight rule, Ochsner has enhanced its internal controls and workflows related to level of care assignments, conducted education for our providers, as well as case management and utilization management staff, involved in these assessments, and developed an internal physician utilization management advisor program. Further, Ochsner is developing several new initiatives to mitigate the risk of error in level of care assignment, including optimizing our electronic health record workflows to further support physician documentation efforts.

The results of this review have been shared with the hospital and physician leaders responsible for utilization and case management workflows, and multi-disciplinary education on the workflow process for consultation with our physician advisors is ongoing. Ochsner's compliance department is currently working with hospital and physician leadership to develop a process to further share review results and create additional opportunities for auditing and monitoring these processes.

Incorrectly Billed Diagnosis-Related Group Codes

OIG Findings

For 9 of the 76 sampled inpatient claims, the Hospital billed Medicare for incorrect DRG codes. For these claims, the Hospital used an incorrect diagnosis code to determine the DRGs.

Hospital officials stated that the Hospital had billed six of the nine claims incorrectly because of human error. The Hospital did not provide a cause for the remaining three errors because it did not agree that it had made the billing errors. As a result of these errors, the Hospital received overpayments of $59,985.

Ochsner Comments

Ochsner concurs with OIG's findings on 6 of the 9 identified errors and respectfully disagrees with OIG's determination on the remaining 3 claims. Ochsner recognizes that coding assignment is a process that can be open to coder interpretation of complex physician documentation and the coding guidelines available to the coder at the time of review. Ochsner researched each of these 9 claims thoroughly and concluded with confidence that there are no trends or commonalities attributable to the claims or the findings, based on the nature of the claims, different treatment processes, or varying levels of coder experience. Ochsner attributes these findings to individual coder error and misapplication of coding guidelines. For that reason, we have revised and resubmitted each of the 9 claims to our MAC.

Ochsner has numerous internal controls to ensure accurate and appropriate DRG coding: highly qualified and experienced hospital coders and clinical documentation improvement ("CDI") nurses, objective workflow assessments, senior level hospital coding leadership and expertise, departmental focus on education and corrective actions and routine internal departmental reviews to ensure continuous process improvement.

Additionally, the hospital coding and CDI departments work collaboratively to develop and present ongoing education to the coding and CDI staff based on review results, industry trends, education needs-assessments or changes to coding guidelines. The results of this review has been shared with department leadership, and the hospital coding Senior Consultant has developed and presented education to both the hospital coding and CDI departments based on

key items identified during this review. Ochsner's compliance department is currently working with the hospital coding and CDI teams to develop a process to further share review results and identify additional ways to enhance the existing robust monitoring processes where the groups can collaborate.

Incorrectly Billed Cochlear Implants

OIG Findings

For 2 of the 82 sampled outpatient claims, the Hospital billed Medicare for cochlear implants that did not meet Medicare coverage requirements:

- For one claim, a patient scored 42% correct on a hearing test. The Hospital billed for a cochlear implant. Hospital officials stated that the Hospital had relied on the treating physician's medical judgment that the procedure was medically necessary.

- For another claim, the medical records did not contain hearing test documentation. Hospital officials stated that the hearing test had been performed but that the test documentation was not scanned into the medical record because of human error or technical scanning errors.

Ochsner Comments

Ochsner concurs with OIG's technical findings with respect to these 2 isolated claims and has submitted revised claims to our MAC. Ochsner asserts, however, that the medical records associated with these two claims, when viewed in their entirety, support the medical necessity of the services rendered. We support the medical expertise and clinical decision making of our treating physicians in performing these procedures. As mentioned previously, Ochsner implemented our new electronic health record in November 2012 (after the review period), and audiograms are now electronically recorded in the electronic health record, which mitigates the risk of future error. Additional education, monitoring and process optimization has been implemented by the clinical department to further mitigate these types of risks in the future.

Incorrectly Billed Number of Units

OIG Findings

For 21 of the 82 sampled outpatient claims, the Hospital submitted claims to Medicare with the incorrect number of units of surgical procedures. Hospital officials stated that the Hospital had incorrectly billed the claims because of human error. As a result, the Hospital received overpayments of $30,577.

Ochsner Comments

Ochsner concurs with OIG's finding with respect to these claims and has submitted adjusted claims to our MAC. During the review period, Ochsner had automated system-edits in place to identify claims containing multiple surgical time units and convert them into one procedure unit. In some of these instances, however, not all components required for the system-edit to launch were on the same code line, and the edit did not function as intended. In the remaining instances, the edit functioned correctly; however, the individuals tasked with reconciling the claim following the edit notification did not reconcile them appropriately to prevent the claim from containing multiple units.

