Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF THE UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES MEDICAL CENTER FOR 2013 AND 2014

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

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

March 2017
A-06-16-00005

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

The University of Arkansas Medical Sciences Medical Center did not fully comply with Medicare requirements for billing inpatient services, resulting in estimated overpayments of at least $278,000 for 2013 and 2014.

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) 2014, Medicare paid hospitals $159 billion, which represents 46 percent of all fee-for-service payments for that year; 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 the University of Arkansas Medical Sciences 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 a 470-bed acute-care hospital located in Little Rock, Arkansas. Medicare paid the Hospital approximately $277 million for 272,910 claims for services provided to beneficiaries during CYs 2013 and 2014 (audit period) based on CMS's National Claims History data.

We selected for review a stratified random sample of 130 claims with payments totaling $2,875,729. These 130 claims had dates of service in the audit period and consisted of 70 inpatient and 60 outpatient claims. We submitted these claims to an independent contractor for focused medical review to determine whether the services met coding requirements.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 114 of the 130 inpatient and outpatient claims we reviewed. However, the Hospital billed incorrect DRG codes for 16 inpatient claims, resulting in net overpayments of $197,172. These errors occurred primarily because the Hospital did not have adequate controls to prevent 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 $278,828 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor $278,828 (of which $197,172 was net overpayments identified in our sample) in estimated overpayments for the audit period for claims that it incorrectly billed;

- exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and

- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF ARKANSAS MEDICAL SCIENCES MEDICAL CENTER COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital agreed that it had incorrectly billed 9 of the 16 claims we identified as errors and described new procedures it has implemented to improve its billing accuracy. However, the hospital did not agree that it incorrectly billed the remaining seven claims and stated that it reserves the right to appeal our determinations and overpayment estimate.

We stand by the independent medical review contractor's determination that the Hospital did not fully comply with Medicare billing requirements for all 16 claims. The Hospital is within its rights to appeal the recommended disallowances through the Medicare appeals process.

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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 CY 2014, Medicare paid hospitals $159 billion. This amount represents 46 percent of all fee-for-service payments in that year. 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 the University of Arkansas Medical Sciences 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. 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 codes and descriptors to identify and group the services within each APC group. 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:

- outpatient claims paid greater than $25,000,
- outpatient manufacturer credits for replaced medical devices,
- inpatient claims paid in excess of charges, and
- inpatient claims billed with high-severity-level DRG codes,

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

Under section 1128J(d) of the Social Security Act and 42 CFR part 401, subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR §§ 401.305(a)(2), and (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

University of Arkansas Medical Sciences Medical Center

The Hospital is a 470-bed acute-care hospital located in Little Rock, Arkansas. Medicare paid the Hospital approximately $277 million for 272,910 claims for services provided to beneficiaries during CYs 2013 and 2014 (audit period) based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $17,358,828 in Medicare payments to the Hospital for 1,220 claims that were potentially at risk for billing errors. From these claims, we selected for review a stratified random sample of 130 claims with payments totaling $2,875,729. These claims consisted of 70 inpatient and 60 outpatient claims with dates of service during CYs 2013 and 2014 (audit period).

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 100 claims to an independent medical review contractor to determine whether they were correctly coded. 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 114 of the 130 inpatient and outpatient claims we reviewed. However, the Hospital billed incorrect DRG codes for 16 inpatient claims, resulting in net overpayments of $197,172. 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 $278,828 for the audit period.

See Appendix B for our statistical sampling methodology, Appendix C for our sample results and estimates, and Appendix D for the results of our review by risk area.

INPATIENT CLAIMS WITH 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)). 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 16 of the 70 selected inpatient claims, the Hospital billed Medicare for incorrect DRG codes that resulted in either higher or lower payments to the Hospital than should have been made. For these claims, the Hospital used incorrect diagnosis codes to determine the DRG codes.

Hospital officials stated that the Hospital billed the claims incorrectly because the claims contained multiple diagnoses and were difficult to code. As a result of these errors, the Hospital received net overpayments of $197,172.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $278,828 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $278,828 (of which $197,172 was net overpayments identified in our sample) in estimated overpayments for the audit period for claims that it incorrectly billed;

- exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and

- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF ARKANSAS MEDICAL SCIENCES MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

UNIVERSITY OF ARKANSAS MEDICAL SCIENCES MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed that it had incorrectly billed 9 of the 16 claims we identified as errors and said that it is in the process of reprocessing those claims. Additionally, the hospital described new procedures it has implemented to improve its billing accuracy.

For the remaining seven claims we identified as errors, the Hospital disagreed and stated that it reserves the right to appeal our determinations and our overpayment estimate. The hospital stated that the coding for these claims is supported.

