
Secretary of State

State of Oregon

DEPARTMENT OF HUMAN RESOURCES

Office of Medical Assistance Programs

Hospital Billings



Audits Division

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This report contains the results of our audit of the Department of Human Resources Office of Medical Assistance Programs' (OMAP) payment of billings from hospitals. The hospitals bill OMAP directly for services provided to Oregon Health Plan recipients who are not enrolled in managed care plans. The purpose of our audit was to determine whether the hospitals were properly billing the state for these services and, if not, whether the state was adequately detecting and correcting these errors. The audit also included a review of OMAP's processing of the annual hospital cost settlements.

We found that hospitals are generally billing OMAP in a proper manner. Incorrect billings were noted which resulted from incorrect coding of diagnoses and procedures, incorrect inpatient and outpatient status, and other miscellaneous issues. In addition, OMAP had a significant backlog of unprocessed annual hospital cost settlements.

Our report includes recommendations to improve OMAP's prevention, detection, and correction of payment errors. These recommendations include increased OMAP involvement in the contracted billing review process, improved communication with hospitals regarding billing issues, clarification and revision of certain rules, and a modification to the automated payment system. It also recommended that OMAP provide sufficient staff to eliminate the backlog of unprocessed hospital cost settlements. OMAP agrees with our recommendations and has already taken corrective action in a number of areas.

OREGON AUDITS DIVISION

John N. Lattimer
Director

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EXECUTIVE SUMMARY

Hospital Billings

Background and Purpose

During 1997, OMAP paid hospitals \$64 million to provide services under the Oregon Health Plan.

The Department of Human Resources Office of Medical Assistance Programs (OMAP) provides health care coverage to approximately 335,000 Oregonians through the Oregon Health Plan, a Medicaid demonstration project. During 1997, OMAP paid hospitals \$64 million to provide services under this program, or 7 percent of the total Oregon Health Plan expenditures. The purpose of this audit was to determine whether hospitals were properly billing the state for these services and, if not, whether the state was adequately detecting and correcting these errors. During the course of this audit, it also came to our attention that the process used by the state to settle certain costs with hospitals was backlogged, so we included a review of the state's "cost settlement" process in this audit.

Results in Brief

Seven percent of the stays reviewed should have been billed as outpatient rather than the more expensive inpatient.

Six percent of the payments reviewed were paid wrong amounts due to incorrect coding.

Our audit found hospital billing problems in the following areas:

- **Hospitals did not always bill short stays correctly.** We found that 31 of the 432 stays reviewed (7 percent) should have been billed as outpatient service, rather than the more expensive inpatient service. Conversely, we also found that nine of the 81 outpatient cases reviewed (11 percent) should have been billed as inpatient claims.
- **Hospitals did not always code diagnoses and procedures correctly.** We found that 24 of the 401 payments reviewed (6 percent) were paid wrong amounts because the bills included incorrect diagnosis and procedure codes. For example, one case had the principal diagnosis incorrectly coded as septicemia rather than dehydration, resulting in an overpayment of \$1,554.
- **Hospitals did not always bill correctly when reimbursed on a cost basis.** We noted miscellaneous billing problems resulting from things such as services billed which were never provided, miscounts, and recurring problems with certain billings for laboratory services, respiratory therapy, and physician services.

Overpayments totaled 2.3 percent of the amount reviewed.

In total, we reviewed approximately \$3.4 million of the \$64 million in payments made to hospitals during 1997. We found overpayments totaling approximately \$80,000, or 2.3 percent of the amount reviewed.

OMAP can take the following steps to prevent, detect and correct these billing errors in the future:

- **Better target hospital billing reviews in higher risk areas.** OMAP's contractor has not changed its case selection criteria in recent years. Over half of the contractor's reviews during 1997 were in the area of psychiatric services, finding less than a 1 percent error rate. OMAP should ensure that its contractor targets higher risk areas, such as uncomplicated births with three-day hospital stays (we found errors in 38 percent of the cases reviewed) or certain surgeries that were billed as inpatient (we found errors in 22 percent of the cases reviewed).
- **Ensure the quality of its contractor's medical coding review meets minimum quality standards.** OMAP needs to ensure that its contractor is adequately performing. During 1997, the contractor reviewed 3,004 cases and only identified coding errors in 0.4 percent of the cases. In contrast, our review of 401 cases identified coding errors in 6 percent of the cases.
- **Promptly initiate payment adjustments when billing errors are detected.** OMAP is not processing payment adjustments in a timely manner. For the calendar year 1997 cases identified by the contractor needing adjustment, 22 percent of the cases had not been reversed until six months later, and 33 percent of the cases had not been reversed one year later. Six of the 116 cases alone will allow OMAP to recover more than \$25,000.
- **Improve communication with hospitals regarding billing issues.** During our review, we noted that some hospitals lacked knowledge of certain billing requirements. OMAP should consider implementing an outreach effort to better educate providers about billing issues.
- **Consider clarifying or modifying some of its rules.** OMAP should consider: (1) modifying its time limits on outpatient stays to match the Medicare definition, (2) revising its rule covering billing for laboratory tests to preclude the practice of billing for a group of tests rather than the individual tests

ordered when more costly, and (3) limiting payment for ambulatory surgery to the amount that would have been paid for inpatient admission for the service.

- **Modify automated system to capture data that can be used to automatically detect billing errors.** OMAP should include in its automated system the ability to capture the time of discharge, so that automated tests on lengths of stay can be performed.

Finally, our audit also found that OMAP has not remained current with its annual hospital cost settlement process. The delays in processing settlements have resulted in lost potential earnings for the federal and state government and some hospitals. We estimate that the cost of OMAP's delay in processing the 1998 settlements is \$504,000.

Agency Response

The Office of Medical Assistance Programs generally agreed with the conclusions and recommendations in this report and has already taken steps to implement most of the recommendations.

Introduction

Background

OMAP administers the medical-services portion of the Medicaid program.

The Department of Human Resources administers Oregon's Medicaid program. Medicaid is funded jointly by the state and federal governments; the federal government provides approximately 61 percent of the funding in Oregon with the remaining resources provided by the state. The department's Office of Medical Assistance Programs (OMAP) administers the medical-services portion of the Medicaid program. OMAP writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of recipient eligibility, and pays providers. Essentially, all recipients receive their medical services through the Oregon Health Plan, a Medicaid demonstration project implemented in 1994. Approximately 336,000 recipients were enrolled in the Oregon Health Plan as of December 1997.

OMAP paid hospitals \$64 million for services during 1997.

As of December 1997, about 81 percent of the Oregon Health Plan recipients were in managed care plans to which OMAP pays a monthly amount, called a capitated payment, for each recipient. The plans then cover the recipient for medical services, including hospital services. The remaining 19 percent of the recipients who are not covered by managed care plans are covered on a fee-for-service basis. Under a fee-for-service arrangement, the providers of the medical services submit bills to OMAP for reimbursement. Fee-for-service payments by OMAP to in-state hospitals during calendar year 1997 totaled \$64 million (7 percent of OMAP's Medicaid medical assistance expenditures.)

