APR 2 1 2009

**TO:** Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

**FROM:** Joseph E. Vengrin
Deputy Inspector General for Audit Services

**SUBJECT:** Review of Emergency Health Services at Florida Hospital Furnished to Undocumented Aliens Covered by Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (A-04-06-07007)

Attached is an advance copy of our final report on emergency health services at Florida Hospital furnished to undocumented aliens covered by section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). We will issue this report to Florida Hospital within 5 business days.

Section 1011 of the MMA, "Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens" (section 1011), provided $250 million per year for fiscal years 2005 through 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens pursuant to Emergency Medical Treatment and Labor Act (EMTALA) requirements. Under EMTALA, a Medicare-participating hospital is to provide an appropriate medical screening examination to any person, regardless of ability to pay, who comes to the hospital emergency department to determine whether an emergency medical condition (EMC) exists. If the examination reveals an EMC, the hospital must also provide either treatment necessary to stabilize the EMC or an appropriate transfer to another medical facility. Florida Hospital's designated section 1011 program contractor was TrailBlazer Health Enterprises, LLC (TrailBlazer).

Our objective was to determine whether claims submitted by Florida Hospital for services provided under section 1011 for the period May 10 through September 30, 2005, were submitted on behalf of individuals who met eligibility requirements, were for eligible services, and were adequately supported and not reimbursed from other sources as required by Federal regulations.

We selected for review a judgmental sample of 31 claims totaling $116,049 that Florida Hospital submitted for payment for the period May 10 through September 30, 2005. In total, Florida Hospital received $198,342 for 82 claims for that period.

Of the 31 sampled claims, 7 claims totaling $23,126 met section 1011 requirements and were eligible for section 1011 program reimbursement. The 24 remaining claims totaling $92,923 were either partially or completely unallowable for section 1011 program reimbursement. As a result, Florida Hospital received $67,200 in unallowable payments. The unallowable payments occurred because Florida Hospital did not always follow its own policies and procedures for ensuring that treatments were for EMCs and that medical records contained sufficient documentation to support the eligibility of the patients and that the services had been provided. Furthermore, Florida Hospital's written policies and procedures did not address section 1011 requirements limiting coverage of services up to the point of patient stabilization.

We recommend that Florida Hospital:

- refund to TrailBlazer $67,200 for services that did not meet section 1011 reimbursement requirements;

- review the 51 remaining claims for our audit period, totaling $82,293, and claims for subsequent periods and submit adjustments for any claims that did not meet section 1011 reimbursement requirements;

- follow its existing policies and procedures to ensure that future section 1011 program claims meet section 1011 reimbursement requirements; and

- develop and implement procedures to ensure that section 1011 program claims are for covered services up to the point of stabilization rather than through the patients' entire hospital stays.

In written comments on our draft report, Florida Hospital did not directly comment on the first three of our four recommendations. Regarding the fourth recommendation, the hospital said that it had modified its internal processes and would ensure that all future claims are not billed past the point of stabilization. The hospital disagreed with some findings but did not provide any documentation with its written comments. In addition, Florida Hospital stated that it had made modifications in its process to ensure that claims under section 1011 reimbursement met the specific guidelines.

We reviewed Florida Hospital's comments, but nothing we reviewed caused us to revise our findings or recommendations.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through e-mail at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-06-07007.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

APR 27 2009

Report Number: A-04-06-07007

Mr. Coy L. Ingram
Director, Patient Financial Services
Florida Hospital
601 East Rollins Street
Orlando, Florida 32803

Dear Mr. Ingram:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Emergency Health Services at Florida Hospital Furnished to Undocumented Aliens Covered by Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Andrew A. Funtal, Audit Manager, at (404) 562-7762 or through e-mail at Andrew.Funtal@oig.hhs.gov. Please refer to report number A-04-06-07007 in all correspondence.

