

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF  
JFK MEDICAL CENTER FOR CALENDAR  
YEARS 2009 AND 2010**

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# *Office of Inspector General*

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, 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.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of claims using computer matching, data mining, and analysis of claims. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected types of claims for inpatient and outpatient services.

JFK Medical Center (the Hospital) is a 460-bed acute care facility located in Atlantis, Florida. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$208 million for 30,572 inpatient and 40,770 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010.

Our audit covered \$25,195,979 in Medicare payments to the Hospital for 3,816 claims that were potentially at risk for billing errors. We randomly selected a sample of 200 (196 inpatient and 4 outpatient) claims with payments totaling \$1,320,562 for review. These 200 claims had dates of service in CYs 2009 and 2010.

### **OBJECTIVE**

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

## **SUMMARY OF FINDINGS**

The Hospital complied with Medicare billing requirements for the majority of the claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 70 inpatient claims resulting in overpayments of \$293,869.

Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors.

Based on our random sample results, we estimated that the Hospital received overpayments totaling \$4,395,269 for CYs 2009 and 2010.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare program \$4,395,269 in estimated overpayments for CY 2009 and 2010 claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare requirements.

## **JFK MEDICAL CENTER COMMENTS**

In written comments on our draft report, the Hospital did not agree with our first recommendation and stated that CMS is time-barred from recovering any claims paid in 2009. Section 1870(b) of the Act prohibits recovery of any paid claims subsequent to the third calendar year after the year of payment because providers are deemed to be “without fault.” For claims paid in 2009, the last day to recover an overpayment was December 31, 2012. In addition, even if the Hospital were not “without fault,” many of the 2009 claims could not be reopened beyond 4 years under Medicare’s reopening rules, even if CMS could establish “good cause.”

The Hospital also contested that it improperly billed 39 inpatient claims. For these, the Hospital either did not agree with our error determinations (noting that we did not use physician medical reviewers) or argued that the claims were time-barred. The Hospital also objected to the application of extrapolation as being erroneous as a matter of law and statistical integrity. In regard to our second recommendation, the Hospital discussed steps it had taken or planned to take to strengthen its internal controls to ensure compliance with Medicare billing requirements.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

### **Claims Remain Subject to Reopening and Recovery**

We disagree with the Hospital’s assertion that the 2009 claims are time-barred. The claims from 2009 are eligible to be reopened under the “similar fault” provisions of the reopening regulations (42 CFR part 405, subpart I). Section 405.980(b) provides that an initial determination or redetermination can be reopened at any time if there is reliable evidence of fraud or similar fault.

Although OIG is not alleging that the Hospital engaged in fraud, its improper billings are sufficient to establish “similar fault” under current Medicare guidance (42 CFR § 405.902 and 70 Fed. Reg. 11420 and 11450 (March 8, 2005)). Therefore, no time limit prohibits the reopening of the claims questioned in this report.

The Hospital is not “without fault” with respect to the claims questioned in the report and, therefore, recovery is not time-barred under section 1870(b) of the Act. CMS guidance states that a provider is not without fault if, among other circumstances, the provider should have known that the underlying services were non-covered. Furthermore, a provider should know of a policy or rule if the policy or rule is in the provider manual or in Federal regulation (*Medicare Financial Management Manual*, Pub. 100-06, chapter 3, § 90.1). We questioned the claims in this report on the basis of criteria drawn from statutory, regulatory, and manual provisions with which the Hospital is expected to be familiar. Therefore, the Hospital is not “without fault” with respect to our findings above.

### **Contested Determinations of Claims**

In response to the Hospital’s contestation that it improperly billed 39 inpatient claims, we obtained an independent, physician medical review of all of these claims for medical and coding errors, and our report reflects the results of the review.

### **Statistical Sampling**

During the course of the audit, we discussed with a Hospital official our plans to use statistical sampling. As the hospital compliance review initiative has matured, we have refined our audit methodologies. Some reviews use statistical sampling and estimation techniques to draw conclusions about a larger portion of a hospital’s claims while other reviews use judgmental sampling. Each hospital review is unique, and the sampling method used in each of these reviews will vary. For this reason, we review different risk areas at different hospitals and use both statistical and non-statistical methods for selecting our samples.

We acknowledge that most previously published compliance reviews did not use statistical sampling and estimation. However, we maintain that the statistical sampling and estimation techniques planned and used for this review are statistically valid methodologies that we have successfully used to identify overpayments. Therefore, we recommend that the Hospital refund to the Medicare program \$4,395,269 in estimated overpayments for CYs 2009 and 2010.

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## INTRODUCTION

### BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

#### **Hospital Inpatient Prospective Payment System**

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, 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.

#### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>1</sup> The OPPS is effective for services furnished on or after August 1, 2000. 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.<sup>2</sup> All services and items within an APC group are comparable clinically and require comparable resources.

#### **Hospital Claims at Risk for Incorrect Billing**

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG

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<sup>1</sup> In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

<sup>2</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

identified these types of hospital claims using computer matching, data mining, and analysis of claims. The types of claims identified included:

- inpatient claims for short stays,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims with same day discharges and readmissions,
- inpatient claims paid in excess of charges, and
- outpatient claims greater than \$25,000.

For purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.”

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected types of claims for inpatient and outpatient services.

### **Medicare Requirements for Hospital Claims and Payments**

Section 1862(a)(1)(A) of the Act states that 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.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

### **JFK Medical Center**

JFK Medical Center (the Hospital) is a 460-bed acute care facility located in Atlantis, Florida. According to CMS’s National Claims History (NCH) data, Medicare paid the Hospital approximately \$208 million for 30,572 inpatient and 40,770 outpatient claims for services provided to beneficiaries during calendar years (CYs) 2009 and 2010.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

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

### **Scope**

Our audit covered \$25,195,979 in Medicare payments to the Hospital for 3,816 claims that were potentially at risk for billing errors from which we randomly selected a sample of 200 (196 inpatient and 4 outpatient) claims with payments totaling \$1,320,562 for review. These 200 claims had dates of service in CYs 2009 and 2010.

We focused our review on the risk areas that we had identified during prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 84 inpatient claims to focused medical review to determine whether the services met medical necessity and coding requirements.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the NCH file, but we did not assess the completeness of the file.

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 our fieldwork at the Hospital during April of 2012.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's NCH file for CYs 2009 and 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a random sample of 200 claims (196 inpatient and 4 outpatient) totaling \$1,320,562 for detailed review (Appendix A);

- 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;
- reviewed the Hospital’s procedures for assigning DRG, HCPCS, and admission status codes for Medicare claims;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- used CMS’s Medicare administrative contractor (MAC) medical review staff and an independent medical review contractor to determine whether a selection of sampled claims met medical necessity and coding requirements;
- calculated the correct payments for those claims requiring adjustment;
- used OIG/Office of Audit Services (OAS) software to estimate the total overpayment to the Hospital (Appendix B); and
- discussed the results of our review 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.

## **FINDINGS AND RECOMMENDATIONS**

The Hospital complied with Medicare billing requirements for the majority of the claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 70 inpatient claims resulting in overpayments totaling \$293,869.

Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors.

Based on our sample results, we estimated that the Hospital received overpayments totaling at least \$4,395,269 for CYs 2009 and 2010. See Appendix A for details on our sample design and methodology, Appendix B for our sample results and estimates, and Appendix C for the results of our review by risk area.

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 70 of the 196 inpatient claims that we reviewed. These errors resulted in overpayments totaling \$293,869.

### **Incorrectly Billed as Inpatient**

Section 1862(a)(1)(A) of the Act states that 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.”

For 56 of the 196 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed either as outpatient or as outpatient with observation services. These errors occurred because the Hospital’s staff either relied on evidence-based decision support software to determine the patients’ levels of care or failed to follow established criteria. As a result, the Hospital received overpayments totaling \$266,925.<sup>3</sup>

### **Incorrect Diagnosis-Related Groups**

Section 1862(a)(1)(A) of the Act states that 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.” Chapter 1, § 80.3.2.2, of the Manual requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 14 of the 196 inpatient claims, the Hospital billed Medicare for incorrect DRG codes. These errors occurred because the Hospital’s medical coders incorrectly assigned procedure or diagnosis codes that the medical records did not support. As a result, the Hospital received overpayments totaling \$26,944.

## **OVERALL ESTIMATE OF OVERPAYMENTS**

Based on our random sample results, we estimated that the Hospital received overpayments totaling at least \$4,395,269 for CYs 2009 and 2010. See Appendix A for details on our sample design and methodology, and Appendix B for our sample results and estimates.

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<sup>3</sup> The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the MAC prior to the issuance of our report.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare program \$4,395,269 in estimated overpayments for CY 2009 and 2010 claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare requirements.

## **JFK MEDICAL CENTER COMMENTS**

In written comments on our draft report, the Hospital disagreed with our first recommendation. Concerning our second recommendation, the Hospital discussed steps it had taken or planned to take to strengthen its internal controls to ensure compliance with Medicare billing requirements.

### **2009 Claims Are Time-Barred**

The Hospital stated that CMS is time-barred from recovering any claims paid in 2009. Section 1870(b) of the Act prohibits recovery of any paid claims subsequent to the third calendar year after the year of payment because providers are deemed to be “without fault.” For claims paid in 2009, the last day to recover an overpayment was December 31, 2012. In addition, even if the Hospital were not “without fault,” many of the 2009 claims could not be reopened beyond 4 years under Medicare’s reopening rules, even if CMS could establish “good cause.”