The hospitals submit their billings, usually electronically, to OMAP on a prescribed form. Required information includes the recipient's name, date(s) of service, admission and discharge status, diagnoses, procedures performed and services provided. OMAP relies on a complex series of automated controls in its payment processing system to ensure that payments are for medically necessary services and conform to current laws and regulations. The \$64 million paid by OMAP during 1997 for hospital services was comprised of 129,000 claims, an average of about \$500 per claim. Included in these totals were 15,000 claims totaling \$41 million (an average of \$2,700 per claim) for inpatient services at large urban hospitals. OMAP also contracts with a professional review organization that reviewed approximately 3,000 claims paid in 1997 (2.3 percent).

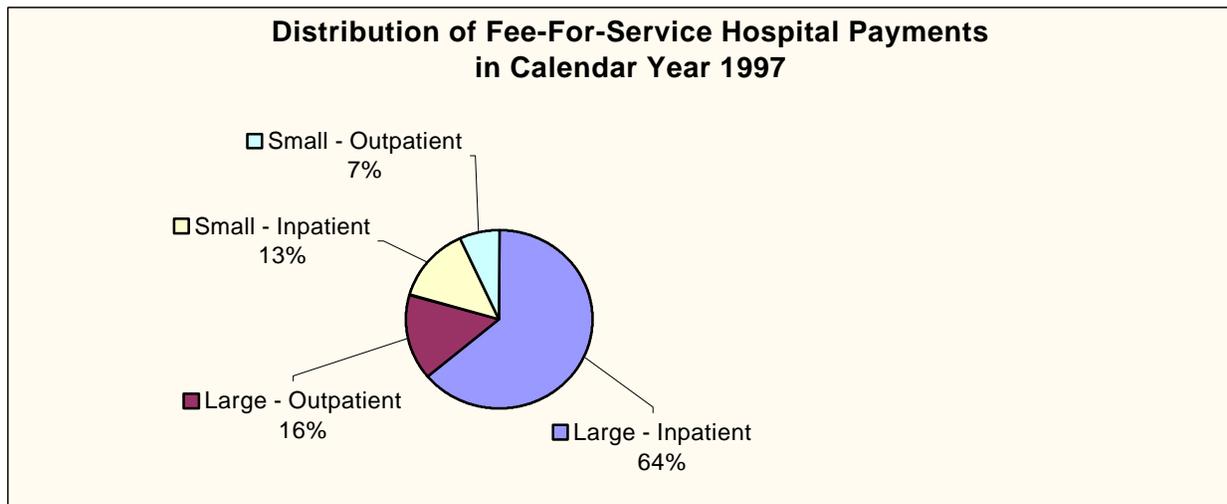
Hospital Types

OMAP payment method depends on the type of hospital.

The method used by OMAP to reimburse hospitals for their services depends on the type of hospital. About half of the hospitals in the state are designated as rural hospitals.¹ These hospitals (small hospitals) have fewer than 50 beds. They are reimbursed at 100 percent of their costs for covered inpatient and outpatient services as required by law.² In contrast, the larger urban hospitals (large hospitals) are reimbursed at 59 percent of their costs for covered outpatient services, while inpatient services are reimbursed based on the diagnosis related groups (DRG) method. This method pays a pre-established amount for various services, with the amount adjusted annually to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

The \$64 million paid by OMAP during 1997 is comprised of the following: large hospital inpatient \$40.8 million; large hospital outpatient \$9.8 million; small hospital inpatient \$8.6 million; and small hospital outpatient \$4.7 million. Figure 1 shows the distribution of these 1997 payments.

Figure 1



¹ ORS 442.470 defines these hospitals as Type A or Type B Rural hospitals.

² ORS 414.065

Scope and Methodology

Our audit reviewed the Office of Medical Assistance Programs' fee-for-service payments to Oregon hospitals from January 1, 1997, through December 31, 1997. Specifically, we had the following objectives:

- Determine whether hospitals are properly billing OMAP for inpatient and outpatient services; and
- Determine whether the contracted post payment review process is effectively detecting improper billings.

In addition, as a result of concerns expressed by a hospital administrator regarding the delays his hospital was experiencing in the annual hospital cost settlement process, we reviewed the cost settlement process as well.

In order to meet our audit objective of determining whether hospitals are properly billing OMAP for services provided, we:

- Reviewed applicable federal and state laws, regulations, and agency policies;
- Reviewed audits done by other states and the U. S. General Accounting Office;
- Interviewed staff at the Office of Medical Assistance Programs, hospitals, and an expert in medical coding;
- Hired a consultant with expertise in auditing hospital bills to assist us in our reviews of hospital billings;
- Read the national guidelines and various articles regarding coding for the diagnosis related groups (DRG) method;
- Extracted and analyzed the 1997 hospital payment and adjustment transactions recorded on OMAP's Medicaid Management Information System (MMIS);
- Reviewed medical records for more than 400 claims from 25 large hospitals for inpatient admissions (DRG payments);
- Visited four hospitals and reviewed more than 100 claims for inpatient and outpatient services (cost reimbursement payments);

- Referred cases to the Oregon Medical Professional Review Organization (OMPRO) for their determination of medical necessity and the validity of DRG coding;
- Had an expert in medical coding review the DRG coding for certain cases OMPRO determined to be properly coded; and
- Had an independent organization review the DRG coding for the cases in which OMPRO and the expert in medical coding disagreed on the DRG assignment.

We verified the reliability of computer-processed data used in our audit procedures by comparing the amounts and coding recorded in MMIS to a sample of paper claims filed at OMAP, with itemized billings provided by hospitals and the medical records for the cases reviewed during our audit.

To review OMAP's contracted post payment review process, we:

- Reviewed the reports and other documents prepared by the contractor for the 1997 reviews;
- Analyzed this information to determine the types of admissions reviewed and the recommended payment adjustments; and
- Determined whether the recommended payment adjustments were made in a timely manner.

To review the annual hospital cost settlement process, we:

- Interviewed OMAP's auditors responsible for processing the settlements;
- Analyzed information provided by OMAP regarding Medicare cost reports received and settlements processed during the past several years;
- Determined the number of settlements processed, settlement amounts, and the average delay in processing the settlements;
- Determined the backlog of settlements awaiting processing; and
- Computed the lost potential earnings resulting from the processing delays.

We conducted this audit from July 1998 to March 1999 in accordance with generally accepted government auditing standards.

Chapter 1: Opportunities to Reduce Payment Errors to Hospitals

The Office of Medical Assistance Programs (OMAP), the state entity responsible for reviewing and paying hospital claims under the Oregon Health Plan, can take steps to reduce the number of incorrect payments it makes to hospitals. During our review of hospital billings, we found problems in the following areas: diagnosis and procedure coding, short stay billing, cost reimbursement billing, and other coding and billing issues. We also identified some of the contributing causes for the payment errors and steps that OMAP can take to reduce these errors.

