Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# MEDICARE HOSPITAL PROVIDER COMPLIANCE AUDIT: JEWISH HOSPITAL

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**Report in Brief**
Date: August 2021
Report No. A-04-19-08077

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

# Medicare Hospital Provider Compliance Audit: Jewish Hospital

## Why OIG Did This Audit

This audit is part of a series of hospital compliance audits. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2018, Medicare paid hospitals $179 billion, which represents 47 percent of all fee-for-service payments for the year.

Our objective was to determine whether Jewish Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

## How OIG Did This Audit

Our audit covered about $43 million in Medicare payments to the Hospital for 2,453 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 85 inpatient and 15 outpatient claims with payments totaling $4.9 million for our 2-year audit period (January 1, 2017, through December 31, 2018).

We focused our audit on the risk areas that we identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements.

## What OIG Found

The Hospital complied with Medicare billing requirements for 62 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 38 claims, resulting in overpayments of $705,976 for the audit period. Specifically, 34 inpatient claims and 4 outpatient claims had billing errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $13.5 million for the audit period.

## What OIG Recommends and Hospital Comments

We recommend that the Hospital: (1) refund to the Medicare contractor $13.5 million in estimated overpayments for the audit period for claims that it incorrectly billed; (2) exercise reasonable diligence to identify, report, and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule; and (3) strengthen controls to ensure full compliance with Medicare requirements. The detailed recommendations are listed in the body of the report.

In written comments on our draft report, the Hospital disagreed with almost all of our findings and recommendations. The Hospital disagreed with the inpatient rehabilitation facility claims that we found to be in error and with some of the other errors identified in this report. In addition, the Hospital disagreed with our medical review contractor and extrapolation.

After review and consideration of the Hospital's comments, we maintain that our findings and recommendations are correct. We submitted the claims selected for review to an independent medical review contractor that reviewed the medical records in their entirety to determine whether the services were medically necessary and provided in accordance with Medicare coverage and documentation requirements. The use of statistical sampling to determine overpayment amounts in Medicare is well established and has repeatedly been upheld on appeal in Federal courts.

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# INTRODUCTION

## WHY WE DID THIS AUDIT

This audit is part of a series of hospital compliance audits. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2018, Medicare paid hospitals $179 billion, which represents 47 percent of all fee-for-service payments; accordingly, it is important to ensure that hospital payments comply with requirements.

## OBJECTIVE

Our objective was to determine whether Jewish Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

## BACKGROUND

### The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS uses Medicare contractors to, among other things, process and pay claims submitted by hospitals.

### Hospital Inpatient Prospective Payment System

Under the inpatient prospective payment system, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

### Hospital Inpatient Rehabilitation Facility Prospective Payment System

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for inpatient rehabilitation facilities. CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the payment system, CMS established a Federal

prospective payment rate for each of the distinct case-mix groups (CMGs). The assignment to a CMG is based on the beneficiary's clinical characteristics and expected resource needs.

**Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.[1] All services and items within an APC group are comparable clinically and require comparable resources.

**Hospital Claims at Risk for Incorrect Billing**

Previous Office of Inspector General (OIG) audits at other hospitals identified types of claims at risk for noncompliance. Out of the areas identified as being at risk, we focused our audit on the following:

- inpatient rehabilitation facility claims,
- inpatient claims billed with DRG codes that have high Comprehensive Error Rate Testing (CERT) error rates
- inpatient high-severity level DRG codes,
- inpatient mechanical ventilation,
- inpatient same day discharge and readmit,
- inpatient claims paid in excess of charges,
- inpatient claims paid in excess of $25,000,
- outpatient bypass modifiers,
- outpatient claims paid in excess of $25,000,
- outpatient claims paid in excess of charges,

[1] The health care industry uses HCPCS codes to standardize coding for medical procedures, services, products, and supplies.

- outpatient skilled nursing facility (SNF) consolidated billing, and

- outpatient home health agency (HHA) consolidated billing.

For the purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas." We reviewed these risk areas as part of this audit.[2]

**Medicare Requirements for Hospital Claims and Payments**

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§§ 1815(a) and 1833(e)).

Federal regulations state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

Claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)). The *Medicare Claims Processing Manual,* Pub. No. 100-04 (the Manual), chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23 § 20.3).[3]

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[4]

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[2] For purposes of selecting claims for medical review, CMS instructs its Medicare contractors to follow the "two-midnight presumption" in order not to focus their medical review efforts on stays spanning two or more midnights after formal inpatient admission in the absence of evidence of systemic gaming, abuse, or delays in the provision of care (*Medicare Program Integrity Manual*, ch. 6, § 6.5.2). We are not constrained by the two-midnight presumption in selecting claims for medical review.

[3] "Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS)" (42 CFR § 419.2(a)). Moreover, claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)).

[4] The Act § 1128J(d); 42 CFR §§ 401.301–401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claim determinations, submit amended cost reports, or use any other appropriate reporting process.[5]

**Jewish Hospital**

The Hospital is an 820-bed short-term, acute care, nonprofit hospital, located in Louisville, Kentucky.[6] According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately $326 million for 19,505 inpatient and 134,924 outpatient claims from January 1, 2017, through December 31, 2018 (audit period).

