Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

MAR 14 2002

CIN: A-01-01-00515

Mr. Robert J. Trefry
President and CEO
Bridgeport Hospital
267 Grant Street
Bridgeport, Connecticut 06610

Dear Mr. Trefry:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "***Review of Medicare Outlier Payments at Bridgeport Hospital for Fiscal Year 1999.***" A copy of this report will be forwarded to the action official named below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-01-01-00515 in all correspondence relating to this report.

Sincerely,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:
Mr. Roger Perez
Acting Regional Administrator
Centers for Medicare & Medicaid Services – Region I
Room 2325
JFK Federal Building
Boston, MA 02203

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE OUTLIER PAYMENTS AT BRIDGEPORT HOSPITAL FOR FISCAL YEAR 1999

JANET REHNQUIST
Inspector General

MARCH 2002
A-01-01-00515

Office of Inspector General

http://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:

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The OIG's Office of Audit Services (OAS) provides all 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 in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

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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 in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

Background

Under Medicare's prospective payment system (PPS), fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to program beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). An additional payment is made for atypical cases that generate extremely high costs when compared to most discharges in the same DRG; these atypical cases are referred to as outliers. In fiscal year (FY) 1999, Bridgeport Hospital received, in addition to its DRG payments, $3.3 million for 224 outlier claims.

Objective

The objective of our review was to determine whether hospital outlier payments were reimbursed in accordance with Medicare laws and regulations. Our review focused on outlier payments made to Bridgeport Hospital during FY 1999.

Results of Review

We analyzed Bridgeport Hospital's FY 1999 outlier claims to identify high risk claims, such as those where charges for a single revenue center code represented a significant percentage of total claim charges. Based on our analysis, we judgmentally selected 15 FY 1999 outlier claims for review. We reviewed these claims in conjunction with medical review staff from Qualidigm, the peer review organization (PRO).

Our review found that due to control problems related to the billing process, Bridgeport Hospital billed $48,081 in charges involving services that were not ordered by a physician, were not properly documented, or resulted from a clerical billing error. Based on the Medicare reimbursement methodology for outliers, we determined that these billed services resulted in overpayments to Bridgeport Hospital of $23,409.

Recommendations

Given the importance of proper medical record documentation for both patient treatment and accurate reimbursement, we recommend Bridgeport Hospital:

- Review documentation requirements with hospital staff to ensure that all services provided are appropriately documented in the medical record in accordance with standards of practice and Medicare laws and regulations, emphasizing the need to document physician orders.

- Improve its controls over the billing process to ensure that only services that are ordered by a physician, supported by appropriate documentation and related to an inpatient stay are billed.
- Return to the appropriate FI, the $23,348 associated with payments for services identified

as not ordered by a physician, not properly documented, duplicate billing and not related to an inpatient stay.

Regarding the $61 overpayment related to incorrect DRG coding, we recommend Bridgeport Hospital improve its controls over the coding process to ensure that diagnoses, procedures and discharge status are correctly coded and billed.

The draft report was issued to Bridgeport Hospital for comment on February 4, 2002. In response to the draft report, Bridgeport Hospital concurred with our findings and identified steps they have taken, and plan to take, to address our recommendations.

INTRODUCTION

BACKGROUND

The Medicare program, established by the Title XVIII of the Social Security Act provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Centers for Medicare & Medicaid Services (CMS). Under Medicare's prospective payment system (PPS), fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis-related group (DRG).

Section 1886(d)(5)(A) of the Social Security Act requires the Medicare program to pay an additional amount beyond the basic DRG payment for outlier cases. Outliers are those cases that have extraordinarily high costs when compared to most discharges classified in the same DRG.

Bridgeport Hospital, located in Bridgeport, Connecticut, is a private, not-for-profit hospital affiliated with Yale University School of Medicine. We found that outlier payments to Bridgeport Hospital increased by approximately 136 percent from $1.4 million in fiscal year (FY) 1996 to $3.3 million in FY 1999. Part of this increase can be attributed to changes in the methodology used for calculating outlier payments at teaching and/or disproportionate share hospitals which became effective October 1, 1997, under provisions of the Balanced Budget Act of 1997. In FY 1999, Bridgeport Hospital received, in addition to its DRG payments, $3.3 million for 224 outlier claims.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine whether hospital outlier payments were reimbursed in accordance with Medicare laws and regulations. Our review included outlier payments made to Bridgeport Hospital during FY 1999.

