Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF UNIVERSITY OF WASHINGTON MEDICAL CENTER

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

June 2014
A-09-13-02049

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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

University of Washington Medical Center did not fully comply with Medicare requirements for billing inpatient services, resulting in net overpayments of approximately $2.2 million over more than 3 years.

WHY WE DID THIS REVIEW

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

Our objective was to determine whether University of Washington Medical Center (the Medical Center) complied with Medicare requirements for billing inpatient 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.

The Medical Center is an acute-care hospital located in Seattle, Washington. Medicare paid the Medical Center approximately $317 million for 16,555 inpatient claims for services provided to beneficiaries during CYs 2010 through 2012.

Our audit covered $4,526,396 in Medicare payments to the Medical Center for 157 inpatient claims that we judgmentally selected as potentially at risk for billing errors. Of the 157 claims, 154 claims had dates of services in CYs 2010, 2011, or 2012, and 3 claims (involving inpatient short stays) had dates of service in CY 2013.

WHAT WE FOUND

The Medical Center complied with Medicare billing requirements for 94 of the 157 inpatient claims we reviewed. However, the Medical Center did not fully comply with Medicare billing requirements for the remaining 63 claims, resulting in net overpayments of $2,218,829 for CYs 2010 through 2012 (60 claims) and CY 2013 (3 claims). These billing errors occurred primarily because the Medical Center did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that the Medical Center:

- refund to the Medicare contractor $2,218,829 in net overpayments for the incorrectly billed inpatient claims and

- strengthen controls to ensure full compliance with Medicare requirements.

MEDICAL CENTER COMMENTS

In written comments on our draft report, the Medical Center concurred with our recommendations and provided the status of corrective actions that it had taken.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

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

OBJECTIVE

Our objective was to determine whether University of Washington Medical Center (the Medical Center) complied with Medicare requirements for billing inpatient 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 Claims at Risk for Incorrect Billing

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- inpatient short stays and
- inpatient claims paid in excess of charges.

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).

University of Washington Medical Center

The Medical Center is an acute-care hospital located in Seattle, Washington. Medicare paid the Medical Center approximately $317 million for 16,555 inpatient claims for services provided to beneficiaries during CYs 2010 through 2012.[1]

HOW WE CONDUCTED THIS REVIEW

Our audit covered $4,526,396 in Medicare payments to the Medical Center for 157 inpatient claims that we judgmentally selected as potentially at risk for billing errors. Of the 157 claims, 154 claims had dates of service in CYs 2010, 2011, or 2012 and 3 claims (involving inpatient short stays, which have a higher risk of billing errors) had dates of service in CY 2013. We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 16 claims to focused medical review to determine whether the services were medically necessary. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Medical Center for Medicare reimbursement.

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

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

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

FINDINGS

The Medical Center complied with Medicare billing requirements for 94 of the 157 inpatient claims we reviewed. However, the Medical Center did not fully comply with Medicare billing requirements for the remaining 63 claims, resulting in net overpayments of $2,218,829 for CYs 2010 through 2012 (60 claims) and CY 2013 (3 claims). These billing errors occurred primarily because the Medical Center did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

INCORRECT BILLING OF MEDICARE PART A FOR BENEFICIARY STAYS THAT SHOULD HAVE BEEN BILLED AS OUTPATIENT OR OUTPATIENT WITH OBSERVATION SERVICES

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 34 of 157 selected claims, the Medical Center incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services.[2] Of the 34 claims, 22 claims related to bone marrow and peripheral blood stem cell transplantation, accounting for 95 percent of the total overpayments.[3] The Medical Center attributed these patient admission errors primarily to hospital staff's misunderstanding that these procedures should be billed as inpatient. The staff believed these procedures were on Medicare's "Inpatient-Only" list referred to at 42 CFR § 419.22(n), which defines services that support an inpatient admission and Part A payment as appropriate, regardless of the expected length of stay. Consequently, hospital staff did not verify that an inpatient level of care was needed. For the remaining 12 claims, the Medical Center attributed the patient admission errors primarily to human error. As a result of the 34 errors, the Medical Center received overpayments of $2,217,294.[4]

INCORRECT DIAGNOSIS-RELATED GROUPS

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

[2] Of the 34 claims, 31 claims had dates of service in CYs 2010, 2011, or 2012, and 3 claims had dates of service in CY 2013.

[3] The Medical Center identified 6 of the 22 errors during our review. Three of these claims had dates of service in CY 2013.

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

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 29 of 157 selected claims, the Medical Center billed Medicare with the incorrect DRGs. The Medical Center stated that these errors occurred because of misinterpretation of coding guidelines or human error. As a result of these errors, the Medical Center received net overpayments of $1,535.

RECOMMENDATIONS

We recommend that the Medical Center:

- refund to the Medicare contractor $2,218,829 in net overpayments for the incorrectly billed inpatient claims and

- strengthen controls to ensure full compliance with Medicare requirements.