Diagnosis and Procedure Coding Problems

Through our testing of hospital billings, we found that large hospitals did not always use the correct codes for inpatient admissions. Incorrect coding results in the state paying hospitals the wrong amount for the services provided.

OMAP pays for inpatient admissions at large hospitals according to the DRG method.

The state pays the 30 large hospitals in Oregon for inpatient admissions using a method that categorizes patients with similar diagnoses and treatment into groups, called diagnosis related groups (DRGs). Rather than pay the large hospitals for inpatient services based on detailed billings for each patient, the state pays a set amount, based on the assigned DRG. The theory behind this payment method is that patients with similar diagnoses will generally receive similar treatments and have similar lengths of stay. In other words, the expected use of hospital resources would be similar. The payment system is simplified by paying a set amount for each DRG, rather than varying the payment amount for each individual patient. This method is used nationwide for Medicare inpatient admissions and in some states, including Oregon, for Medicaid inpatient admissions.

Accurate coding is necessary for correct DRG payments.

The accurate coding of diagnoses and procedures on hospital billings is critical because the coding is used to determine the DRG assignments and therefore the reimbursed amounts. Hospital staff review medical records and use their training and experience to abstract and prioritize the principal and other diagnoses and procedures on each billing. While medical coding

Amounts paid for the various DRGs can vary dramatically.

is a somewhat subjective process, OMAP requires that national medical coding standards be followed.³

OMAP's automated payment system assigns a DRG to each admission based on the principal and other diagnoses, procedures, age, sex, and discharge status coded on the hospital billing. Hospitals are then paid a set amount (revised annually) for each DRG assignment. In some cases, the standard DRG amount is supplemented for very costly stays (called cost outliers).

The accurate coding of diagnoses and procedures is important because the amounts paid for the various DRGs vary dramatically. For example, at one of the hospitals, the 1997 standard payment for the care of a normal newborn (in addition to \$1,030 for a normal birth) was \$287, while the payment was \$66,908 for the care of a premature newborn weighing less than 1,000 grams (2.2 pounds). In other words, this hospital would be paid \$287 for the care of every normal newborn and \$66,908 for the care of every premature newborn weighing less than 1,000 grams. Figure 2 lists some selected DRGs for one hospital during 1997, with expected lengths of stay and standard payments. These examples illustrate the importance of proper diagnosis and treatment coding and the impact that improper coding can have on payment amounts.

**Figure 2
Selected DRGs for a Large Hospital During 1997**

DRG	Description	Average Length of Stay	Payment
031	Concussion with complications in an adult	2.1 days	\$ 3,041.50
032	Concussion, simple, in an adult	1.8 days	\$ 1,961.73
089	Pneumonia with complications in an adult	3.7 days	\$ 2,859.48
090	Pneumonia, simple, in an adult	2.7 days	\$ 1,951.93
096	Bronchitis and Asthma with complications in an adult	3.1 days	\$ 2,485.66
097	Bronchitis and Asthma, simple, in an adult	2.2 days	\$ 1,640.04
391	Normal newborn	1.3 days	\$ 286.93
801	Newborn weighing less than 1,000 grams (about 2.2 pounds)	56.7 days	\$ 66,907.94

³ OAR 410-120-1280

The most frequent coding error was a miscoded principal diagnosis.

During our review, we found some errors in hospitals' diagnosis and procedure coding which resulted in incorrect DRG assignments. These errors included the miscoding of principal diagnosis, the coding of invalid other diagnoses, and the coding of incorrect procedures.

The most common coding error we found was the miscoding of patients' principal diagnosis. We determined that this error was the cause of 15 of the 24 incorrect DRG assignments noted in our audit. The definition of principal diagnosis is the "condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."⁴ The admitting diagnosis, which may be a symptom or ill-defined condition, can change based on the diagnostic tests and studies performed during the hospitalization. Thus, the circumstances of admission, after study, govern the selection of the principal diagnosis. Note that the principal diagnosis is not necessarily the condition having the largest impact on the patient's health, rather it is the reason the patient was admitted. For example, an individual with cancer who was admitted to the hospital for treatment of a broken leg would result in OMAP paying the hospital for the DRG for treating the broken leg rather than the DRG for cancer.

Other diagnoses were sometimes miscoded.

Our audit found that the principal diagnosis coded on the billings was not always the reason the patients were admitted to the hospital. For example, one case we reviewed had the principal diagnosis incorrectly coded as septicemia rather than dehydration. The resulting overpayment was \$1,554. We determined that 15 of the cases we reviewed were paid for an incorrect DRG because the principal diagnosis was miscoded. Eight of the fifteen cases were overpayments totaling \$27,512 while seven were underpayments totaling \$10,312.

We also noted five cases in which errors in the coding of other diagnoses affected the DRG assignment. Other diagnoses are defined as conditions that exist at the time of admission, that develop subsequently, or that affect the treatment received or the length of stay. Diagnoses that relate to an earlier hospital admission and have no bearing on the current stay are to be excluded from the billing. Some other diagnoses, in conjunction with certain principal diagnoses, result in the assignment of a higher paying DRG. For example, a hospital is paid more to treat

⁴ As defined in the Uniform Hospital Discharge Data Set (UHDDS) promulgated by the U.S. Department of Health, Education, and Welfare.

an individual for pneumonia who also has diabetes as compared to treating an individual for pneumonia who does not have diabetes or other complicating conditions.

We found two cases of hospitals coding an invalid other diagnosis that resulted in overpayments by OMAP. For example, one of our cases, a cesarean birth, had maternal anemia coded as an other diagnosis. A review of the medical records determined that this diagnosis was invalid; the resulting overpayment was \$517. We also found three cases of hospitals not coding a valid other diagnosis that would have increased their payment from OMAP. The net result for all five cases was an underpayment of \$819 by OMAP.

Procedures were sometimes miscoded.

Finally, we found three cases in which the operating room procedure coded on the billing to OMAP was incorrect. These cases resulted in OMAP paying a higher DRG amount than would have resulted from coding the actual procedure performed. The resulting total overpayment for the three cases was \$15,980. We also found one case in which the hospital did not code a procedure that was performed and would have resulted in a higher paying DRG. The net result for all four cases was an overpayment of \$9,604 by OMAP.

Six percent of the payments reviewed were paid wrong amounts due to incorrect coding.

We reviewed 432 DRG payments selected from 25 hospitals that totaled \$3,136,737. We found that 31 of these payments (7.2 percent) should have been for outpatient stays rather than inpatient admissions (for further information on short stays see page 8.) For the remaining 401 payments, we determined that at least 24 (6 percent) appear to have been paid with an incorrect DRG assignment. Of those, 13 were overpayments totaling \$45,377 (1.5 percent of the \$3,062,438 paid for the 401 cases). The remaining 11 payments were underpayments totaling \$19,392, resulting in a net overpayment of \$25,985.