The Hospital did not address our recommendation that it exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

We stand by the independent medical review contractor's determination that the Hospital did not fully comply with Medicare billing requirements for all 16 claims. The independent contractor examined all of the medical records and documentation that the hospital submitted and carefully considered this information to determine whether the Hospital billed the claims in accordance with Medicare requirements. Therefore, we maintain that all of our findings and recommendations are valid.

The Hospital is within its rights to appeal the recommended disallowances through the Medicare appeals process.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $17,358,828 in Medicare payments to the Hospital for 1,220 claims that were potentially at risk for billing errors. From these claims, we selected for review a stratified random sample of 130 claims with payments totaling $2,875,729. These claims consisted of 70 inpatient and 60 outpatient claims with dates of service during CYs 2013 and 2014 (audit period).

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 70 inpatient and 30 outpatient claims to an independent contractor for focused medical review to determine whether the services met coding requirements.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History (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 audit work from March through October 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's NCH file for the audit period;
- obtained information on known credits for replacement medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and other data analysis techniques to identify 1,220 claims totaling $17,358,828 that were potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 130 claims (70 inpatient and 60 outpatient) totaling $2,875,729;

- reviewed available data from CMS's Common Working File for the selected 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 selected claims;

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

- submitted 100 claims to an independent contractor for focused medical review to determine whether the claims met coding requirements;

- reviewed 30 outpatient claims to determine whether medical device credits were properly claimed;

- 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; and

- used the results of the sample review to calculate the estimated Medicare overpayment to the hospital (Appendix C).

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

POPULATION

The population was inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during the period January 1, 2013, through December 31, 2014, (audit period).

SAMPLING FRAME

According to CMS's NCH data, Medicare paid the Hospital approximately $277 million for 272,910 inpatient and outpatient claims for services provided to beneficiaries during the audit period.

We obtained from NCH a database of claims for the audit period totaling approximately $164 million for 104,025 claims in 41 high-risk areas. From the 41 high-risk areas, we selected 4 areas that consisted of 3,186 claims totaling $40,239,920 for further review. The four high-risk areas were:

- outpatient claims with payments greater than $25,000,
- outpatient medical device credits for replaced medical devices,
- inpatient claims paid in excess of charges, and
- inpatient claims billed with high-severity-level DRG codes.

We performed data analysis of the claims within each of the four risk areas. We then removed the following:

- claims with payment amounts of less than $10,000 over the charged amount (inpatient claims in excess of charges),
- claims with certain patient discharge status codes (inpatient claims billed with high-severity-level DRG codes),
- $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 risk area based on the following hierarchy: Claims Paid in Excess of Charges, Claims Billed with High-Severity-Level DRG Codes. For duplicated outpatient claims, we used the

following hierarchy: Manufacturer Credits for Replaced Medical Devices, High Dollar Claims Paid Greater Than $25,000.

This resulted in a sampling frame of 1,220 unique Medicare claims in 4 risk areas totaling $17,358,828, as shown below.

Table 1: Risk Areas Sampled

Risk Area	Number of Claims	Amount of Payments
1. Outpatient Claims With Payments Greater Than $25,000	76	$2,786,941
2. Outpatient Manufacturer Credits for Replaced Medical Devices	350	4,997,616
3. Inpatient Claims Paid in Excess of Charges	26	827,448
4. Inpatient Claims Billed With High-Severity-Level DRG Codes	768	8,746,823
Total	**1,220**	**$17,358,828**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

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

SAMPLE SIZE

We selected 130 sample claims for review as follows:

Table 2: Sampled Claims by Stratum

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Outpatient Claims With Payments Greater Than $25,000	76	30
2	Outpatient Manufacturer Credits for Replaced Medical Devices	350	30
3	Inpatient Claims Paid in Excess of Charges	26	26
4	Inpatient Claims Billed With High-Severity-Level DRG	768	44
	Total	**1,220**	**130**

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 1, 2, and 4. After generating the random numbers for these strata, we selected the corresponding frame items. We selected all claims in stratum 3.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of any improper Medicare payments in our sampling frame paid to the Hospital for the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

TOTAL MEDICARE OVERPAYMENTS

Table 3: 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
3	26	$827,448	26	$827,448	9	$179,111
4	768	8,746,823	44	514,030	7	18,061
1	76	2,786,941	30	1,092,202	0	0
2	350	4,997,616	30	442,049	0	0
Total	**1,220**	**$17,358,828**	**130**	**$2,875,729**	**16**	**$197,172**

ESTIMATES

Table 4: Estimates of Overpayments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$494,359
Lower limit	278,828
Upper limit	709,890