MEDICAL CENTER COMMENTS

In written comments on our draft report, the Medical Center concurred with our recommendations and provided the status of corrective actions that it had taken. The Medical Center's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $4,526,396 in Medicare payments to the Medical Center for 157 inpatient claims that we judgmentally selected as potentially at risk for billing errors. Of the 157 claims, 154 claims had dates of services in CYs 2010, 2011, or 2012, and 3 claims (involving inpatient short stays, which have a higher risk of billing errors) had dates of service in CY 2013.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 16 claims to focused medical review to determine whether the services were medically necessary.

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

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

We conducted our fieldwork at the Medical Center from May to September 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Medical Center's inpatient and outpatient paid claim data from CMS's National Claims History file for the audit period;
- used computer matching, data mining, and data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 157 inpatient claims for detailed review;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;
- requested that the Medical Center conduct its own review of the selected claims to determine whether the services were billed correctly;

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

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

- used an independent medical review contractor to determine whether 16 selected claims met medical necessity requirements;

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

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

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

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Billing Errors	Value of Net Overpayments
Inpatient Short Stays	110	$2,945,218	46	$1,356,375
Inpatient Claims Paid in Excess of Charges	47	1,581,178	17	862,454
Total	**157**	**$4,526,396**	**63**	**$2,218,829**

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

APPENDIX C: MEDICAL CENTER COMMENTS

UW Medicine

May 15, 2014

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region IX
90-7th Street, Suite 3-650
San Francisco, CA 94103

RE: Report Number A-09-13-02049

Dear Ms. Ahlstrand:

I am responding to your April 21, 2014 letter and draft report titled "Medicare Compliance Review of University of Washington Medical Center." University of Washington (UW) Medicine, which includes UW Medical Center, has an active compliance program and is committed to full compliance with Medicare regulations. We appreciate the opportunity to comment on the draft report.

We recognize that the OIG used a judgmental selection process to identify high-risk claims. We worked closely with your auditors over a several month period to review each case. Through this process we discovered and addressed a specific issue concerning bone marrow transplant admissions. As part of the resolution, we proactively identified six additional high-risk claims of this type for OIG review.

I worked with my team and UW Medicine executive leaders to review the draft report. We concur with the two recommendations and offer the following additional information about the findings and status of corrective actions for each:

1. **The OIG recommends refunding the net overpayments for the incorrectly billed claims.**
   a. We submitted corrected claims to the Medicare Contractor for each incorrectly billed claim identified in the draft report, and the appropriate payment adjustments were made. Where applicable, we then submitted rebilled outpatient claims.

2. **The OIG recommends strengthening controls to ensure full compliance with Medicare requirements.**

   Coding errors:

   The auditors found diagnosis coding errors that led to incorrect DRGs with a mix of overpaid and underpaid inpatient claims. Feedback about the errors in general was provided in educational forums to the coders as a group, and case-specific feedback was provided to individual coders (if still employed at the hospital.) In addition, we continue with proactive, ongoing coder education and a routine cycle of compliance program audits and coder feedback/education.

Lisa Westlund, Compliance Officer
UW Medicine
UW Box 358049 Seattle, WA 98195-8049 206.543.3098 Fax: 206.221.5172 ljw@uw.edu

Outpatient services incorrectly billed as inpatient claims:

a. *Bone Marrow Transplant Short-Stay Cases*: The 22 denials related to this issue accounted for $2.1M of the $2.2M overpayment identified in the report because bone marrow DRG coding (and associated payment) does not allow for distinction between types of bone marrow procedures with quite different intensity levels. Operationally, the 22 admissions for the less intensive procedures pre-dated controls (admission screening) that had been established prior to this OIG review. In addition to the real-time admission medical necessity screening process, the clinical resource management (CRM) team and bone marrow transplant clinical teams have been educated that inpatient admission is not required for Medicare payment for bone marrow transplant procedures. Finally, the Compliance Program implemented data monitoring to identify and review any inpatient bone marrow transplant cases with a short length of stay.

b. *Other Short Stay Cases*: Several of the 12 denied short stay cases resulted from human errors that generated inpatient claims in spite of internal reviews that determined inpatient was not the correct care setting. These cases were used to conduct a process review with retraining and other improvements as warranted. In addition, the Patient Financial Services Quality Auditor now performs a monthly audit of all short stay inpatient claims to assure each claim is consistent with the internal review determination. The remaining denied short stay cases were discussed by the Clinical Resource Management (CRM) team in routine meetings for ongoing education and calibration regarding real-time admission screening.

We believe the actions described above have furthered our ongoing efforts to submit accurate claims. In closing, we would like to thank your staff for their professionalism, their collaborative approach to the review, and their availability to answer questions throughout the process.

Sincerely,

Lisa Westlund
Compliance Officer
UW Medicine

cc: Sue Clausen
Paul Ishizuka
Lori Mitchell
Johnese Spisso
Stephen Zieniewicz