## HOW WE CONDUCTED THIS AUDIT

Our audit covered about $43 million in Medicare payments[7] to the Hospital for 2,453 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (85 inpatient and 15 outpatient) with payments totaling $4.9 million.[8] Medicare paid these 100 claims during our audit period.

We focused our audit on the risk areas identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted all claims to an independent medical review contractor to determine whether the claim was supported by the medical record. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

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

See Appendix A for the details of our scope and methodology.

[5] 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1, § 2931.2; and 81 Fed. Reg. at 7670.

[6] Jewish Hospital was sold on November 1, 2019, to the University of Louisville. Jewish Hospital was owned by KentuckyOne Health, Inc., during our audit period.

[7] The total Medicare payments were $42,977,698.

[8] The total paid was $4,912,247.

## FINDINGS

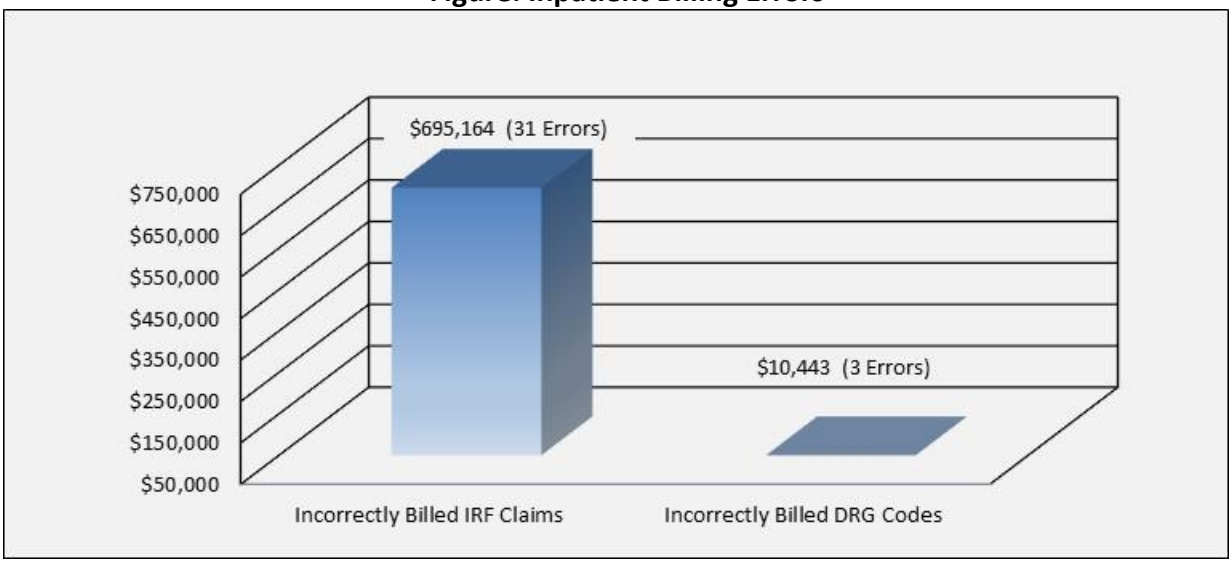
The Hospital complied with Medicare billing requirements for 62 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 38 claims, resulting in overpayments of $705,976 for the audit period. Specifically, 34 inpatient claims had billing errors resulting in overpayments of $705,607, and 4 outpatient claims had billing errors resulting in overpayments of $369. These errors occurred primarily because the Hospital did not have adequate internal controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $13,486,524 for the audit period.[9] As of the publication of this report, this amount included claims outside of the 4-year claim reopening period. See Appendix B for statistical sampling methodology, Appendix C for sample results and estimates, and Appendix D for the results of our audit by risk area.

### BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 34 of the 85 inpatient claims that we reviewed. These errors resulted in overpayments of $705,607, as shown in the Figure.

**Figure: Inpatient Billing Errors**




[9] To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

**Incorrectly Billed Inpatient Rehabilitation Facility Claims**

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act, § 1862(a)(1)(A)).

For an IRF claim to be considered reasonable and necessary, Federal regulations require that there be a reasonable expectation that, at the time of admission, the patient (1) requires the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; and (4) requires physician supervision by a rehabilitation physician (42 CFR § 412.622(a)(3)(i-iv)).[10]

For 31 of the 85 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation. IRF services for these beneficiaries were not reasonable and necessary because these beneficiaries did not require the active and ongoing therapeutic intervention of multiple therapy disciplines; generally did not require and could not reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; were not sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; or did not require supervision by a rehabilitation physician.

Our independent medical reviewer determined that there was insufficient medical documentation to support the medical necessity of the IRF admissions. The Hospital's quality management and quality assurance procedures controlling IRF admissions did not prevent this improper billing from occurring or subsequently detect these oversights.

Hospital officials did not provide a cause for these errors because they generally contended that these claims met Medicare requirements. However, Hospital officials did not provide any additional medical record documentation that would affect our finding.

Overpayments associated with the 31 claims that did not meet Medicare requirements totaled $695,164.