To accomplish our objective, we:

- Used CMS's National Claims History file to identify 224 outlier payments made to Bridgeport Hospital during FY 1999.

- Analyzed Bridgeport Hospital's FY 1999 outlier claims to identify high risk claims, such as those where charges for a single revenue code represented a significant percentage of total claim charges. Based on our analysis, we selected a judgmental sample of 15 outlier claims for review; these claims represent total billed charges of $1,379,326 and total Medicare payments to the hospital of $571,573 (of which $305,916 represents outlier payments).

- Utilized medical review staff from Qualidigm, the peer review organization (PRO), to review the medical and billing records for the 15 sample claims. The PRO determined whether the care was medically necessary and appropriate, whether services were correctly billed, furnished to the beneficiary, and ordered by a physician.

- Reviewed unusual or aberrant charges on the itemized bills associated with the 15 judgmentally selected claims.

- Discussed with hospital personnel, Bridgeport Hospital's procedures for accumulating charges, creating inpatient bills and submitting Medicare claims.

- Reviewed the fiscal intermediary's calculation of, and supporting documentation for, the inpatient cost-to-charge ratio used to calculate Bridgeport Hospital's FY 1999 outlier payments.

We limited consideration of the internal control structure to those controls concerning the accumulation of charges, creation of inpatient bills and submission of Medicare claims because the objective of our review did not require an understanding or assessment of the complete internal control structure at the hospital.

We conducted our audit during the period March 2001 through January 2002 at Bridgeport Hospital in Bridgeport, Connecticut, the PRO in Middletown, Connecticut and the Boston regional office of the Office of Inspector General (OIG).

The draft report was issued to Bridgeport Hospital for comment on February 4, 2002. Their written comments are included as an appendix to this report.

FINDINGS AND RECOMMENDATIONS

Our review found that due to control problems related to billing, Bridgeport Hospital received $23,409 in overpayments related to its FY 1999 outlier claims. These overpayments involved billed charges for services that were not ordered by a physician, were not properly documented, represented duplicate billing, resulted from submission of incorrect DRG codes and involved charges not related to an inpatient stay.

DOCUMENTATION ISSUES

Our review found that $25,286 in billed charges examined were in error due to documentation problems. As a result, under the Medicare reimbursement methodology for outliers, Bridgeport Hospital received overpayments of $12,398. Documentation problems include services that were not ordered by a physician or were not properly documented in the medical record.

A properly documented medical record is essential to good clinical care. Medical record documentation is required to record pertinent facts, findings and observations about an individual's

health history. The medical record documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his or her health care over time; and

- communication and continuity of care among physicians and other health care professionals involved in the patient's care.

Proper documentation, as well as adequate controls relative to billing functions, ensures that Medicare payments are made in accordance with laws and regulations.

Not Ordered by a Physician

Bridgeport Hospital submitted $21,729 in charges where the medical records do not contain physician orders for the services billed.

42 CFR, Section 482.24(c)(2)(vi) requires that medical records document all practitioner's orders.

The PRO's review found instances where Bridgeport Hospital billed for services that were not ordered by a physician. For example:

> The hospital billed for a glucose test; however, the medical records did not contain a physician's order for the test.

It should be noted that while Medicare regulations do not specify where physician orders should be located in the medical record, the PRO's standard of practice is that orders must be documented on the physician's order sheet. The rationale for this standard is that orders not recorded on the order sheet may be overlooked by hospital staff or not acted upon timely. Given the importance of medical record documentation to patient care, the requirement to record orders on the physician's order sheet provides assurance of consistency and continuity.

Because Bridgeport Hospital billed for services that were not ordered by a physician, the hospital received overpayments of $10,643.

Services Billed Not Properly Documented

Bridgeport Hospital submitted $3,557 in charges for products or services that were not properly documented in the medical record.

The PRO's review of medical records found instances where Bridgeport Hospital charged for services where the medical records do not support services billed. For instance:

> Services such as chemistry profile tests were billed; however, there are no laboratory reports in the medical record to support these services.

