AUDIT DEPARTMENT

Audit Report

Medicare Non-Covered Charges

July 2012

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Audit Director

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Angela M. Darragh, CPA, CFE, CISA, Director

July 11, 2012

Mr. Don Burnette
Clark County Manager
500 South Grand Central Parkway, 6th Floor
Las Vegas, Nevada 89106

Dear Mr. Burnette:

In accordance with our annual audit plan, we have conducted an audit of Medicare Non-covered Charges. The audit covered the period from March 1, 2011 through August 31, 2011.

The objectives of the audit were to determine whether:

- Adequate controls are in place to capture non-covered charges when Medicare has declared those charges to be patient responsibility.
- UMC is properly billing Medicare patients for such non-covered charges to the program.

From the results of our detailed testing, it appears that adequate controls are in place to capture non-covered charges declared by Medicare as patient responsibility and patients are indeed being billed for such items. However, we identified the following opportunities for improvement:

- Inappropriate postings to the Medicare non-covered charges adjustment account due to lack of controls.
- Payments for items were denied by Medicare because there was not a covered diagnosis for the procedures performed.
- Processes are not in place to initiate an Advanced Beneficiary Notice (ABN) for Observation patients subsequently transferred from the emergency room.
- Inpatient drugs charges were placed as non-covered on the claim form.
- Account notes did not match actions taken for the account.

A draft report was provided to the Chief Executive Officer of UMC, and a response has been received. The assistance and cooperation of UMC's staff was sincerely appreciated.

Sincerely,

/s/ Angela M. Darragh

Angela M. Darragh, CPA
Audit Director

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BACKGROUND

Medicare is a federal health insurance program for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (permanent kidney failure that requires dialysis or a transplant). It is managed by the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services. The program consists of two main parts for hospital and medical insurance (Part A and Part B) and two additional parts that provide flexibility and prescription drugs (Part C and Part D).

Medicare has specific coverage policies that may result in denial of payment for some beneficiary services. Some of these services are excluded from coverage by statute; some are excluded under Medicare national coverage determinations; others may be covered but are not determined to be medically necessary for a particular condition.

University Medical Center of Southern Nevada (UMC) reports items and services rendered to a Medicare patient that are not covered by Medicare and deemed as patient responsibility to the Medicare Non-covered Charges adjustment account. During the six-month period from March 1, 2011 through August 31, 2011, outpatient non-covered charges totaled $169,537 and inpatient non-covered charges totaled $8,822, with the largest single transaction being $12,274 and the smallest at $1.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of the audit are to determine whether:

- Adequate controls are in place to capture non-covered charges when Medicare has declared those charges to be patient responsibility.
- UMC is properly billing Medicare patients for such non-covered charges.

Our examination covered the period from March 1, 2011 through August 31, 2011. Our procedures included interviews of Business Office management and staff at UMC, examination of Medicare patient accounts and supporting documentation, and analysis of data.

We conducted this performance audit in accordance with generally accepted government auditing standards except for the standard relating to personal independence. An auditor working on the engagement has an immediate family member in County management. Generally accepted government auditing 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 and that any threats to independence were appropriately mitigated through audit supervision.

RESULTS IN BRIEF

It appears that adequate controls are in place to capture non-covered charges declared by Medicare as patient responsibility and patients are indeed being billed for such items. However, we identified the following opportunities for improvement:

- Payments for items were denied by Medicare because there was not a covered diagnosis for the procedures performed.
- Processes are not in place to initiate an Advanced Beneficiary Notice (ABN) for Observation patients subsequently transferred from the emergency room.
- Inappropriate postings to the Medicare non-covered charges adjustment account.
- Inpatient drug charges were placed as non-covered on the claim form.
- Account notes did not match actions taken for the account.

DETAILED RESULTS

No Covered Diagnosis for Procedures Performed

We noted five patients where payments for items were denied by Medicare because there was not a covered diagnosis for the procedures performed. We found physicians ordering tests to rule out a specific diagnosis, which is not a coverable reason under Medicare, or no documentation was provided at all as to the rationale or diagnosis used as a basis for ordering a particular service. In one case, the physician did include a diagnosis, but it was not one that resulted in coverage of the ordered test.