**Incorrectly Billed Diagnosis-Related Group Codes**

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(a)). DRG codes are assigned to specific hospital discharges

[10] 42 CFR § 412.622(a)(3)(iv) was amended effective October 1, 2018, to provide that the post-admission physician evaluation described in 42 CFR § 412.622(a)(4)(ii) may count as one of the face-to-face visits (83 Fed. Reg. 38514, 38573 (Aug. 6, 2018)).

based on claim data submitted by hospitals (42 CFR § 412.60(c)), so claim data must be accurate. Consequently, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 3 of the 85 selected inpatient claims, the Hospital submitted claims to Medicare that were incorrectly coded, resulting in incorrect DRG payments to the Hospital. Specifically, certain procedure or diagnosis codes were not supported by the medical records.

Our independent medical reviewer determined that the medical record did not contain documentation to support the coding of the patient's diagnoses and procedures used to substantiate the DRGs. The Hospital's training of coding staff in the proper use of procedure and diagnosis codes and its quality assurance over coding reviews did not prevent this improper billing from occurring or subsequently detect these oversights.

Hospital officials agreed with these errors but could not identify a cause because they no longer had access to the Hospital's documentation or processes because the Hospital was sold on November 1, 2019.

Overpayments associated with these 3 claims that did not meet Medicare requirements totaled $10,443.

**BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 4 of the 15 outpatient claims that we reviewed. These errors resulted in overpayments of $369.

**Incorrectly Billed Modifiers**

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§§ 1815(a) and 1833(e)). Claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)). Acute care hospitals are required to report HCPCS codes, of which CPT codes are a subset, on outpatient claims (the Manual, ch. 4, § 20.1),[11] and providers are required to complete claims accurately so that Medicare contractors may process them correctly and promptly (the Manual, ch. 1, § 80.3.2.2).

"The '59' modifier is used to indicate a distinct procedural service. This may represent a different session or patient encounter, different procedure or surgery, different site or organ

[11] "Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS)" (42 CFR § 419.2(a)).

system, separate incision/excision, or separate injury (or area of injury in extensive injuries)" (the Manual, ch. 23, § 20.9.1.1(B)).[12]

Effective January 1, 2015, CMS established four new HCPCS modifiers to define subsets of the "59" modifier. The four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services are: Modifier XE-Separate Encounter, Modifier XS-Separate Structure, Modifier XP-Separate Practitioner, and Modifier XU-Unusual Non-Overlapping Service. CMS will continue to recognize the "59" modifier, but providers should use one of the more descriptive modifiers when it is appropriate (Pub 100-20, "One Time Notification," Transmittal 1422 Aug. 15, 2014).

For 4 of 15 selected outpatient claims, the Hospital incorrectly billed Medicare Part B for HCPCS codes appended with the "59" or XU modifier that were not separate from other services or procedures billed on the same claim.

Our independent medical reviewer determined that the medical records did not contain documentation supporting that a distinct procedural service or an unusual non-overlapping service occurred that was separate from other services or procedures billed on the same claim. The Hospital's training of coding staff in the proper use of bypass modifiers and its quality management procedures for bypass modifiers did not prevent this improper billing from occurring or subsequently detect these oversights.

Hospital officials agreed with three of these errors and disagreed with the other. For the errors with which the Hospital agreed, Hospital officials could not identify a cause because they no longer had access to the Hospital's documentation or processes because the Hospital was sold on November 1, 2019. For the error with which the Hospital disagreed, Hospital officials did not provide a cause for this error because they generally contended that this claim met Medicare requirements. However, Hospital officials did not provide any additional information that would impact our finding.

Overpayments associate with these 4 claims that did not meet Medicare requirements totaled $369.

**OVERALL ESTIMATE OF OVERPAYMENTS**

The overpayments on the 38 sampled claims that did not fully comply with Medicare billing requirements totaled $705,976. On the basis of our sample results, we estimated that the Hospital received overpayments of at least $13,486,524 for the audit period.

[12] This manual provision was revised after our audit period by Change Request 10868, dated December 28, 2018, and effective January 30, 2019.

## RECOMMENDATIONS

We recommend that Jewish Hospital:

- refund to the Medicare contractor $13,486,524 in estimated overpayments for the audit period for claims that it incorrectly billed that are within the 4-year claim reopening period;[13]

- based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule [14] and identify any of those returned overpayments as having been made in accordance with this recommendation; and

- strengthen internal controls by:

    - strengthening procedures to verify that all IRF beneficiaries meet Medicare criteria for acute inpatient rehabilitation,

    - developing processes to ensure that procedure and diagnosis codes are supported in the medical records,

    - providing additional training to inpatient and outpatient coding staff on the use of bypass modifiers, and

    - developing procedures to verify that the use of bypass modifiers is supported in the medical records.

[13] OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

[14] This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

## HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital disagreed with almost all of our findings and recommendations.[15] We summarized the Hospital's agreements, disagreements, and objections below. After review and consideration of the Hospital's comments, we maintain that our findings and recommendations are correct.

### MEETING WITH OUR INDEPENDENT MEDICAL REVIEW CONTRACTOR

#### Hospital Comments

The Hospital stated that it engaged an independent reviewer to review each claim and both expected they would have discussions with our independent medical review contractor to better understand our positions and conclusions. The Hospital contended that the conclusions reached by our medical review contractor were based on a highly selective reading of the patient's medical records and stated that the meetings would have ensured that OIG's medical reviewer considered the entirety of medical records in making medical necessity determinations. The Hospital contends that if such a meeting took place, OIG's findings would be very different.