Contrary to Medicare regulations, Bridgeport Hospital billed for services that were not properly documented. As a result, the hospital was overpaid $1,755.

DUPLICATE BILLING

Bridgeport Hospital submitted $22,691 in charges for services that were provided by the hospital but were billed more than one time.

The Hospital Manual, Chapter IV, Section 400 (G), requires that hospitals bill only for services provided.

Our review identified instances where Bridgeport Hospital billed for the same service more than once. For example:

> Because of a clerical error, the hospital billed for two pacemakers for the same patient on the same day.

Because Bridgeport Hospital billed more than once for the same service, the hospital received overpayments of $10,893.

INCORRECT DRGs

The PRO found that Bridgeport Hospital submitted incorrect diagnosis codes on 2 of the 15 outlier claims reviewed. As a result, incorrect DRGs were assigned to these claims.

Section 1886(a)(1)(F)(i) of the Social Security Act, gives the PROs the statutory authority to perform DRG validation on PPS claims. The purpose of the DRG validation is to ensure that diagnostic and procedural information and the discharge status of the patient, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the medical record.

The correct DRG for one claim resulted in a higher Medicare payment to the hospital (a $375 underpayment), while the correct DRG for the second claim resulted in a lower payment (a $436 overpayment). Consequently, the hospital received a net overpayment of $61. At the PRO's request, the hospital's FI issued adjustments to correct the DRGs on the two claims and to recover the $61 overpayment identified by this review.

CHARGES NOT RELATED TO INPATIENT STAY

On one inpatient bill reviewed, we found that Bridgeport Hospital included $104 for laboratory charges with a date of service almost 2 weeks prior to the patient's date of admission.

Medicare regulations require that nonphysician outpatient services rendered up to 3 days prior to the date of an inpatient admission are to be deemed inpatient services. Payment for such outpatient services are to be included in the payment for the inpatient stay.

Bridgeport Hospital included charges not related to an inpatient stay on its inpatient bill; as a result, the hospital was overpaid $57.

RECOMMENDATIONS

Given the importance of proper medical record documentation for both patient treatment and accurate reimbursement, we recommend Bridgeport Hospital:

- Review documentation requirements with hospital staff to ensure that all services provided are appropriately documented in the medical record in accordance with standards of practice and Medicare laws and regulations, emphasizing the need to document physician orders.

- Improve its controls over the billing process to ensure that only services that are ordered by a physician, supported by appropriate documentation and related to an inpatient stay are billed.

- Return to the appropriate FI, the $23,348 associated with payments for services identified as not ordered by a physician, not properly documented, duplicate billing and not related to an inpatient stay.

Regarding the $61 overpayment related to incorrect DRG coding, we recommend Bridgeport Hospital improve its controls over the coding process to ensure that diagnoses, procedures and discharge status are correctly coded and billed.

AUDITEE COMMENTS

In response to our draft report, Bridgeport Hospital concurred with our findings and identified steps they have taken, and plan to take, to address our recommendations.

APPENDIX

BRIDGEPORT HOSPITAL
YALE NEW HAVEN HEALTH

March 1,2002

Office of Inspector General
Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

Attn: Mr. Michael J. Armstrong

Re: Bridgeport Hospital
CIN: A-01-01-00515

Dear Mr. Armstrong:

This letter is in response to your letter of February 4,2002. I have set forth below Bridgeport Hospital's views relative to (i) the validity of the facts presented in the *"Review of Medicare Outlier Payments at Bridgeport Hospital for Fiscal Year 1999"* (hereinafter "Outlier Payment Review") that was enclosed with your letter; (ii) the reasonableness of the recommendations presented therein; and (iii) the status of actions taken or contemplated by Bridgeport Hospital relative to the aforesaid recommendations.