Based on the discussions with Business Office billing staff and our testing results, the largest dollar amounts being posted to the Medicare Non-covered charges adjustment account appear to be for CT Scans, MRI, MRA, physical therapies and occupational therapies that do not include a proper diagnosis.

Physicians should order tests related to the symptoms and diagnosis, order only when medically necessary, and maintain accurate and complete medical records of the services they provide, in accordance with Section 4317 of the Balanced Budget Act of 1997, which states that the referring physician is required to provide diagnostic information to the testing facility at the time the test is ordered. Additionally, Coders should be communicating with physicians when documentation is incomplete or inaccurate, in accordance with UMC

Administrative Policy and Procedures: ICD-9-CM and CPT-4 Coding Assignment # VI-2 dated September 28, 2005, which requires Coders to query the physicians regarding documentation questions.

Why is this important?

As a result of the lack of covered diagnosis for the procedures performed, the dollar amount deemed unbillable by UMC for these five patients totaled $20,475, or 43.9 % of the total dollar amount of our audit sample size.

Recommendation

UMC recently implemented a clinical documentation improvement program. As part of this program, a Clinical Documentation Specialist reviews all Medicare patient accounts and queries physicians when documentation does not support services ordered. We believe this process should reduce the amount of non-covered charges. We recommend that the Director of Medical Records continue to work with physicians on improving documentation to support medical necessity.

We further recommend that the Director of Medical Records remind Coders to communicate with the ordering physician in determining justification and medical necessity if it is not apparent from the record.

Comprehensive Processes Not in Place to Initiate ABNs

Processes are not in place to initiate an Advance Beneficiary Notice (ABN) when a patient is transferred from Emergency to Observation status. During our testing we noted four patients who received procedures after the point of stabilization, which were denied by Medicare. Each patient came through the emergency room and transferred to observation; tests were subsequently ordered. Note that these are the same patients whose procedures were not covered due to not having a covered diagnosis code (see first finding).

The ABN is a written notice that a provider gives to a Medicare patient before items or services are rendered when the provider believes Medicare probably/certainly will not pay for some or all of the items or services. The ABN allows the patient to make an informed decision about whether to receive services that he/she may be financially responsible for paying and serves as proof the patient had knowledge prior to receiving the service that Medicare might not pay. According to the Medicare Claims Processing Manual, Chapter 30, Section 50.3.1, it is mandatory to issue an ABN when Medicare is expected to deny payment (entirety or in part) for the items or services because it is not reasonable and necessary under Medicare Program standards, such as it is not indicated for diagnosis and/or treatment in this case.

Why is this important? When a proper ABN is not delivered to the patient, UMC cannot shift financial liability to the patient when claims for items or services are denied by Medicare. UMC is therefore forfeiting money that can be billed to patients.

Recommendation Due to the efforts involved in implementing procedures to correct this finding, we do not recommend a correction to current practice. Instead, we recommend that the Admitting Director work with McKesson Technologies during the upcoming hospital-wide healthcare information system design to establish processes for issuing an ABN to patients transferred from Emergency to Observation status, taking into consideration appropriate staffing and training requirements.

Charges Posted to the Incorrect Account

During our fieldwork, we noted four patient accounts whose charges were improperly posted to the Medicare non-covered outpatient charges adjustment account, resulting in an overstatement of $14,993. Charges should have been posted to either the Medicaid non-covered charges adjustment account, Medicare Clark County Social Services Indigent account, or the Untimely Follow-up adjustment account.

Upon discussion with Business Office management, corrections were made to two of the four patient accounts. The other two required additional research before corrections could be made.

Recommendation We recommend that the Director of Patient Financial Services remind staff of the different charge numbers available for writing off non-payment. As the integrity of data is compromised when accounts do not represent accurate balances, we recommend that amounts be reclassified to the appropriate account.

Claims Processing Discrepancies

Non-prescription drugs totaling $651 and emergency room charges of $2,034 for three inpatients were submitted as non-covered charges. As a result, the Medicare non-covered charges adjustment account is overstated, as the charges should have been included in the main Medicare adjustment account: 9704610 CA/D-MCRE PART A&B.