Short Stay Billing Problems

Our review found that hospitals do not always bill short hospital stays as required by Oregon Medicaid requirements. Resulting payments may be either too high or too low, but our review found that in most instances payments were too high.

Medical practice provides that certain short hospital stays should be billed as outpatient observation care. Observation status allows for evaluation and treatment of patients in a hospital setting when an inpatient admission is not medically necessary. There

Seven percent of inpatient hospital claims reviewed should have been billed as outpatient.

Incorrectly billed short stays resulted in a net overpayment.

are standards that must be met to justify an inpatient admission involving both severity of illness and intensity of services provided. One Oregon rule states that there will be no payment for services that are not medically necessary.⁵ Another rule limits observation status to a maximum of 30 hours.⁶ If a hospital stay exceeds that limit, it must be billed as an inpatient admission.

We found that short hospital stays were sometimes incorrectly characterized and billed. In our review of large hospital inpatient claims, we found 31 of 432 stays (7.2 percent) that were incorrectly billed and paid as inpatient claims. These cases did not meet the standards for an inpatient admission and involved stays of less than 30 hours. In addition, we reviewed 81 outpatient cases during our on-site reviews of cost reimbursement billings and found nine cases (11.1 percent) that were incorrectly billed and paid. These nine cases had stays in excess of 30 hours and should have been billed and paid as inpatient claims.

Incorrectly billed short stays resulted in both over- and underpayments. Because DRG inpatient claims account for the largest portion of fee-for-service hospital dollars, errors in billing those claims have the greatest effect. Converting the 31 DRG claims we identified as incorrectly billed to outpatient observation status would result in OMAP recouping about \$39,500. In addition, appropriate billing of the nine incorrect short stays identified during our on-site visits would result in a net additional payment of \$2,000 to the hospitals.

Cost Reimbursement Billing Problems

Our on-site review of hospital billings found that some hospitals did not always bill correctly for services when they were paid on a cost reimbursement basis. We identified a minor net overpayment for the billings we reviewed. While there were various causes for the overpayments, certain problems appear to be common among several hospitals.

The state pays small hospitals and outpatient services at large hospitals on a cost reimbursement basis. Hospitals submit detailed bills to OMAP for payment. Unlike the DRG payment method, this method pays an amount to hospitals based on a percentage of the billed services provided to the individual patient.

⁵ OAR 410-120-1200

⁶ OAR 410-125-360

Certain problems were common among several hospitals and should be addressed.

The bills are often complex because each procedure, diagnostic test, professional service, medication administered, and supply item used must be documented by the hospital in order to be billed.

Our on-site review included 106 cases that were paid \$238,356 at four hospitals, two small and two large. We identified a total of \$7,980 in overpayments, a rate of 3.3 percent. As part of the review, we also found some underpayments totaling \$2,979. While the total dollar amount of these overpayments is not significant, these issues bring to light systematic problems OMAP needs to address. For example:

- Respiratory therapy was misbilled at three of the four hospitals we visited when it was provided by someone other than a respiratory therapist. Hospital providers are not allowed to bill for these services when they are provided by a nurse; providers are allowed to bill for the services only when a respiratory therapist provides them. Nurses' services are included in the hospital charge for room and board. In one case reviewed, the state paid \$318 for 15 nebulizer treatments. Our audit found that only six were allowable because the treatments were provided by respiratory therapists, resulting in an overpayment for the remaining nine treatments of \$191.
- We noted that laboratory work at three of the four hospitals we visited was not billed correctly. Laboratory tests are very specifically defined. There are many codes for specific tests and panels of tests, resulting in an increased risk of miscoding. For example, there are six different codes for similar blood tests, all commonly known as complete blood counts (CBC), but each code defines a slightly different test and a different reimbursement amount. We found a standard blood test that a hospital was consistently miscoding; we estimate that the resulting overpayment during the year was \$400. In addition, OMAP has a rule that when all tests ordered are included in a panel (examples of panels include the obstetric panel, hepatic function panel, and lipid panel) the panel should be billed, not the separate tests.⁷ We found instances at two hospitals in which panels were billed as the component tests rather than the panel. In addition, we found that one hospital was routinely billing for one of the CBCs that contained the two specific tests actually ordered. The charge for the CBC, which

⁷ OAR 410-130-0680

is not a panel, was more than that for the two separate tests. The potential overpayment from this practice was \$600 for the year.

- The level of physician services provided was sometimes billed at a higher level than justified. Physician services are defined by a national set of codes. There are several different series of codes, generally ranging from level one to level five, denoting increasingly complex and time consuming professional care. Billing and payment is scaled, with higher levels billed and paid at higher rates. As an example, the guidelines for coding new patient office visits, along with average billing rates, for one large hospital are provided in figure 3 below.

**Figure 3
Physician's Services
New Patient Office or Outpatient Visit
Guidelines for Coding and Average Rates Billed at a Hospital**

Code	99201	99202	99203	99204	99205
Time Spent with Patient	10 minutes	20 minutes	30 minutes	45 minutes	60 minutes
Patient's History	Problem focused	Expanded problem focused	Detailed	Comprehensive	Comprehensive
Examination	Problem focused	Expanded problem focused	Detailed	Comprehensive	Comprehensive
Medical Decision Making	Straightforward	Straightforward	Low complexity	Moderate complexity	High complexity
Billing Rate	\$39.18	\$75.16	\$105.58	\$145.00	\$179.96

The appropriate level to bill is determined judgmentally by medical coders at each hospital. Our analytical procedures identified one hospital as billing a higher than expected rate of high level emergency department services. On-site work at that hospital confirmed that in 25 percent of the emergency department visits we reviewed, coding for physician's services was higher than justified. Depending on the levels billed, overpayments ranged from \$45 to \$132 per instance.

- Short stays were sometimes billed incorrectly. This issue is explained in further detail starting on page 8.

We also found the following problems that are more difficult to deal with on a system-wide basis:

- Quantities of items were sometimes billed incorrectly. For example, we found a duplicate billing for an epidural tray paid at \$39 at one hospital. Conversely, at another hospital we found four IV solutions billed while use of six was documented in the medical records, resulting in an underpayment of \$55.
- Some services were billed that had not been ordered. OMAP requires that services billed must be ordered by licensed practitioners acting within the scope of their practice or licensure.⁸ We noted several instances in which laboratory work was done without orders, resulting in overpayments of as much as \$15 per instance.
- In some cases, services were ordered but there was no evidence that these services were actually provided. For example, a pelvic CT scan was billed and paid at \$575 although there was no documentation in the medical records that it had been done.
- Finally, room and board was billed although the midnight census requirement was not met. Patients must be admitted to their beds by midnight to be charged room and board for the prior day. We found an instance of a patient admitted to a bed at 12:15 a.m. but billed and paid for the prior day at \$447.