Sincerely,

Peter J. Barbera

Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosure

**Direct Reply to HHS Action Official**:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri  64106

Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# REVIEW OF EMERGENCY HEALTH SERVICES AT FLORIDA HOSPITAL FURNISHED TO UNDOCUMENTED ALIENS COVERED BY SECTION 1011 OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

Daniel R. Levinson
Inspector General

April 2009
A-04-06-07007

# *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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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

## OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## EXECUTIVE SUMMARY

### BACKGROUND

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Social Security Act impose specific obligations on Medicare-participating hospitals that offer emergency services. Section 1867 is frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA). Congress enacted EMTALA in 1986 because of its concerns with an increasing number of reports that hospital emergency rooms were refusing to accept or treat individuals with emergency conditions if the individual did not have insurance. Under EMTALA, a Medicare-participating hospital is to provide an appropriate medical screening examination to any person, regardless of ability to pay, who comes to the hospital emergency department "to determine whether or not an emergency medical condition [(EMC)] . . . exists" (section 1867(a)). If the examination reveals an EMC, the hospital must also provide either treatment necessary to stabilize the EMC or an appropriate transfer to another medical facility.

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. No. 108-173) (MMA). Section 1011 of the MMA, "Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens" (section 1011), provided $250 million per year for fiscal years 2005 through 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens pursuant to EMTALA requirements.

Located in Orlando, Florida, Florida Hospital is a Medicare-participating hospital that also participates in the section 1011 program. Florida Hospital belongs to the Adventist Health System. With the assistance of the designated section 1011 program contractor, TrailBlazer Health Enterprises, LLC (TrailBlazer), we reviewed 31 judgmentally selected claims totaling $116,049 Florida Hospital submitted for payment for the period May 10 through September 30, 2005. In total, Florida Hospital received $198,342 for 82 claims for that period.

### OBJECTIVE

Our objective was to determine whether claims submitted by Florida Hospital for services provided under section 1011 for the period May 10 through September 30, 2005, were submitted on behalf of individuals who met eligibility requirements, were for eligible services, and were adequately supported and not reimbursed from other sources as required by Federal regulations.

### SUMMARY OF FINDINGS

From a sample of 31 Florida Hospital claims totaling $116,049, we found that 24 claims totaling $92,923 were either partially or completely unallowable for section 1011 program reimbursement. As a result, Florida hospital received $67,200 in unallowable payments. The 24 claims did not meet section 1011 program reimbursement requirements because:

- Nine claims totaling $43,750 were for non-EMCs beyond initial screening by the hospital or for services that should have been excluded as having been for nonemergent conditions.

- Four claims totaling $12,055 were for services provided beyond the point of patient stabilization.

- Ten claims totaling $11,353 did not have sufficient documentation to support the patient's eligibility determination.

- One claim totaling $42 did not have sufficient documentation in the medical record to support the services provided.

The seven remaining claims totaling $23,126 met section 1011 requirements and were eligible for section 1011 program reimbursement.

Although Florida Hospital had written policies and procedures that, if followed, might have precluded some of the errors identified, Florida Hospital did not always follow its own policies and procedures for ensuring that services were provided pursuant to section 1011 reimbursement requirements. Furthermore, Florida Hospital's written policies and procedures did not address section 1011 requirements limiting coverage of services up to the point of stabilization. Although the medical records documented when patients became stable during the EMC treatment process, Florida Hospital did not establish procedures to use the point of stabilization as the last day of covered services. Florida Hospital staff stated that they did not know that services covered by section 1011 end at the point of stabilization. Florida Hospital routinely submitted claims for the entire hospital stay.

## RECOMMENDATIONS

We recommend that Florida Hospital:

- refund to TrailBlazer $67,200 for services that did not meet section 1011 reimbursement requirements;

- review the 51 remaining claims for our audit period, totaling $82,293, and claims for subsequent periods and submit adjustments for any claims that did not meet section 1011 reimbursement requirements;

- follow its existing policies and procedures to ensure that future section 1011 program claims meet section 1011 reimbursement requirements; and

- develop and implement procedures to ensure that section 1011 program claims are for covered services up to the point of stabilization rather than through the patients' entire hospital stays.

## FLORIDA HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Florida Hospital did not directly comment on the first three of our four recommendations. Regarding the fourth recommendation, the hospital said that it had modified its internal processes and would ensure that all future claims are not billed past

the point of stabilization. The hospital disagreed with some findings but did not provide any documentation with its written comments. In addition, Florida Hospital stated that it had made modifications in its process to ensure that claims under section 1011 reimbursement met the specific guidelines.