#### Office of Inspector General Response

We obtained an independent medical review to determine the medical necessity for all claims in our sample. We submitted the claims to our contractor, who reviewed the medical records in their entirety to determine whether the services were medically necessary and provided in accordance with Medicare coverage and documentation requirements. We worked with the medical reviewer to ensure that it applied the correct Medicare criteria and that it used professionals with appropriate medical expertise. Our medical reviewer considered the patient's entire clinical picture. We gave the Hospital numerous opportunities to submit additional documentation that it did not originally provide in response to the medical necessity determinations by our medical reviewer, but the Hospital provided no additional documentation. Although our contract with the independent medical reviewer does not allow for direct interaction between it and the Hospital, we tried to ensure that the contractor heard and considered the Hospital's opinions. Because the Hospital provided no new additional documentation, the reviewer's original determinations stand.

[15] KentuckyOne Health, Inc., the owner of the Hospital during our audit period, submitted written comments on behalf of the Hospital.

## INCORRECTLY BILLED INPATIENT REHABILITATION FACILITY CLAIMS

### Hospital Comments

For IRF claim denials, the Hospital stated that it disputed all 31 claims found to be in error and that it provided us with specific rebuttals for the errors we initially identified in each claim. The Hospital also contended that the conclusions we reached were based on a highly selective reading of parts of the patient's medical record, sometimes "extracting" only portions of sentences to support our findings. The Hospital also asserted that a reading of the full sentences within the complete medical record clearly establishes that each patient met the admission criteria. In addition, the Hospital stated that it does not believe that any of the 31 claims contained errors, and it did not intend to make any repayments, individually or based on our extrapolation. The Hospital further stated that when the MAC pursues recoupment, it intends to pursue all available administrative appeal rights.

### Office of Inspector General Response

We obtained an independent medical review to determine the medical necessity for all inpatient claims in our sample, including the 31 incorrectly billed IRF claims. We acknowledge that the Hospital provided specific rebuttals for the 31 IRF claims found to be in error. However, the Hospital's rebuttals were based on the medical records that it provided to us at the beginning of the audit. The Hospital has provided no additional documentation since then.

We disagree with the Hospital's contention that the conclusions our medical reviewer made were based on a highly selective reading of the patient's medical record. Our medical reviewer considered the full medical record in reaching the medical necessity determinations.

With respect to the Hospital's assertion that the 31 IRF claims did not contain errors and that it did not intend to make any repayments until it pursued all available appeal rights, our audit recommendations do not represent final determinations by Medicare. The Hospital has a right to appeal CMS overpayment determinations and does not need to return overpayments until after the second level of appeal.

## INCORRECTLY BILLED DIAGNOSTIC RELATED GROUP CODES AND OUTPATIENT BYPASS MODIFIERS

### Hospital Comments

For claims that included incorrect DRG codes, the Hospital stated that it agreed with our conclusion for the three claims and will initiate repayment in the amount of $10,443. The Hospital also stated that it agreed with three of the four claims that included incorrect outpatient bypass modifiers and disagreed with one. Regarding the three claims that included incorrect outpatient bypass modifiers, the Hospital said that it would initiate repayment of $313 for those three claims.

**Office of Inspector General Response**

For the one claim that included incorrect outpatient bypass modifiers in which the hospital disagreed with our conclusion, the Hospital did not provide any additional information that would impact our finding. Therefore, we continue to recommend repayment of this claim.

**EXTRAPOLATION**

**Hospital Comments**

The Hospital stated that it agreed with 6 of the 38 errors that we found. The Hospital also stated that the errors resulted in an overpayment of $10,756, which represented a financial error rate of less than 1 percent and a claim-based error rate of 6 percent. In addition, the Hospital stated that such a nominal rate was not suggestive of a systemic error requiring extrapolation. The Hospital contended that, under CMS's standards, medical reviewers are directed to extrapolate only in the event of a "sustained or high level payment error" rate, meaning 50 percent or more.[16] The Hospital also argued that this standard was not met because our claim-based error rate was 38 percent and the Hospital's financial error rate was 14 percent. The Hospital pointed out that the standard applies directly to Medicare review contractors but should not be ignored in the context of an OIG audit recommending extrapolation. Finally, the Hospital concluded that, because Medicare overpayments are at issue, the MAC that processes and demands any applicable overpayments at OIG's recommendations is subject to Federal law limiting the use of extrapolation to recover overpayments.[17]

The Hospital contended that extrapolation was equally unwarranted in the context of highly individualized issues related to medical necessity, particularly in the context of IRF claims. The Hospital also stated that all of the admission criteria must be applied to an individual beneficiary's medical condition and ability to tolerate intensive therapy.

In addition, the Hospital stated that we should remove any recommendations related to extrapolation until the MAC has made a determination regarding repayment and the Hospital has had the opportunity to challenge that determination through the appeal process.

**Office of Inspector General Response**

We disagree with the Hospital's contention that extrapolation was inappropriate because our claim-based error rate and financial error rate were too low. In addition, the Hospital is wrong in its conclusion that the MAC that processes the overpayments we recommended is subject to the requirement limiting the use of extrapolation in recovering overpayments. The

[16] *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.4.1.4; 42 U.S.C. § 1395ddd(f)(3).