Ochsner has implemented several measures to address these isolated errors and minimize risk of error in the future, one of which was activated in late 2012 with Ochsner's new electronic health record. Ochsner also created an automated, post-coding, pre-billing system-edit to alert our billing staff when outpatient Medicare claims contain certain revenue codes combined with units greater than one. Additionally, we developed a regularly scheduled exception report to monitor the effectiveness of the system-edit that allows us to review, monitor and detect these types of errors quickly. Both the system-edit and the automated exception report trigger secondary billing and coding quality reviews that result in opportunities for real-time feedback and education for our billing staff.

Incorrectly Billed Outpatient Services with Modifier -50

OIG Findings

For 1 of the 82 sampled outpatient claims, the Hospital billed an ear surgery with modifier -50. However, the medical record indicated that surgery was performed on only one ear. Hospital officials stated that the Hospital had incorrectly billed the claim because of human error. As a result, the Hospital received an overpayment of $12,844.

Ochsner Comments

Ochsner concurs with OIG's finding with respect to this isolated claim and has submitted an adjusted claim to our MAC. In addition to adjusting this claim, Ochsner implemented a sustainable process improvement to mitigate this risk of error in the future. This inadvertent error resulted from a manual coding process where a bilateral modifier -50 was applied to a single procedure.

As a result of the single error identified in this review, Ochsner created an automated, post-coding, pre-billing system-edit to alert our billing staff when bilateral procedure codes and revenue codes contain conflicting units in the same claim. Additionally, Ochsner developed a regularly scheduled exception report to monitor the system-edit, which allows us to review,

monitor and detect these types of errors quickly. Both the system-edit and the automated exception report trigger a secondary coding and billing quality review with opportunities for real-time feedback and education. To further support this sustainable process optimization, our compliance and revenue cycle departments have provided education to the applicable coding and billing staff and have instituted a monitoring component of this automated workflow, resulting in generation of periodic exception reports for process review and claim validation.

Incorrectly Billed Duplicate Service

OIG Findings

For 1 of the 82 sampled outpatient claims, the Hospital billed for services that it had billed previously. Hospital officials stated that the Hospital had incorrectly billed the claim because of human error. As a result of this error, the Hospital received an overpayment of $8,847.

Ochsner Comments

Ochsner concurs with OIG's finding with respect to this isolated claim and has adjusted this claim with our MAC. This isolated error relates to technical processes that occur when late charges are applied to a bill that requires adjustments to the type of bill submitted. During the time of review, Ochsner's process for changing the type of bill, while in accordance with CMS billing guidelines, was a manual process, rather than an automated one. In November 2012 (after the review period), Ochsner successfully implemented a new electronic health record and billing system. As a result, these billing edits are now automated, and the current claim processing workflows mitigate the risk of this error. To further support this sustainable process optimization, our compliance and revenue cycle departments have provided focused education to the applicable coding and billing staff and have instituted a monitoring component of this automated workflow, resulting in the generation of periodic exception reports for process review and claim validation.

CONCLUSION

Ochsner is committed to meeting and exceeding our compliance responsibilities and obligations and appreciates this opportunity to learn from the items reviewed. In analyzing the claims chosen for this review, Ochsner identified additional opportunities to strengthen internal controls, which have already been implemented. Ochsner will continue to monitor and review Medicare billing related to these issues and others outlined by OIG.

We will continue to use the constructive feedback received during this review process in our ongoing process improvement efforts. As part of our routine action planning efforts, Ochsner shared the results of this review with hospital administrative and physician leadership, as well as with leaders and staff in the applicable revenue cycle, coding, case management, clinical and

compliance departments. Further, re-education has been provided to Ochsner departments involved in the documentation, communication and billing of these claims, and we are developing plans for continuing education. Existing applicable policies and procedures were reviewed, updated and enhanced, as needed, and new processes have been implemented to further strengthen our internal control system around these Medicare billing regulations. As noted previously, Ochsner is working with our MAC to revise and adjust the claims discussed and resolve the resulting estimated overpayment. Finally, to underscore our organizational commitment to compliance, we shared the results of this review and details of our corrective actions with members of the audit and oversight committee of our board of directors.

Ochsner sincerely appreciates the opportunity to review and respond to the draft audit report, and we believe our remediation efforts have already significantly mitigated and minimized the risk and likelihood of similar issues in the future. We appreciate the courtesy, cooperation and professionalism demonstrated by OIG Audit Staff during the course of this review.

Should you have any questions or require additional information related to Ochsner's compliance efforts, please feel free to contact me.

Sincerely yours,

/Eden C. Ezell/

Eden C. Ezell, JD, MBA, CHC
VP & Chief Compliance Officer

Ochsner Medical Center

1514 Jefferson Highway • New Orleans, LA 70121 • ochsner.org