We reviewed Florida Hospital's comments, but nothing we reviewed caused us to revise our findings or recommendations. Florida Hospital's comments appear in their entirety as the Appendix.

## TABLE OF CONTENTS

# INTRODUCTION

## BACKGROUND

### Emergency Medical Treatment and Labor Act

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Social Security Act[1] (the Act) impose specific obligations on Medicare-participating hospitals that offer emergency services. Section 1867 is frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA). Congress enacted EMTALA in 1986 because of its concerns with an increasing number of reports that hospital emergency rooms were refusing to accept or treat individuals with emergency conditions if the individuals did not have insurance. Under EMTALA, a Medicare-participating hospital is to provide an appropriate medical screening examination to any person, regardless of ability to pay, who comes to the hospital emergency department "to determine whether or not an emergency medical condition [(EMC)]. . . exists" (section 1867(a)). If the examination reveals an EMC, the hospital must also provide either treatment necessary to stabilize the EMC or an appropriate transfer to another medical facility.

### Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P. L. No. 108-173)[2] (MMA). Section 1011 of the MMA, "Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens" (section 1011), provided $250 million per year for fiscal years (FY) 2005 through 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens pursuant to EMTALA requirements. Two-thirds of the funds was divided among all 50 States and the District of Columbia based on their relative percentages of undocumented aliens. One-third was divided among the six States with the largest number of undocumented alien apprehensions for each FY.[3] From the respective State allotments, payments were made directly to hospitals, certain physicians, and ambulance providers using Medicare payment rules to calculate the payment amount for some or all of the costs of providing eligible individuals with emergency health care required under section 1867 of the Act and related hospital inpatient, outpatient, and ambulance services.

Payments could be made for services furnished to certain individuals described in section 1011 of the MMA as (1) undocumented aliens, (2) aliens who have been paroled into the United States at a U.S. port of entry for the purpose of receiving eligible services, and (3) Mexican citizens

[1] 42 U.S.C. §§ 1866(a)(1)(I), 1866(a)(1)(N), and 1867.

[2] The Act, § 1860D-1(a), 42 U.S.C. § 1395w-101(a).

[3] The numbers of undocumented alien apprehensions were determined using the four consecutive quarters ending before the beginning of the FY for which information is available. For FY 2005, the numbers from the period April 1, 2003, to March 31, 2004, were used. During that period, data from the Department of Homeland Security indicated that the six States with the largest number of undocumented alien apprehensions were Arizona, California, Florida, New Mexico, New York, and Texas.

permitted to enter the United States under the authority of a biometric, machine-readable, border-crossing identification card (also referred to as a "laser visa").[4]

### TrailBlazer Health Enterprises

The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, designated TrailBlazer Health Enterprises, LLC (TrailBlazer), as the national processing and compliance contractor for the section 1011 program. TrailBlazer enrolls eligible providers, assists with enrollment and billing questions, and calculates provider payment amounts. In addition, TrailBlazer conducts prepayment or postpayment claim reviews, identifies and assesses overpayments if necessary, and ensures compliance with section 1011.

### Florida Hospital

Located in Orlando, Florida, Florida Hospital is a Medicare-participating hospital that also participates in the section 1011 program. Florida Hospital belongs to the Adventist Health System.

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

Our objective was to determine whether claims submitted by Florida Hospital for services provided under section 1011 for the period May 10 through September 30, 2005, were submitted on behalf of individuals who met eligibility requirements, were for eligible services, and were adequately supported and not reimbursed from other sources as required by Federal regulations.

### Scope

Our review covered the period of May 10 through September 30, 2005. For this period, Florida Hospital received section 1011 program payments of $198,342 for 82 claims.

We limited our review of internal controls to obtaining an understanding of the procedures for implementing the section 1011 program.

We conducted fieldwork at TrailBlazer in Dallas, Texas, and at Florida Hospital in Orlando, Florida.

[4]According to 8 U.S.C. § 1011(a)(6) the term 'border crossing identification card' means a document of identity bearing that designation issued to an alien who is lawfully admitted for permanent residence, or to an alien who is a resident in foreign contiguous territory, by a consular officer or an immigration officer for the purpose of crossing over the borders between the United States and foreign contiguous territory in accordance with such conditions for its issuance and use as may be prescribed by regulations.