Other Coding and Billing Problems

In addition to the findings previously mentioned, we noted two other issues that resulted in four overpayments by OMAP. Two of the overpayments were the result of a hospital miscoding the discharge status on the hospital billing. The other two overpayments resulted from hospitals billing OMAP for an excluded service.

Discharge Status Miscoded

We found two instances in which a patient was transferred to another hospital for one-day treatments and was then transferred back to the sending hospital. Both return transfers were

⁸ OAR 410-120-1200

inappropriately coded as discharges to a skilled nursing facility rather than transfers to another hospital. When a patient is transferred between large hospitals using the DRG payment method, the rule is that only the final discharging hospital receives the full DRG payment.⁹ The transferring hospital receives a pro rata payment based on the length of time that the hospital cared for the patient in relation to the average length of stay and its standard payment for the DRG. For example, if the transferring hospital cared for a patient for one day and the average length of stay for the DRG was 2.5 days with a standard payment of \$2,660 for the hospital, the hospital would be paid \$1,064 ($1/2.5 \times \$2,660$).

The result of the receiving hospital miscoding the discharge status on the billings to OMAP was two overpayments totaling \$5,781. OMAP paid two full DRG payments totaling \$7,169 rather than two pro rata payments that would have totaled \$1,388.

Excluded Services Paid

We also found two cases involving hospitals treating prisoners brought from jail. In both cases, the hospitals inappropriately billed OMAP, and OMAP paid for the services.

Hospitals should not bill OMAP for services to recipients who are in the custody of a law enforcement agency. These services are not covered under any of the programs, including Medicaid, administered by OMAP.¹⁰ The two cases involved an inpatient admission and outpatient services for which OMAP paid \$3,533 and \$1,436, respectively. The total overpayment for these two cases was \$4,969.

OMAP CAN REDUCE THE NUMBER OF INCORRECT PAYMENTS MADE TO HOSPITALS

OMAP can take steps to reduce incorrect payments made to hospitals.

Steps can be taken by OMAP to improve the effectiveness of the contracted post payment reviews of hospital bills, to better educate hospitals about billing requirements, and to clarify a rule covering the billing of laboratory services. In addition, OMAP

⁹ OAR 410-125-165

¹⁰ OAR 410-120-1200

should consider revising its time limit on short stays, establishing payment limits on ambulatory surgery at large hospitals, and adding a field for the discharge time when its automated payment system is enhanced or replaced.

OMAP Can Improve the Effectiveness of the Billing Review Process

OMAP contracts with the Oregon Medical Professional Review Organization (OMPRO) to provide both prior authorization services and post payment reviews of hospital inpatient services. OMPRO is a private, non-profit, physician-sponsored organization. During the course of our audit, we found that OMAP could improve its management and oversight of its contract with OMPRO. First, OMAP should modify its contract with OMPRO to ensure that reviews are better targeted in higher risk areas. In addition, OMAP should ensure that the quality of OMPRO's medical coding review meets minimum standards. Finally, OMAP should ensure that it promptly initiates payment adjustments in response to OMPRO determinations. Delays in initiating the adjustment process result in both monetary losses and a waste of resources.

Federal regulations mandate post payment reviews of hospital services as part of the Medicaid program. To fulfill this requirement, OMAP contracts with OMPRO to provide that service. Reviews include the following elements: appropriateness of admission, medical necessity of procedures performed and lengths of stay, validation of DRG assignments, validation of admission coding for services requiring prior authorization, and quality of care screening. OMPRO conducts their review and reports their results to OMAP for action. These results include cases that require payment adjustments or denial of a claim in total.

Payment adjustments are required when it is determined that an inpatient admission should have been billed as an outpatient service or that the DRG paid for an inpatient admission was incorrect as a result of miscoding a diagnosis or procedure. A claim would be denied in total if the hospital did not obtain the required advance authorization for certain services or the services provided were not medically necessary.

To make a payment adjustment, the original payment is usually reversed in total and then must be resubmitted by the hospital as directed by OMPRO. In cases of denial, no resubmission should occur.

Focus Can Be Improved

Targeting high-risk areas could improve the effectiveness of the reviews.

OMAP should modify its contract for post payment reviews to ensure that the reviews are better focused. The case selection criteria have been substantially unchanged in recent years. Targeting high-risk areas could improve the effectiveness of these reviews.

In the area of psychiatric cases, OMPRO has continued to target this area, even though its own results have found that this is a low-risk area. OMPRO has reviewed 100 percent of certain psychiatric cases since at least 1996. These reviews accounted for half of all of the reviews done by OMPRO in 1997. A review of recent results shows that OMPRO has found few problems in this area. During the last six months of 1997, OMPRO reviewed 652 of these cases and determined that only six cases (less than 1 percent) had problems requiring a payment adjustment.

The results of OMPRO's reviews of psychiatric cases should be contrasted with its results of more targeted reviews. For example, during the last six months of 1997, OMPRO reviewed 379 cases involving hospital stays of one and two days. These reviews resulted in 32 cases (8 percent) requiring a payment adjustment, including two denials. In addition to the psychiatric and one and two day stay cases, OMPRO also reviewed cases selected randomly and 100 percent of DRG 468 "Extensive Operating Room Procedure Unrelated to the Principal Diagnosis." Figure 4 presents the results for the cases reviewed by OMPRO for the final six months of 1997.

Figure 4
OMPRO's Post Payment Review Results for July-December 1997

Cases Reviewed	Selection Reason				TOTAL
	Random	Psychiatric	1 & 2 Day Stays	DRG 468	
Quarter 3 1997	49	435	264	12	760
Quarter 4 1997	215	217	115	9	556
Total cases reviewed	264	652	379	21	1316
Results					
Payment adjustments	11	6	32	0	49
As a percentage of cases reviewed	4.17%	0.92%	8.44%	0.00%	3.72%

Payment adjustments include all causes: DRG changes, denials for medical necessity or setting, cases that should have been billed as observation, and denials for cases lacking prior authorization

OMPRO's results should also be contrasted to our review of targeted areas we judged to be high risk. For example, during our on-site reviews, uncomplicated births with three-day hospital stays were reviewed at one hospital. Of eight such cases reviewed, we found three (38 percent) in which the last day of the stay was determined to be not medically necessary. Savings were about \$450 per case. During our DRG validation reviews we identified a surgery usually performed as ambulatory surgery. Of 23 uncomplicated inpatient procedures reviewed, it was determined that five (22 percent) could have been provided as ambulatory surgery, an outpatient service rather than an inpatient service. The average savings per case was \$835.

A recent review by the U. S. Department of Health and Human Services Office of Inspector General (OIG) supports the concept of targeting high-risk billings.¹¹ The OIG reviewed 2,622 inpatient Medicare claims from 70 hospitals and found that over 50 percent of the coding errors resulting in overpayments were concentrated in 10 DRGs.

¹¹ *Basis for Errors Among DRGs with the Highest Rates of Upcoding*, U.S. Department of Health and Human Services, Office of Inspector General, OEI-01-98-00421, March 23, 1999.