It is first important to note that Bridgeport Hospital does not believe that any inferences should be drawn from the 15 outlier claims that were reviewed by Qualdigm which formed the basis of the Outlier Payment Review. We believe that the problems identified in the 15 claims reviewed are not systemic probiems. Rather, we believe they are isolated probiems that have arisen despite Bridgeport Hospital policies and procedures that are intended to prevent the types of problems identified in the Outlier Payment Review. In fact, the Outlier Payment Review specifically notes that in accomplishing OIG's objective, i.e. "to determine whether hospital outlier payments were reimbursed in accordance with Medicare laws and regulations," OIG identified and reviewed only high risk claims. The 15 claims identified represent only 6.7% of the 224 total 1999 Bridgeport Hospital outlier claims yet represent 9.3% of the dollar value of the outlier claims.

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203.384.3000

I will now identify and comment upon each of the issues raised in the Outlier Payment Review:

I. Documentation Issues. Bridgeport Hospital does not disagree with the OIG finding that $25,286 in billed charges were made in error due to documentation problems and these resulted in overpayments to Bridgeport Hospital of $12,398. Of this amount, $10,643 is attributable to medical records not containing a physician's orders and $1,755 is attributable to payments for products or services not properly documented.

With respect to the lack of physician's orders for services billed, Bridgeport Hospital agrees that the medicai records reviewed did not properly document physician orders. Nonetheless, we believe that this is simply a documentation problem and not a case of services either not being rendered or being rendered without physician orders.

Bridgeport Hospital understands the need for physician orders to be documented and, therefore, agrees with the OIG recommendations. Bridgeport Hospital requires that all physician orders must be in writing and included in the medical record with one exception. A physician may order that a patient be treated according to an established and approved clinical protocol which has been approved by the Bridgeport Hospital medical staff. In these cases, while the physician must designate that treatment be pursuant to that clinical pathway, the physician need not specifically order each test and procedure that is to be performed. The requirement that physician orders be in writing and be part of the medical record will be reviewed again with Hospital staff and the importance will be stressed. Also, a physician order entry system that will help avoid this problem in the future is expected to be in place next year.

With respect to the $1,755 overpayment for services billed but not documented or ordered, Bridgeport Hospital agrees with the facts cited. Bridgeport Hospital wishes to stress, however, that we do not believe that bills were rendered or payments were made for services that were not provided or that services were provided without physician orders. Bridgeport Hospital will review its billing controls to insure that only services ordered by a physician and properly documented are billed and also will review documentation requirements with Hospital staff. In addition, as indicated above, a computerized physician order entry system should be implemented next year and this will minimize problems in the future.

II. Duplicate Billing. Bridgeport Hospital agrees that it submitted charges in the amount of $22,691 for services that were provided by the Hospital but were billed twice due to a clerical error resulting in an overpayment to Bridgeport Hospital of $10,893. This was a simple clerical error that Bridgeport Hospital tries very hard to avoid. Bridgeport Hospital will continue to observe and stress billing controls and policies and procedures designed to minimize problems of this nature in the future.

III. Incorrect DRGs. Bridgeport Hospital agrees that it submitted incorrect diagnostic codes on two of the 15 outlier claims which resulted in incorrect DRGs being assigned to those claims.

Consequently, Bridgeport Hospital received a $375 underpayment in one instance and a $436 overpayment in another instance for a net $61 overpayment. Bridgeport Hospital recognizes the importance of proper coding and has an on-going continuing education program for coding to further improve its accuracy.

IV. Charges Not Related to In-Patient Stay. Bridgeport Hospital agrees that an in-patient bill contained $104 for laboratory charges incurred almost two weeks prior to the patient's date of admission resulting in an overpayment of $57. Bridgeport Hospital is aware of the "72-hour rule" which is incorporated within Bridgeport Hospital's billing procedures but which in this particular instance was not observed. Bridgeport Hospital will continue to educate Hospital staff on this and other billing policies and procedures and will reemphasize and improve control over its billing process to avoid future problems of this nature.

Bridgeport Hospital takes seriously the OIG Outlier Payment Review and will implement all of the recommendations contained therein and will refund to our fiscal intermediary the sum of $23,409. I want to again stress the fact that the problems found in your review are not systemic problems but, rather, isolated problems that resulted from a failure to follow policies and procedures implemented by Bridgeport Hospital to insure compliance with Medicare rules and regulations.

If I can be of any further assistance, please do not hesitate to contact me.

Very truly yours,

Robert J. Trefry
President & Chief Executive Officer