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				
Claims Paid in Excess of Charges*	26	$827,449	9	$179,111
Claims Billed With High-Severity-Level-Diagnosis-Related-Group Codes*	44	514,030	7	18,061
Inpatient Totals	**70**	**$1,341,479**	**16**	**$197,172**
Outpatient				
Claims Paid Greater Than $25,000*	30	$1,092,201	0	$0
Manufacturer Credits for Replaced Medical Devices	30	442,049	0	0
Outpatient Totals	**60**	**$1,534,250**	**0**	**$0**
Inpatient and Outpatient Totals	**130**	**$2,875,729**	**16**	**$197,172**

* We submitted these claims to an independent contractor for focused medical review to determine whether the services met 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: UNIVERSITY OF ARKANSAS MEDICAL SCIENCES MEDICAL CENTER COMMENTS

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Robert W. Bishop, JD
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January 11, 2017

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

Re: Draft Report titled *"Medicare Compliance Review of the University of Arkansas for Medical Sciences Medical Center for 2013 and 2014"*
Report Number: A-06-16-00005

Dear Ms. Wheeler:

The University of Arkansas Medical Sciences (UAMS) is in receipt of the draft report provided by the US Department of Health and Human Services, Office of Inspector General (OIG), entitled *"Medicare Compliance Review of the University of Arkansas for Medical Sciences Medical Center for 2013 and 2014"*, dated December 15, 2016. We appreciate the opportunity to respond to the draft report.

A total sample consisting of 130 claims was selected for review in four areas. These 130 claims had service dates in the audit period and consisted of 70 inpatient claims and 60 outpatient claims. The Report states that UAMS "complied with Medicare billing requirements for 114 of the 130 inpatient and outpatient claims reviewed, and states further that UAMS "billed incorrect DRG codes for 16 inpatient claims, resulting in net overpayments of $197,172." UAMS' response to the OIG's proposed findings and recommendation are set forth below.

Incorrectly Billed Diagnosis – Related - Group Codes

Inpatient Claims Paid in Excess of Charge

Of the 26 claims identified for this section, 9 claims were identified as requiring a different DRG than was billed.

UAMS agrees with 8 of these DRG changes.

UAMS does not agree with Case #4, Sample 12. The original diagnosis of urinary complication should stand as principal diagnosis. UAMS will appeal the claim with the Medicare Contractor.

Inpatient Claims Billed with High Severity Level DRG Codes

Of the 44 claims selected for this section, 7 claims were identified as requiring a DRG change.

UAMS agrees with 1 DRG change, Case #11, Sample 16.

UAMS respectfully disagrees with the findings for 6 of the recommended DRG changes:

- Case #10, Sample 2 -- acute renal failure as secondary diagnosis was documented – DRG 638 is correct.
- Case #12, Sample 23 -- secondary diagnosis of ileus was documented to support coding and is a secondary condition – DRG 742 is correct.
- Case #13, Sample 33 -- acute renal failure was supported as the principal diagnosis – DRG 683 is correct.
- Case #14, Sample 35 -- acute renal failure was supported as the principal diagnosis – DRG 683 is correct.
- Case #15, Sample 37 -- chronic systolic and diastolic heart failure was documented. A physician query, documented in the medical record, further clarified chronic systolic and diastolic heart failure – DRG 164 is correct.
- Case #16, Sample 44 -- the principal diagnosis of C Difficile is supported as principal diagnosis – DRG 371 is correct.

In addressing agreed findings, UAMS has implemented the following measures to further improve its processes:

- All cases have been reviewed with the Coding Director, Coding Manager and the coding staff.
- Workflows have been developed and are in place requiring a second coding review on similar claims before the claim is billed.
- Sample size of compliance DRG audits will be increased to enhance review of DRG coding and billing.

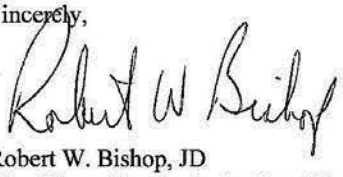
UAMS is committed to complying with all federal laws, regulations, and rules, and to maintaining an active and effective compliance program. UAMS is proud of its Compliance Program which works continuously to identify areas of noncompliance and risk, provide training and education, and implement controls designed to achieve accurate and compliant coding and billing.

UAMS is in the process of reprocessing all claims where UAMS agrees with the OIG findings. UAMS reserves the right to appeal those claims where UAMS disagrees with the OIG findings. As these claims are included in the extrapolation analysis, UAMS also reserves the right to appeal or otherwise challenge any extrapolation determination.

UAMS would again like to thank the OIG for the opportunity to respond to the proposed findings of the Report. In addition, UAMS would like to thank the audit staff for their cooperation and professionalism during the audit process.

Should you have any questions regarding UAMS responses to the draft Report or need any additional information, please contact me at (501) 686-5699.

Sincerely,



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