Targeting high-risk areas for review offers an opportunity to both educate providers and recover inappropriate payments.

Targeting high-risk areas for review offers an opportunity to both educate providers and recover inappropriate payments. Reviews in low-risk areas with few resulting findings waste the opportunity to identify and correct problem practices. Coding errors that result in higher payments and that are undetected may result in significant increased costs if these practices become standard because they were unchallenged by the contracted reviewer. For instance, in one case we reviewed, a code indicating insufficient prenatal care resulted in a higher payment for a cesarean section. Review indicated that this code was inappropriate. The difference in payment when the code was disallowed was about \$500. In another case, a newborn experienced transient respiratory distress, but the claim was coded for respiratory distress syndrome, a more severe condition. The payment difference for this error was about \$14,000.

Post payment reviews of hospital claims for outpatient services are not being performed. The contracted post payment reviews involve only inpatient claims; OMAP's Medicaid provider audit group has not been auditing hospital billings. We found problems in this area such as the billing for short stays, respiratory therapy, and laboratory work as discussed in the Short Stay Billing Problems (page 8) and Cost Reimbursement Billing Problems (page 9) sections.

RECOMMENDATIONS

We recommend that OMAP more actively manage its post payment review contract. OMAP should actively participate in identifying and changing the criteria used to select the cases to be reviewed to ensure that high-risk issues are adequately covered. Results should be regularly analyzed and appropriate changes to the selection criteria made as a result of that analysis. Areas that result in a low rate of payment adjustments should be de-emphasized while areas with higher rates of payment adjustments should receive increased emphasis. For example, the one and two day stay reviews resulted in payment adjustments for 8 percent of the cases reviewed by OMPRO during the last half of 1997; OMAP should consider expanding those reviews.

We also recommend that OMAP implement post payment reviews of hospital bills for outpatient services. This could be accomplished by adding these reviews to the current inpatient post payment review contract, contracting the reviews under a

separate contract, or having OMAP's Medicaid provider audit group perform the reviews.

Agency Response

OMAP will hold monthly meetings with the Contractor. The first meeting was June 8th. At that time, we directed the Contractor to redesign their sampling method to allow for a more focused review of hospital payments. The new sampling method includes the review of a greater number of one- and two-day inpatient stays. OMAP also requested some additional reports that will facilitate DRG assignment analysis of the claims. The Contractor and OMAP have also agreed to make some procedural changes that will result in a quicker recoupment of inappropriate payments. OMAP will continue to actively manage the contract, and will initiate improvements as dictated by our analysis of the data.

OMAP accepts the recommendation of the Secretary of State and will require a post payment review of outpatient hospital claims in the new Utilization Review contract.

Coding Validation Needs Improvement

OMAP relies on the contracted post payment reviews of inpatient billings from large hospitals to verify that the coding of diagnoses and procedures is proper. The verification consists of the contractor comparing the diagnoses and procedures coded on the billing with the medical records from hospitals. Incorrect coding can result in OMAP paying for the wrong DRG. OMAP needs to ensure that the contractor is performing the DRG validation portion of the post payment review contract adequately.

The billing review contractor found very few DRG miscodes.

OMPRO's 1997 case reviews, which included a DRG validation for each case selected, resulted in few DRG reassignments. OMPRO reviewed 3,004 cases and identified only 11 (0.4 percent) with the wrong DRG assigned as a result of coding an incorrect diagnosis or procedure. In contrast, our review of 401 DRG payments determined that 24 (6 percent) were paid for the wrong DRG (see page 8).

The quality of the OMPRO DRG validations also became an issue during the audit. As part of our audit, we referred 54 cases with questionable DRG coding to OMPRO for their review and determination. OMPRO determined that 12 cases were miscoded. We then had an independent accredited medical records

professional review the 42 cases that OMPRO concluded were properly coded. That expert determined that 16 of the 42 cases were miscoded. We presented these results with the expert's explanation to OMPRO and, after a re-review, OMPRO agreed with the expert on nine of the 16 cases. We then referred the remaining seven cases to a Clinical Data Abstraction Center (CDAC), an organization with expertise in coding. The CDAC determined that three of the seven cases were miscoded. In summary, OMPRO's initial determination was that 12 of our referred cases had incorrect DRGs; after a review by an independent expert, a re-review by OMPRO, and a review by the CDAC, the number of incorrect DRG assignments doubled to 24.

RECOMMENDATION

We recommend that OMAP consider incorporating a process in the contracted reviews to ensure that the DRG validations are performed adequately. One possibility is to have an independent medical coding expert or organization periodically revalidate some of the cases reviewed by the contractor. OMAP, when analyzing the contracted post payment review results, should also question unusual results, for example OMPRO's determination that only 0.4 percent of the 1997 cases reviewed were paid for incorrect DRGs.

Agency Response

OMAP agrees with the Secretary of State's finding. We are requesting that OMPRO submit a corrective action plan which addresses this issue. It is OMAP's expectation that the Utilization Review contractor will maintain a method for validation of DRG assignment that reflects the industry's standard level of accuracy. OMAP of Medical Assistance Programs will be issuing a request for proposal for an Utilization Review (UR) contractor in late summer which will require that the UR contractor propose and incorporate a validation process in the DRG assignment review. OMAP will also require the UR contractor's medical coder meet stringent academic and experience requirements. OMAP will participate in the selection of DRG audit criteria.

Reversals Not Timely

OMAP is not making timely payment reversals when adjustments are

We found that OMAP is not making timely payment reversals when OMPRO identifies cases needing payment adjustments. These reversals are necessary before the hospitals can rebill and be properly paid as directed by OMPRO. At the time of our audit,

identified.

OMAP lacked policies and procedures for these adjustments and the process was not standardized. For 1997 claims reviewed, OMPRO reported to OMAP that payment reversals were required for 116 cases. Our review found that 22 percent of the reversals required in these cases were not made until July 1998, a delay of at least six months. Further, in 33 percent of the cases, reversals had not been made as of February 1999, a delay of at least a year, with six of those cases being denied in total by OMPRO. OMAP can recover \$25,100 by reversing these six cases.

Delays in processing reversals both slow and complicate the rebilling process. Payments are processed by the Medicaid Management Information System (MMIS) and most claims are submitted electronically. MMIS has edits and audits that must be passed before payment is made. One of these edits precludes payment if the claim is for outpatient care on the same date of service as inpatient care. If OMAP has not processed the reversal before a hospital rebills a claim that should have been outpatient rather than inpatient, the rebilling will be rejected by MMIS. Another edit denies payment if the date of service occurred more than twelve months earlier. When OMAP does not process reversals in a timely manner and hospitals rebill as directed by OMPRO, the claims will be rejected if it is more than one year since the date of service. In order for hospitals to be appropriately paid for these claims, they require special handling. Claims must be submitted on paper with supporting documentation rather than submitted electronically. We noted many instances in which multiple resubmissions were required before a correct payment was achieved. This wastes resources of both OMAP and hospitals.