[17] 42 U.S.C. § 1395ddd(f)(3).

requirement that a determination must be made of a sustained or high level of payment error before extrapolation applies only to extrapolations by Medicare contractors.[18] Moreover, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[19]

The Hospital is incorrect that extrapolation is equally unwarranted in the context of highly individualized issues related to medical necessity because the Hospital has the opportunity to challenge the medical necessity determinations and extrapolation on appeal. The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[20] We properly executed our statistical sampling methodology because we defined our sampling frame and sampling unit, selected a sample of claims at random from each stratum, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation. The statistical lower limit that we use for our recommended recovery represents a conservative estimate of the overpayment that we would have identified if we had reviewed each and every claim in the sampling frame. The conservative nature of our estimate is not changed by the nature of the errors identified in this audit.

With respect to the Hospital's contention that we should remove any recommendations related to extrapolation, OIG audit recommendations do not represent final determinations by Medicare. If any of the errors are overturned on appeal, we will provide an updated estimate of overpayments to the MAC, if necessary, at the conclusion of the appeals process.

## RESPONSE TO AUDIT RECOMMENDATIONS

### Hospital Comments

The Hospital stated that it agreed with our conclusion for six claims and is initiating refunds of those claims, totaling $10,756. The Hospital also stated that it disagrees with our findings with respect to 32 claims and intends to fully pursue all appeal avenues for these claims, implicitly non-concurring with our first recommendation to refund to the Medicare contractor

[18] *See* Social Security Act § 1893(f)(3) and *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8.4, § (effective January 2, 2019).

[19] Yorktown Med. Lab., Inc. v. Perales, 948 F.2d 84 (2d Cir. 1991); Illinois Physicians Union v. Miller, 675 F.2d 151 (7th Cir. 1982); Momentum EMS, Inc. v. Sebelius, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), adopted by 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); Anghel v. Sebelius, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); Miniet v. Sebelius, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); Bend v. Sebelius, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

[20] See John Balko & Assoc. v. Sebelius, 2012 WL 6738246 at *12 (W.D. Pa. 2012), aff'd 555 F. App'x 188 (3d Cir. 2014); Maxmed Healthcare, Inc. v. Burwell, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), aff'd, 860 F.3d 335 (5th Cir. 2017); Anghel v. Sebelius, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); Transyd Enters., LLC v. Sebelius, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

$13,486,524 in estimated overpayments. The Hospital did not concur or non-concur with our second recommendation to exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule. As for our third recommendation, to strengthen various internal controls, the Hospital (i.e., KentuckyOne Health) stated that it cannot provide a corrective action plan because it no longer operates Jewish Hospital.

**Office of Inspector General Response**

Regarding the Hospital's claim that it plans to fully pursue all appeal avenues for most of the errors, we stand by our findings and recommendations and maintain that this audit report constitutes credible information of potential overpayments. With respect to the sale of the Hospital in November of 2019 and our third recommendation, we expect the subsequent owners responsible for operations at the Hospital to strengthen internal controls.

See Appendix E for the Hospital's comments on our draft report.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered $42,977,698 in Medicare payments to the Hospital for 2,453 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (85 inpatient and 15 outpatient) with payments totaling $4,912,247. Medicare paid these 100 claims from January 1, 2017, through December 31, 2018 (audit period).

We focused our audit on the risk areas identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted all claims to an independent medical review contractor to determine whether the claims were supported by the medical records.

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

During our audit, we did not assess the overall internal control structure of the Hospital. Rather, we limited our review to the Hospital's internal controls for compliance with Medicare billing requirements. To evaluate these internal controls, we:

- interviewed Hospital officials regarding the Hospital's internal controls for compliance with Medicare billing requirements;

- reviewed the Hospital's policies and procedures for IRF admissions, assigning DRG codes, and using bypass modifiers for Medicare claims;

- reviewed a stratified random sample of 85 inpatient claims and 15 outpatient claims to determine if claims were properly billed and reimbursed; and

- discussed with Hospital officials the causes of the identified errors.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- completed an internal control assessment to document the Hospital's internal control structure;

- extracted the Hospital's inpatient and outpatient paid claim data from CMS's NCH database for the audit period;

- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;

- selected a stratified random sample of 85 inpatient claims and 15 outpatient claims totaling $4,912,247 for detailed review (Appendix B);

- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;

- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;

- used an independent medical review contractor to determine whether all claims complied with selected billing requirements;

- calculated the correct payments for those claims requiring adjustments;

- used the results of the sample review to calculate the estimated Medicare overpayment to the Hospital (Appendix C); and

- discussed the results of our audit with Hospital officials.

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

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

Our sampling frame[21] contained 2,453 Medicare paid claims in 12 high-risk areas totaling $42,977,698 from which we selected our sample (Table 1). The sampling frame included claims:

- with only certain discharge status and diagnosis codes,
- with payments greater than $0, and
- not under review by the Recovery Audit Contractor as of August 5, 2019.

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: IRF Claims, Inpatient Claims Billed with CERT DRG Codes, Inpatient Claims Billed with High-Severity Level DRG Codes, Inpatient Mechanical Ventilation Claims, Inpatient Same Day Discharge and Readmit, Inpatient Claims Paid in Excess of Charges, Inpatient Claims Paid in Excess of $25,000, Outpatient Claims with Bypass Modifiers, Outpatient Claims Paid in Excess of $25,000, Outpatient Claims Paid in Excess of Charges, Outpatient SNF Consolidated Billing Claims, and Outpatient HHA Consolidated Billing Claims.