**Methodology**

To accomplish our objective, we:

- met with and maintained ongoing communications with TrailBlazer officials;
- reviewed applicable laws, regulations, and CMS guidelines regarding the section 1011 program;
- obtained and reviewed a listing of all emergency health claims submitted, approved, and paid under the section 1011 program during the audit period;
- obtained and reviewed a listing of all approved section 1011 program providers;
- selected for our review a judgmental sample of 31 section 1011 program claims submitted by Florida Hospital;
- interviewed Florida Hospital officials to obtain an understanding of the policies, procedures, and controls relating to the section 1011 program;
- obtained and reviewed the medical records and other documentation associated with the selected claims;
- requested TrailBlazer to perform a review of the medical and nonmedical documentation associated with the selected claims to determine whether:
    - claims were made on behalf of individuals who met eligibility criteria,
    - claims were for services that met the definition of emergency health services,
    - claims were for services provided during the patient's stabilization period,
    - claims were made for properly supported services, and
    - providers exercised due diligence in ensuring that section 1011 program payments were the payments of last resort; and
- requested that TrailBlazer quantify any overpayments.

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

## FINDINGS AND RECOMMENDATIONS

From a sample of 31 Florida Hospital claims totaling $116,049, we found that 24 claims totaling $92,923 were either partially or completely unallowable for section 1011 program reimbursement. As a result, Florida hospital received $67,200 in unallowable payments. The 24 claims did not meet section 1011 program reimbursement requirements because:

- Nine claims totaling $43,750 were for non-EMCs beyond initial screening by the hospital or for services that should have been excluded as having been for nonemergent conditions.

- Four claims totaling $12,055 were for services provided beyond the point of patient stabilization.

- Ten claims totaling $11,353 did not have sufficient documentation to support the patient's eligibility determination.

- One claim totaling $42 did not have sufficient documentation in the medical record to support the services provided.

The seven remaining claims totaling $23,126 met section 1011 requirements and were eligible for section 1011 program reimbursement.

Although Florida Hospital had written policies and procedures that, if followed, might have precluded some of the errors identified, Florida Hospital did not always follow its own policies and procedures for ensuring that services were provided pursuant to section 1011 reimbursement requirements. Furthermore, Florida Hospital's written policies and procedures did not address section 1011 requirements limiting coverage of services up to the point of stabilization. Although the medical records documented when patients became stable during the EMC treatment process, Florida Hospital did not establish procedures to use the point of stabilization as the last day of covered services. Florida Hospital staff stated that they did not know that services covered by section 1011 end at the point of stabilization. Florida Hospital routinely submitted claims for the entire hospital stay.

## FEDERAL REQUIREMENTS

Section 1011 of the MMA sets forth the requirements governing Federal reimbursement of emergency health services furnished to undocumented aliens. CMS issued as additional guidance a final implementation notice delineating CMS's section 1011 program implementation approach, general framework, procedural rules, and general statements of policy. In addition, 42 CFR § 482.24(b) and (c) establishes medical record requirements for hospitals. The requirements for each finding follow:

- **Eligible Services**—Section 1011(c)(4) states that "[p]ayments made to eligible providers . . . may only be used for costs incurred in providing eligible services to aliens." Paragraph (e)(2) of section 1011 defines eligible services as "health care

services required by the application of section 1867 of the . . . Act . . . and related hospital inpatient and outpatient services and ambulance services." Eligible health care services are described in section 1867 as those provided to treat emergency medical conditions, which are defined as:

> (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or
>
> (B) with respect to a pregnant woman who is having contractions—(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child [section 1867 (e)(1)].

- **Point of Stabilization**—Section VI of CMS's final implementation notice (70 Fed. Reg. 25,583 (May 13, 2005)) states that section 1011 program payments will be made for eligible services that begin when an individual arrives at the hospital emergency department and requests examination or treatment for a medical condition. If the hospital determines that the individual has an EMC, the hospital must either provide stabilizing treatment or transfer the individual. To be considered stable, a patient's EMC must be resolved, even though the underlying medical condition may persist.