RECOMMENDATION

We recommend that OMAP establish policies and procedures for processing OMPRO's recommended payment adjustments promptly and monitoring resubmissions of bills. These procedures and timeframes should be coordinated with the post payment review contractor and clearly communicated to the hospitals.

Agency Response

OMAP is currently addressing the issue of processing the Utilization Review contractor's recommended payment adjustments. OMAP has implemented a standardized UR recoupment process to ensure the systematic and timely

recoupment of inappropriate payments identified by the UR contractor. Policy and procedures are clearly defined, responsibilities described and timelines specified. OMAP will review the procedures and timelines with the current UR contractor in order to ensure hospitals are notified of appropriate claim resubmission procedures when applicable. As part of the recoupment process, the UR contractor will be required to develop a process for monitoring hospital claim payments to ensure that a hospital does not resubmit an inappropriate claim that has been previously recouped.

Hospitals Lack Knowledge of Certain Billing Requirements

OMAP does not routinely communicate with hospitals regarding billing issues.

While OMAP publishes a providers' guide for hospital services, it does not routinely communicate with hospitals regarding billing issues. During our audit we found that some hospitals lacked knowledge of certain billing requirements. We provided the regulations for billing respiratory therapy to two hospitals, at their request. In addition, management at one hospital stated that they were unaware of the rule that prohibits billing separately the individual components of certain sets of laboratory tests that are defined as a panel.¹² Our review also revealed two cases in which hospitals billed for excluded services provided to recipients in the custody of law enforcement agencies. Clarification of these and other issues could help reduce the incidence of misbillings.

RECOMMENDATION

We recommend that OMAP consider implementing an outreach effort to better educate providers about hospital billing issues. OMAP could establish a newsletter, published either in print or online, aimed specifically at hospital providers and billing issues. This newsletter would provide a forum for information about OMAP's billing requirements. A primary source of topics for the newsletter would be problems revealed in the post payment reviews of hospital billings.

Agency Response

OMAP will issue quarterly updates on policy and billing issues on the OMAP web site. If OMAP determines additional updates are

¹² OAR 410-130-0680

necessary, OMAP agrees to issue updates more frequently. Billing issues will be identified through both the UR contractor review and OMAP's provider services unit. The hospitals will be notified of the new service by letter.

Differing Rules Create Confusion for Short Stays

As noted on page 9, we found that nine of 81 outpatient billings reviewed involved stays that exceeded 30 hours and should have been billed as inpatient claims. While OMAP limits outpatient status to 30 hours, Medicare allows up to 48 hours. This difference in requirements apparently contributes to the hospitals' incorrect billings for these stays.

RECOMMENDATION

We recommend that OMAP consider revising its limit for outpatient stays from 30 hours to 48 hours. This revision would bring OMAP's rule into conformity with the Medicare requirement and should reduce the frequency of incorrect billings for these stays.

Agency Response

OMAP will change its definition of outpatient hospital observation stay in conformity with Medicare's definition with the next Hospital Guide revision, scheduled for October 1, 1999.

Laboratory Tests Rule Needs Clarification

As we noted on page 10, we found problems with hospitals billing for laboratory tests. There are many billing codes for specific tests and groups of tests. Some of the groups of tests are defined as panels while others are not considered to be panels. Currently, a hospital can bill for a group of tests which costs more than the individual tests included in the group that were actually ordered.

RECOMMENDATION

We recommend that OMAP revise its rule covering the billing for laboratory tests to preclude the practice of billing for a group of tests rather than the individual tests ordered when the result is an increased payment by OMAP.

Agency Response

The language in the current regulations governing laboratory work will be revised.

Other Billing Issues that OMAP Should Consider

We noted that OMAP sometimes pays more for procedures performed as ambulatory surgery (an outpatient service) at large hospitals than the payment would have been for an inpatient admission using the DRG payment method. For instance, OMAP paid \$2,252 for outpatient surgery for a detached retina. The payment would have been \$1,845 for the resulting DRG for an inpatient admission to perform the surgery.

While performing our audit, we noted that OMAP payment system, MMIS, does not have a field for the time a recipient was discharged from the hospital. Even though the MMIS does have fields for the admission date and time and the discharge date, without a discharge time, a computer edit cannot be used to check for compliance with OMAP's time limit (currently 30 hours) for outpatient observation status.

RECOMMENDATION

We recommend that OMAP consider limiting payment for ambulatory surgery and similar outpatient services at large hospitals to the amount that would have been paid for an inpatient admission for the service.

Agency Response

In the design of the planned replacement MMIS, OMAP will consider limiting outpatient surgery payment to no more than the inpatient (DRG) payment for those same services if it is cost-effective to do so.

RECOMMENDATION

We recommend that future enhancements to or a replacement of MMIS include the capability of capturing both admission and discharge times for hospital in- and outpatient claims.

Agency Response

OMAP accepts the recommendation of the Secretary of State and will require the MMIS replacement to have the capability to capture admission and discharge hours.

Chapter 2: Cost Settlement Process Backlogged

OMAP has not remained current with its annual cost settlement process. There is a significant backlog of settlements waiting to be processed. The delay in processing settlements has resulted in lost potential earnings for the federal government, the state, and some hospitals. In addition, collection of funds owed OMAP may become more difficult as time passes and circumstances at individual hospitals change.

The cost settlement process involves four steps.

1. One year after the end of a hospital's fiscal year, OMAP produces a printout of all billings from and payments to the hospital for the fiscal year and sends it to the hospital.
2. Using this information, the hospital files a preliminary statement of costs with OMAP within 30 days.¹³
3. OMAP then waits until they receive a copy of the hospital's Medicare Cost Report. This report is Medicare's determination of reasonable costs for each hospital as calculated by Medicare Northwest for Oregon. (These reports are received between two and three years after the hospital's fiscal year end.)
4. Upon receipt of the Medicare Cost Report, OMAP revises the preliminary statement of costs and calculates the over- or underpayment for the hospital's fiscal year. OMAP then recovers the overpayments or pays the underpayments to the hospitals. At this time OMAP establishes a new interim rate that is used until the next settlement is completed.

Throughout the year, OMAP makes payments based on each hospital's interim rate (a percentage of the billed amount). The cost settlement process later adjusts the hospitals' payments to a percentage of hospitals' costs. Currently, there are 61 hospitals in the state subject to the cost settlement process. The 31 small hospitals receive full cost for covered services as directed by Oregon law. The 30 large hospitals receive 59 percent of their cost for covered outpatient services.

¹³ "Calculation of Reasonable Cost Statement" (form OMAP-42)

In recent years, the settlement process has resulted in significant recoveries by OMAP.

In recent years, this process has resulted in significant recoveries of net overpayments by OMAP. For example, the 26 settlements completed in 1997 resulted in a net recovery of \$2,863,000 and the 63 settlements completed in 1998 resulted in a net recovery of \$7,560,000. Figure 5 shows these settlement results for 1997 and 1998.