**Table 1: Risk Areas**

| Medicare Risk Area | Frame Size | Value of Frame |
|---|---|---|
| 1. IRF Claims | 1,026 | $21,125,367 |
| 2. Inpatient Claims Billed With CERT DRG Codes | 159 | 799,757 |
| 3. Inpatient Claims Billed With High Severity Level DRGs | 501 | 4,793,762 |
| 4. Inpatient Mechanical Ventilation Claims | 10 | 328,776 |
| 5. Inpatient Same Day Discharge and Readmit | 44 | 419,673 |
| 6. Inpatient Claims Paid in Excess of Charges | 274 | 2,079,493 |
| 7. Inpatient Claims Paid in Excess of $25,000 | 41 | 7,859,969 |
| 8. Outpatient Claims With Bypass Modifiers | 129 | 76,073 |
| 9. Outpatient Claims Paid in Excess of $25,000 | 200 | 5,412,566 |
| 10. Outpatient Claims Paid in Excess of Charges | 9 | 54,021 |
| 11. Outpatient SNF Consolidated Billing Claims | 38 | 4,138 |
| 12. Outpatient HHA Consolidated Billing Claims | 22 | 24,103 |
| **Total** | **2,453** | **$42,977,698** |

[21] The sampling frame contained the totality of sample units from which the sample was drawn.

**SAMPLE UNIT**

The sample unit was a Medicare paid claim.

**SAMPLE DESIGN AND SAMPLE SIZE**

We used a stratified random sample. We stratified the sampling frame into five strata on the basis of claim type, relative risk of improper payment based on previous OIG audit work, and paid claims amount. Strata 1 and 2 include risk areas 1 and 2 from Table 1 separated by paid amount;[22] strata 3 and 4 include risk areas 3 through 7 from Table 1 separated by paid amount,[23] and stratum 5 includes all outpatient claims from risk areas 8 through 12 from Table 1. All claims were unduplicated, appearing in only one area and only once in the entire sampling frame.

We selected 100 claims for review as shown in Table 2.

**Table 2: Claims by Stratum**

| Stratum | Claim Type | Frame Size (Claims) | Value of Frame | Sample Size |
|---|---|---|---|---|
| 1 | Inpatient Risk Areas 1-2, Low Dollar Claims | 803 | $10,646,151 | 22 |
| 2 | Inpatient Risk Areas 1-2, High Dollar Claims | 382 | 11,278,973 | 23 |
| 3 | Inpatient Risk Areas 3-7, Low Dollar Claims | 827 | 7,482,857 | 20 |
| 4 | Inpatient Risk Areas 3-7, High Dollar Claims | 43 | 7,998,815 | 20 |
| 5 | All Outpatient Claim Risk Areas | 398 | 5,570,902 | 15 |
| | **Total** | **2,453** | **$42,977,698** | **100** |

**SOURCE OF RANDOM NUMBERS**

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software Random Number Generator.

**METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the claims within strata 1 through 5. After generating the random numbers, we selected the corresponding claims in each stratum.

[22] Paid claims less than $21,078 are in stratum 1 and paid claims greater than or equal to $21,078 are in stratum 2.

[23] Paid claims less than $42,868 are in stratum 3 and paid claims greater than or equal to $42,868 are in stratum 4.

## ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate our estimates. To be conservative, we used the lower limit of the two-sided 90-percent confidence interval to estimate the amount of improper Medicare payments in our sampling frame during the audit period. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

## APPENDIX C: SAMPLE RESULTS AND ESTIMATES

### Table 3: Sample Results

| Stratum | Frame Size (Claims) | Value of Frame | Sample Size | Value of Sample | Number of Incorrectly Billed Claims in Sample | Value of Overpayments in Sample |
|---|---|---|---|---|---|---|
| 1 | 803 | $10,646,151 | 22 | $286,291 | 14 | $218,328 |
| 2 | 382 | 11,278,973 | 23 | 687,882 | 17 | 476,836 |
| 3 | 827 | 7,482.857 | 20 | 188,346 | 3 | 10,443 |
| 4 | 43 | 7,998,815 | 20 | 3,583,487 | | |
| 5 | 398 | 5,570,902 | 15 | 166,241 | 4 | 369 |
| **Total** | **2,453** | **$42,977,698** | **100** | **$4,912,247** | **38** | **$705,976** |

## ESTIMATES

### Table 4: Estimates of Overpayments in the Sampling Frame for the Audit Period

*Limits Calculated for a 90-Percent Confidence Interval*

| | |
|---|---|
| Point estimate | $16,330,227 |
| Lower limit | 13,486,524 |
| Upper limit | 19,173,931 |