- **Adequate Eligibility Documentation**—Section IX of CMS's final implementation notice (70 Fed. Reg. 25,587 (May 13, 2005)) states that because section 1011 program payments are authorized only for the three categories of noncitizens specified in section 1011(c)(5), providers are required to request, collect, and maintain information about the patient's eligibility. Although providers are not required to use the information collection instrument designed by CMS, they must collect and maintain all of the information contained in the approved information collection instrument. If a patient refuses to or is unable to provide proof of eligibility, the provider should not submit an individual claim for the services delivered to that patient.

- **Content of Medical Records**—Hospitals must maintain a medical record for each inpatient and outpatient (42 CFR § 482.24(b)) to ". . . justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services" (42 CFR § 482.24(c)). Records must document evidence of a physical examination, admitting diagnosis, results of all consultative evaluations of the patient, practitioners' orders, nursing notes, discharge summary, and final diagnosis, among other information (42 CFR § 482.24(c)(2)).

## UNMET FEDERAL REQUIREMENTS

Florida Hospital submitted 24 claims totaling $92,923 that were either partially or completely unallowable for section 1011 program reimbursement. As a result, the hospital received $67,200 in payments that did not meet section 1011 program reimbursement requirements during our audit period:

- For nine claims, the treatments provided were not for an EMC. We determined that either the patient did not require immediate medical attention beyond screening or the services in the submitted claims should have been excluded as having been for a nonemergent condition. Therefore, these nine claims did not meet the definition of an EMC as required by section 1011. For example, Florida Hospital submitted claims to the section 1011 program for four follow-up visits related to a previous EMC. The EMC was treated, and the patient was sent home on June 7, 2005, with doctor's instructions to come back every other day for follow-up treatment. The patient came back to the emergency department on June 9, June 11, June 13, and June 15, 2005, and received follow-up treatments. In other cases, Florida Hospital submitted a claim to the section 1011 program for services such as chemotherapy and intravenous therapy. Florida Hospital received $43,750 in unallowable payments for these nine claims.

- For four claims, Florida Hospital received section 1011 program funds for services provided after the patient was stabilized. For these four claims, we reviewed each patient's entire medical record and found that Florida Hospital provided treatment and stabilized the patient's EMC. However, Florida hospital did not follow section VI of CMS's final implementation notice because it submitted claims for the patient's entire stay instead of submitting claims for only the services provided through stabilization. Florida Hospital received $12,055 in unallowable payments for these four claims.

- For 10 claims, the documentation provided did not support the patient's eligibility determination. Florida Hospital screened individuals and collected supporting documentation as required by the section 1011 program requirements. However, for these 10 claims it did not collect and maintain the information required by the CMS-approved information collection instrument to support the patient's eligibility determination. Florida Hospital received $11,353 in unallowable payments for these 10 claims.

- For one claim, Florida Hospital submitted a claim for services that did not have adequate supporting documentation, such as progress notes, doctor's orders, emergency room records, and nursing notes, as required by 42 CFR § 482.24(b) and (c). Florida Hospital received $42 in unallowable payments for this claim.

## FLORIDA HOSPITAL POLICIES AND PROCEDURES

Although Florida Hospital had written policies and procedures that, if followed, might have precluded some of the errors identified, Florida Hospital did not always follow its own policies and procedures for ensuring that treatments were for EMCs and that medical records contained

sufficient documentation to support the eligibility of the patients and that the services had been provided.

Furthermore, Florida Hospital's written policies and procedures did not address section 1011 requirements limiting coverage of services up to the point of stabilization. Although the medical records documented when patients became stable during the EMC treatment process, Florida Hospital did not establish procedures to use the point of stabilization as the last day of covered services. Florida Hospital staff stated that they did not know that services covered by section 1011 end at the point of stabilization. Florida Hospital routinely submitted claims to the section 1011 program for the entire hospital stay.

## RECOMMENDATIONS

We recommend that Florida Hospital:

- refund to TrailBlazer $67,200 for services that did not meet section 1011 reimbursement requirements;

- review the 51 remaining claims for our audit period, totaling $82,293, and claims for subsequent periods and submit adjustments for any claims that did not meet section 1011 reimbursement requirements;

- follow its existing policies and procedures to ensure that future section 1011 program claims meet section 1011 reimbursement requirements; and

- develop and implement procedures to ensure that section 1011 program claims are for covered services up to the point of stabilization rather than through the patients' entire hospital stays.