**Figure 5
Recent Cost Settlement Results**

	No. of Settlements Completed	Time Elapsed Between Receipt of Documentation and Completion	Dollars Recovered
1997	26	21 months	\$2,863,290
1998	63	26 months	\$7,559,520

Process Backlogged

A three-year backlog of settlements existed at the end of 1998.

The cost settlement process has a backlog of more than three years. As of December 1998, sufficient documentation was on hand to begin 154 settlements, for fiscal years back to 1993. Seven hospitals have not had a settlement completed since 1995. Twenty-six settlements were completed in 1997 and 63 were completed in 1998. The average time elapsed between OMAP's receipt of all necessary information and finalizing those settlements was 21 months in 1997 and 26 months in 1998. At the production rate of the last two years, it will take OMAP more than three years to complete the settlements which were ready for processing as of December 1998.

Cost of Backlog

We estimate the cost of the delay in processing the 1998 settlements is \$504,000.

There is a significant cost to the backlog. The cost settlement process can result in both additional payments to and recoveries from individual hospitals. However, the net result in recent years has been significant recoveries. As noted above, the settlements completed during 1998 resulted in a net recovery of \$7.5 million.

We estimate that the cost of OMAP's delay in processing the 1998 settlements is \$504,000. This estimate is based on interest that would have accrued at the average treasury bill rate from the time the 1998 settlements could have been processed (from receipt of the Medicare Cost Report).

Delay May Create Problems in Collecting Overpayments

Extended delays in processing settlements may increase the difficulty of collecting overpayments that are due to OMAP. For instance, Cottage Grove Hospital declared bankruptcy in August of 1998. As of December 1998, cost settlements had not been completed for the fiscal years ending after December 31, 1993. In another instance, cost settlements for the hospital in McMinnville have not been completed for periods after April 30, 1994. There have been two changes of ownership in the intervening period. The state could be at risk for any unsettled overpayments in these types of circumstances.

RECOMMENDATION

We recommend that OMAP evaluate its staffing for the hospital cost settlement process. Staffing should be sufficient to process the backlog of settlements and stay current thereafter. OMAP should consider hiring temporary staff or contracting out to process the settlement backlog.

Agency Response

OMAP has hired two additional hospital audit staff, and has reduced the backlog of hospital settlements by one-third. OMAP expects to continue making rapid progress in reducing the backlog. At the present time, OMAP does not believe it would be cost-effective to hire and train temporary staff or outsource the cost-settlement process.

Commendation

The courtesies and cooperation extended by the officials and staff at the Department of Human Resources Office of Medical Assistance Programs were commendable and much appreciated.

Audit Team

Drummond Kahn, MS, CGFM, Audit Administrator

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Appendix A: Large (DRG) Hospitals

<u>Hospital Name</u>	<u>Location</u>	<u>No. of Beds</u>
Albany General	Albany	106
Bay Area	Coos Bay	172
Douglas Community	Roseburg	118
Eastmoreland	Portland	100
Holy Rosary	Ontario	92
Kaiser Foundation Sunnyside	Clackamas	196
Legacy Emanuel	Portland	554
Legacy Good Samaritan Corvallis	Corvallis	188
Legacy Good Samaritan Portland	Portland	539
Legacy Meridian Park	Tualatin	150
Legacy Mt. Hood Medical Center	Gresham	115
McKenzie Willamette	Springfield	114
Mercy Medical Center	Roseburg	111
Merle West	Klamath Falls	176
OHSU	Portland	509
Portland Adventist	Portland	302
Providence Medford	Medford	168
Providence Milwaukie	Milwaukie	56
Providence Portland	Portland	483
Providence St. Vincent	Portland	451
Rogue Valley Medical Center	Medford	305
Sacred Heart	Eugene	432
Saint Charles	Bend	181
Salem	Salem	406
Three Rivers – Dimmick St.	Grants Pass	87
Three Rivers – Washington St.	Grants Pass	63
Tuality Community	Hillsboro	167
Willamette Falls	Oregon City	143
Willamette Valley Medical Center	McMinnville	80
Woodland Park	Portland	209

Appendix B: Small (Type A and B Rural) Hospitals

<u>Hospital Name</u>	<u>Location</u>	<u>No. of Beds</u>	<u>Type</u>
Blue Mountain	John Day	39	A
Curry General	Gold Beach	24	A
Good Shepherd	Hermiston	49	A
Grande Ronde	LaGrande	49	A
Harney County	Burns	44	A
Lake District	Lakeview	21	A
Pioneer Memorial – Heppner	Heppner	12	A
Saint Anthony	Umatilla	49	A
Saint Elizabeth	Baker City	36	A
Tillamook General	Tillamook	49	A
Wallowa Memorial	Enterprise	33	A
Ashland	Ashland	49	B
Central Oregon District	Redmond	48	B
Columbia Memorial	Astoria	49	B
Coquille Valley	Coquille	30	B
Hood River Memorial	Hood River	32	B
Lebanon Community/Mid-Valley	Lebanon	49	B
Lower Umpqua	Reedsport	21	B
Mid-Columbia	The Dalles	49	B
Mountain View	Madras	36	B
North Lincoln	Lincoln City	37	B
Pacific Communities	Newport	48	B
Peace Harbor	Florence	21	B
Pioneer Memorial – Prineville	Prineville	35	B
Providence Newberg	Newberg	35	B
Providence Seaside	Seaside	34	B
Santiam Memorial	Stayton	40	B
Silverton	Silverton	38	B
Southern Coos	Bandon	24	B
Tuality Forest Grove	Forest Grove	48	B
Valley Community	Dallas	44	B

AGENCY'S RESPONSE TO THE AUDIT REPORT



Oregon

John A. Kitzhaber, M.D., Governor

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July 22, 1999

Cathy Pollino
Deputy Director
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255 Capitol Street NE
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Dear Ms. Pollino:

This letter is in response to the Secretary of State report on the audit of the Office of Medical Assistance Programs (OMAP) Hospital Billings. OMAP generally agrees with the findings and recommendations of the Secretary of State. Our specific comments are found throughout the report in the applicable sections.

In addition, we offer the following comment. In reviewing hospital claims from 1997, the auditors found that the last day of a three-day hospital stay for uncomplicated births was medically unnecessary in several of the reviewed claims. Subsequent to 1997, federal law now allows up to 48 hours of hospital coverage following an uncomplicated delivery. Therefore, current federal law requires OMAP to pay for the third day for most uncomplicated births.

OMAP appreciates the courtesy and high level of professionalism demonstrated by Gary Fredricks, Darcy Johnson, Drummond Kahn, and Karen Leppin in the performance of this audit.

Sincerely,

Hersh Crawford
Director, Office of Medical Assistance Programs

Assisting People to Become Independent, Healthy and Safe
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HRB 1014 (3/98)

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