## APPENDIX D: RESULTS OF AUDIT BY RISK AREA

### Table 5: Sample Results by Risk Area

| Risk Area | Selected Claims | Value of Selected Claims | Claims With Over Payments | Value of Overpayments |
|---|---|---|---|---|
| IRF Claims | 39 | $945,689 | 31 | $695,164 |
| Inpatient Claims Billed With CERT DRG Codes | 6 | 24,484 | | |
| Inpatient Claims Billed With High-Severity Level DRG Codes | 13 | 178,263 | 3 | 10,443 |
| Inpatient Claims Paid in Excess of Charges | 9 | 148,929 | | |
| Inpatient Claims Paid in Excess of $25,000 | 18 | 3,444,640 | | |
| **Inpatient Totals** | **85** | **$4,746,005** | **34** | **$705,607** |
| | | | | |
| Outpatient Claims With Bypass Modifiers | 5 | $3,089 | 4 | $369 |
| Outpatient Claims Paid in Excess of $25,000 | 6 | 161,274 | | |
| Outpatient SNF Consolidated Billing Claims | 1 | 21 | | |
| Outpatient HHA Consolidated Billing Claims | 3 | 1,858 | | |
| **Outpatient Totals** | **15** | **$166,242** | **4** | **$369** |
| | | | | |
| **Inpatient and Outpatient Totals** | **100** | **$4,912,247** | **38** | **$705,976** |

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

KentuckyOne Health™

2525 de Sales Avenue
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June 4, 2021

*Via HHS/OIG Delivery Server*

Lori S. Pilcher
Regional Inspector General for Audit Services
OIG Office of Audit services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

**RE: Response to Draft OIG Report A-04-19-08077**

Dear Ms. Pilcher,

Thank you for the opportunity to respond to the Department of Health and Human Services, Office of Inspector General (OIG) draft report *Medicare Hospital Provider Compliance Audit: Jewish Hospital* (OIG Audit A-04-18-08077 (Audit)). Based on the OIG's audit plan and summary in the Draft Report, OIG reviewed Medicare claims submitted by many hospitals, focusing on an array of billing compliance risk areas that OIG has identified. The Audit did not arise out of any particular concern regarding Jewish Hospital's billing practices.

OIG sampled 100 claims – 85 inpatient claims (46 acute care and 39 inpatient rehabilitation facility) and 15 outpatient claims submitted from January 1, 2017 through December 31, 2018 ("Audit Period"). KentuckyOne Health, Inc. ("KYOne") is responding to Draft Report as the sole member of Jewish Hospital & St. Mary's Healthcare, which in turn, was the sole member of Jewish Hospital during the Audit Period. KYOne sold Jewish Hospital on November 1, 2019. All representations made in this response are limited to the Audit Period and the time period in which KYOne was the member of Jewish Hospital.

KYOne engaged an independent reviewer to review each of the claims in the OIG's audit sample The independent reviewer conducted a thorough audit of each claim and the associated medical record to determine medical necessity and billing compliance. During the Audit, Jewish Hospital, together with its independent reviewer, expected to have discussions with OIG's contracted medical reviewers in order to better understand the OIG's positions and conclusions. As many of the conclusions and findings relate to medical necessity as documented in particular patient medical records, it would have been most efficient if the medical records could have been discussed with respect to the findings to ensure OIG considered the entirety of the record. In footnote 11 of the Draft Report, OIG states that Jewish Hospital "did not provide any additional medical record documentation that would affect our finding." The issue is not additional documentation necessary to show medical necessity. Instead, the issue is a complete reading of the existing and full medical record already in OIG's possession. If OIG, its medical reviewers

and Jewish Hospital could have discussed the records, Jewish Hospital firmly believes the OIG's findings would be very different.

This response first summarizes the OIG's findings in the Draft Report and then provides a specific response to each of these conclusions.

## A. OIG's Audit Findings - Summary

The Draft Report contains several findings related to inpatient acute care hospital claims, inpatient rehabilitation facility ("IRF") claims, and hospital outpatient claims:

- Jewish Hospital complied with the Medicare billing rules for 62 of the 100 inpatient and outpatient claims sampled.
- Of the 38 claims for which OIG found that Jewish Hospital did not fully comply with the Medicare billing requirements, 34 inpatient claims and 4 outpatient claims contained billing errors. The inpatient claims with purported errors total $705,607.
- Of the 34 inpatient claims, 31 relate to IRF claims for a purported overpayment of $695,164. The remaining 3 inpatient claims related to DRG coding errors, for a purported overpayment of $10,443.
- The four outpatient claim errors relate to incorrect modifiers ("59" or "XU") for a total purported overpayment of $369.
- The overpayments for all 38 inpatient and outpatient claims total $705,976, which the OIG extrapolated to a total overpayment of $13,486,524 for the Audit Period.

As described below, Jewish Hospital disagrees with 32 of 38 errors identified by the OIG and intends to pursue all administrative appeals related to any recoupment of these funds.

## B. OIG's Audit Findings--Discussion

### 1. Incorrectly Billed IRF Claims

This purported error category generally relates to the OIG's view that the claims did not meet the Medicare criteria for acute IRF admissions. Of the 39 IRF claims sampled, OIG identified this error in 31 claims. Specifically, the OIG suggested that these claims were incorrectly billed to Part A for one of the following reasons:

- The beneficiaries did not require the active and ongoing therapeutic intervention of multiple therapy disciplines;
- The beneficiaries generally did not require and could not reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program;

- The beneficiaries were not sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; or
- The beneficiaries did not require supervision by a rehabilitation physician.

Jewish Hospital disputes all 31 of those findings, and has provided OIG with specific rebuttals for the errors the OIG identified in each claim. All of these conclusions are made summarily based on a highly selective reading of parts of the patient's record—sometimes extracting only portions of sentences to support these positions. On multiple occasions, Jewish Hospital has offered the complete medical records to the OIG and has specifically identified the parts of the medical records that fully support the medical necessity of the admissions. Rather than engaging in any discussion about the full medical records, the OIG simply continues to restate its position based on selective reading without addressing the full medical record documentation.