## FLORIDA HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Florida Hospital did not directly comment on the first three of our four recommendations. Regarding the fourth recommendation, the hospital said that it had modified its internal processes and would ensure that all future claims are not billed past the point of stabilization. The hospital disagreed with some findings but did not provide any documentation with its written comments. In addition, Florida Hospital stated that it had made modifications in its process to ensure that claims under section 1011 reimbursement met the specific guidelines.

We reviewed Florida Hospital's comments, but nothing we reviewed caused us to revise our findings or recommendations. Florida Hospital's comments appear in their entirety as the Appendix.

# APPENDIX

FLORIDA HOSPITAL
601 East Rollins Street
Orlando, FL 32803

November 26, 2008

Peter J. Barbera
Regional Inspector General
Office of Audit Services
Department of Health and Human Services
Region IV
61 Forsyth Street, SW Suite# 3T41
Atlanta, GA 30303

RE: Report Number: A-04-06-07007

Dear Mr. Barbera:

This letter is in response to your letter dated September 8, 2008 in regards to the draft report that included a review of our claims under section 1011 for the period of May 10 through September 30, 2005. Through our additional review of the eleven claims, we have found four claims that we have supporting information that should meet the guidelines under Section 1011.

Below, here's what our findings indicated based upon the line number reflected on the original spreadsheet submitted by Aner Sanchez:

For lines 4 – 6, we agree with the assessment done by review. We have modified our internally processes and will ensure all future claims are not billed past the point of stabilization.

For line 7, we agree with the assessment done by review. We have modified our internally processes and will ensure all future claims for outpatient chemotherapy are not billed for reimbursement.

For line 9, we disagree as our notes indicated the patient was from the Bahamas and she was illegally here in the U.S.

For line 15, we agree with the assessment done by review. We have modified our internally processes and will ensure all future claims are not billed past the point of stabilization.

For line 18, we disagree as this patient had a visit back in 2004 and we submitted our claim under Section 1011 for reimbursement. With this information in mind, this claim should be covered. We originally applied for EMA Medicaid, but the patient was denied and it is our understanding Section 1011 could be considered after Medicaid has been exhausted.

For line 19, we agree with the assessment done by review. We have modified our internally processes and will ensure all future claims for outpatient chemotherapy are not billed for reimbursement.

For line 21, we agree with the assessment done by review. We have modified our internally processes and will ensure all future claims for outpatient chemotherapy are not billed for reimbursement. With regards to the May 2005 visit, the admission was covered under EMA Medicaid as the patient's medical condition met the guidelines under the Office of Disability Determination with the Dept of Children and Families and this condition was not identified and confirmed on the May 2005 visit.

For lines 24, 26, 27, 29, and 37 we agree with the assessment done by review. We have modified our internally processes and will ensure all future claims are not billed.

For line 45, we disagree as this patient received services due to an OB delivery. For patients who present in the ER and they are pregnant, they are referred directly to the OB unit and this would constitute an emergency as the patient gave birth to a child.

For lines 53 and 54, we agree with the assessment done by review. We have modified our internally processes and will ensure all future claims for outpatient chemotherapy are not billed for reimbursement

For lines 64 and 65, we disagree as we found adequate documentation that supports our position on seeking reimbursement under Section 1011. In addition, we found another date of service from 9/4/05 – 9/7/05.

For line 70, we disagree as we found the rules and regulations are ambiguous as the patient presented for delivery, but she did not give birth. We applied her inpatient hospitalization through Medicaid EMA, but the outpatient claims were not submitted. With this in mind, we find the provisions for Section 1011 are not specific.

For lines 74 – 76 and 79, we agree with the assessment done by review. We have modified our internally processes and will ensure all future claims for outpatient visits are not billed for reimbursement.

We appreciated the opportunity to review these claims one more time prior to finalizing the position on this matter. I would like to request for consideration to be given on OB services or have CMS provide specific regulation on how these types of cases to allow proper handling for claims going forward. As stated earlier, we have made modifications in our process going forward to ensure we are forward claims under Section 1011 reimbursement that meet the specific guidelines.

If you have any further questions or comments in regards to this matter, please contact my office at (407)200-2307.

Sincerely,

Coy L. Ingram
Director
Patient Financial Services