Take-home drugs given to an inpatient to permit or facilitate the patient's discharge from the hospital are covered as an inpatient service. Emergency room charges should have been placed in "covered charges" column of the claim form for reimbursement under the contractual obligation.

These patients were reviewed for Hospital Acquired Conditions by a Business Office data technician and bypassed final review by the billers, who may have caught the error. Upon discussion with the

Business Office Manager, this lapse in control was discovered prior to our audit and they have since changed their procedures so that the billers have final approval and validation rights of all claims sent to Medicare.

Why is this important? In this case, there is no financial impact; UMC is paid on the listed DRG rate because the patients are inpatient. However, the internal control weakness could allow processing of other incorrect claims that do have a financial impact on the organization.

Recommendation We recommend that the Director of Patient Services direct the Business Office to continue reviewing each claim with due diligence and re-process the claim should discrepancies be found.

Consistency in Documentation Needed

There is a section in each patient's account where notes are entered to document updates to the account. We noted two instances of inconsistency between the notes entered and the actions taken on the account. In one instance, there was a discrepancy between the note and the actual procedure code assigned on the claim. In another instance, there was no documentation as to who entered a modifier for a particular item, or why the modifier was added.

Why is this important? Justification for changes to a patient account should be documented, especially when there is a financial impact. Notes identify not only what changes were made, but also the person who made the changes. Documenting changes will aid in efficiencies during claims review.

Recommendation We recommend that the Director of Medical Records remind Coders to ensure the notes they write in the system matches what is entered for the account.

REVENUE CYCLE MANAGEMENT RESPONSE TO MEDICARE NON-COVERED CHARGES AUDIT

NON COVERED DIAGNOSIS FOR PROCEDURES PERFORMED

Clinical Documentation nurses will focus on observation patients in the chest Pain Center and use the opportunity to teach physicians. Focus will be placed on the importance of documenting, in the record, a diagnosis for all conditions treated during the stay. Coders will query physicians if they determine that the record contains insufficient documentation.

CONSISTENCY IN DOCUMENTATION NEEDED

Coders are required to enter an account note to document coding changes within the abstract after the initial claim is dropped. No audit trail exists in MIRA to determine who made the changes. Coders will continue to make the required notations and the Business Office staff are required to validate that the changes made are consistent with the notes entered by the coder. There should be no variation between the notes and what appears in the abstract. If they vary, Business Office staff will notify the coder and document their findings in the notes. It is important that documentation and codes match. The coding staff will ensure that the notes and codes match prior to returning the account to the Business Office.

COMPREHENSIVE PROCESSES NOT IN PLACE TO INITIATE ABN'S

Medicare requires a Medical Necessity Checker be performed for all outpatient diagnostic services. If the procedure is non-covered, or a service not supported by the diagnosis, an ABN (which includes an estimate of total charges) must be provided to the patient, for diagnostic services an ABN is run at time of registration according requirements . In observation cases, various tests are ordered to evaluate whether to admit or discharge safely. Diagnostic services ordered while in observation status would need to have a Medical Necessity Checker performed at the point of service. The challenge to the organization is that employees, outside of admitting, with access to the patient's medical record, may need to be assigned to initiate a Medical Necessity Checker at the time the diagnostic services are ordered.

In an effort to solve the problem, Patient Access Services has contacted other facilities facing the same challenge. None have succeeded in resolving the issue. A post has also been placed on the UHC website to query the nation for possible resolutions. CMS recommendation is that the process be completed at the point of care in these cases. UMC is reviewing the McKesson products being implemented for a best practice resolution for this issue.

CHARGES POSTED TO INCORRECT ACCOUNT

Unit billing specialist reviews all adjustments submitted by the billing staff to ensure the appropriate adjustment code and amount is being reported accurately as stated in the account notes.

CLAIMS PROCESSING DISCREPANCIES

Claims for coding issues are placed on hold in the billing application. Once coding edits are resolved by the Data Technician, accounts are re-assigned to the billing staff where non-coding edits, including non-covered charges, are resolved.