In each case, a reading of the full sentences within the complete record clearly establishes that these patients each met the admission criteria. As a result, Jewish Hospital does not believe any of these 31 inpatient claims contain errors and does not intend to make any repayments, individually or based on the OIG's extrapolation. Instead, if and when the MAC pursues recoupment, Jewish Hospital intends to pursue all available administrative appeal rights.

### 2. Incorrectly Billed DRGs

The OIG identified 3 inpatient acute care claims for which it determined that the medical record documentation did not support the DRG billed.[1] Jewish Hospital agrees with the OIG's conclusion for these 3 claims. For the 3 claims for which Jewish Hospital agrees are overpayments, Jewish Hospital will initiate repayment in the amount of $10,443.25. Based on Jewish Hospital's review of these claims, the errors are individual and not systemic. Therefore, there is no indication that these errors exist across all claims and no extrapolation should occur.

### 3. Incorrectly Billed Outpatient Bypass Modifiers

For this error category, OIG identified 4 of 15 outpatient claims for which it determined that Medicare Part B was billed separately (using modifiers XU or 59) for services that should have been included in the charge for the other services or procedures billed on the same claim. The Hospital agrees with three of the four claim conclusions, and disagrees with one. Jewish Hospital will initiate repayment of $313.41 for the three claims for which it agrees were billed in error. Based on Jewish Hospital's review of these claims, the errors on the three claims were isolated and are not systemic, such that extrapolation of the error is inappropriate.

[1] OIG originally identified 5 inpatient acute care claims for which it concluded that the medical record document did not support the DRG billed. Jewish Hospital submitted rebuttals for 2 of those 5 claims and it appears OIG now agrees with Jewish Hospital.

## C. Extrapolation is Inappropriate

OIG sampled 100 claims and found 38 claims with errors. Jewish Hospitals agrees that 6 claims contain billing errors, valued at $10,756.66 (as noted below). This represents a financial error rate of less than 1% and a claims-based error rate of 6%, neither of which supports extrapolation. Such a nominal error rate is not suggestive of a systemic error requiring extrapolation. Indeed, under CMS' standards, medical reviewers are directed to extrapolate only in the event of a "sustained or high level payment error" rate, meaning 50 percent or more.[2] Even the OIG's error rates of 38% (claims-based error rate) and 14% (financial error rate) do not reach this standard. While the standard applies directly to Medicare review contractors (*e.g.,* UPICs, RACs, the SMRC, and MACs), they should not be ignored in the context of an OIG audit recommending extrapolation. The OIG acknowledges its recommendation does not represent a final determination by Medicare and defers to CMS, acting through a MAC, to determine any overpayment amount. Because Medicare overpayments are at issue here, the MAC that processes and demands any applicable overpayments at OIG's recommendation is subject to federal law limiting the use of extrapolation to recover overpayments.[3]

Extrapolation is equally unwarranted in the context of highly individualized issues related to medically necessity, particularly in the context of IRF claims. All of the admission criteria by definition must be applied to an individual beneficiary's medical condition and ability to tolerate intensive therapy. Because no two patient's conditions are the same, no determinations of medical necessity are the same—the purported lack of medical necessity for one patient can never be systemic as it is an individualized determination. As a result, even if the OIG's conclusions with respect to the 31 IRF claims were correct and did not document medical necessity, each conclusion must be based on different facts and cannot be considered a systemic error that supports extrapolation.

At a minimum, the OIG should remove any recommendations related to extrapolation until the MAC has made a determination regarding repayment and Jewish Hospital has had the opportunity to challenge that determination through the appeal process.

## D. Response to Audit Recommendations

Jewish Hospital agrees with the OIG's conclusion with respect to 6 claims and is initiating refunds of these claims, totaling $10,756.66 ($10,443.25 for inpatient claims and $313.41 for outpatient claims). Jewish Hospital disagrees with OIG's findings with respect to 32 claims and intends to fully pursue all appeal avenues for these claims. Extrapolation is inappropriate for the 6 claims due to the very small error rate and the individualized nature or these errors. Extrapolation is also inappropriate relative to the OIG's findings on 32 claims that are not final determinations.

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[2] Medicare Program Integrity Manual, Ch. 8, § 8.4.1.4; *see also* 42 U.S.C. § 1395ddd(f)(3).
[3] 42 U.S.C. § 1395ddd(f)(3).

KentuckyOne Health™

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OIG also requested that Jewish Hospital describe the cause of the errors and a tentative corrective action plan for each category of errors. For the claims that Jewish Hospital rebuts, no cause or corrective action plan are described. For those errors for which Jewish Hospital agrees with OIG's conclusion, KYOne cannot offer an explanation or corrective action plan because it no longer operates Jewish Hospital nor does it have access to the documentation or processes necessary to respond to these questions.

Please let me know if you have any questions or if we can set a time to discuss our response.

Sincerely,

Larry P. Schumacher
System SVP of Operations &
SE Division CEO

cc: Sharon Hager
Division Vice President – General Counsel
Southeast Region

Mike Meeks RN, JD
Division Senior Corporate Counsel