### **Contested Determinations of Claims**

The Hospital contested that it improperly billed 39 inpatient claims. For these, the Hospital either did not agree with our error determinations (noting that we did not use physician medical reviewers) or argued that the claims were time-barred.

### **Statistical Sampling**

The Hospital objected to the application of extrapolation as being erroneous as a matter of law and statistical integrity.

#### *Matter of Law*

With respect to the matter of law, the Hospital noted that the authority of CMS and its contractors to extrapolate is subject to strict statutory and regulatory limits.

#### *Statistical Integrity*

The Hospital stated that it had concerns with the decision to extrapolate the results of the audit using a post-stratification methodology. Secondly, the Hospital argued that the overall statistical sampling precision level of 21.96 percent at the 90 percent confidence level is not reliable.

Thirdly, the Hospital contends that, for 13 of the 200 claims in the sample, the payment amounts did not match the amounts in the sampling frame. Lastly, the Hospital contends that the sampling frame appears to include a duplicate claim.

The Hospital's response is included as Appendix D. We excluded supporting schedules and reference material from the Hospital's response because it included personally identifiable information.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

### **Claims Remain Subject to Reopening and Recovery**

We disagree with the Hospital's argument that the 2009 claims are time-barred.

#### *Reopening*

The claims from 2009 are eligible to be reopened under the "similar fault" provisions of the reopening regulations (42 CFR part 405, subpart I). Section 405.980(b) provides that an initial determination or redetermination can be reopened at any time if there is reliable evidence of fraud or similar fault. Although OIG is not alleging that the Hospital engaged in fraud, its improper billings are sufficient to establish "similar fault" under current Medicare guidance (42 CFR § 405.902 and 70 Fed. Reg. 11420 and 11450 (March 8, 2005)). Therefore, no time limit prohibits the reopening of the claims questioned in this report.

#### *Recovery*

The Hospital is not "without fault" with respect to the claims questioned in the report and, therefore, recovery is not time-barred under section 1870(b) of the Act. CMS guidance states that a provider is not without fault if, among other circumstances, the provider should have known that the underlying services were non-covered. Furthermore, a provider should know of a policy or rule if the policy or rule is in the provider manual or in Federal regulation (*Medicare Financial Management Manual*, Pub. 100-06, chapter 3, § 90.1). We questioned the claims in this report on the basis of criteria drawn from statutory, regulatory, and manual provisions with which the Hospital is expected to be familiar. Therefore, the Hospital is not "without fault" with respect to our findings above.

### **Contested Determinations of Claims**

In response to the Hospital's contestation that it improperly billed 39 inpatient claims, we obtained an independent, physician medical review of all of these claims for medical and coding errors, and our report reflects the results of the review.

### **Statistical Sampling**

During the course of the audit, we discussed with a Hospital official our plans to use statistical sampling. As the hospital compliance review initiative has matured, we have refined our audit

methodologies. Some reviews use statistical sampling and estimation techniques to draw conclusions about a larger portion of a hospital's claims while other reviews use judgmental sampling. Each hospital review is unique, and the sampling method used in each of these reviews will vary. For this reason, we review different risk areas at different hospitals and use both statistical and non-statistical methods for selecting our samples.

We acknowledge that most previously published compliance reviews did not use statistical sampling and estimation. However, we maintain that the statistical sampling and estimation techniques planned and used for this review are statistically valid methodologies that we have successfully used to identify overpayments. Therefore, we recommend that the Hospital refund to the Medicare program \$4,395,269 in estimated overpayments for CYs 2009 and 2010.

### *Matter of Law*

Courts have long held the validity of using sampling and extrapolation in audits of Federal health programs.<sup>4</sup> Furthermore, such statistical sampling and methodology may be used in cases seeking recovery against States, individual providers, and private institutions.<sup>5</sup>

### *Statistical Integrity*

The decision to post-stratify the results of our audit for estimation purposes allowed us to keep together claims within the same risk area. We did rely on a statistically valid sample.<sup>6</sup> In his book, *Sample Design in Business Research*, W. Edwards Deming (1960) states: "An estimate made from a sample is valid if it is unbiased or nearly so and if we can compute its margin of sampling error for a given probability." We selected our samples according to principles of probability (every sampling unit has a known, nonzero chance of selection). We used the difference estimator (an unbiased estimator) for monetary recovery and recommended recovery at the lower limit of the 90-percent, two-sided confidence interval.

The Hospital also raised concerns about the precision of the overall error estimates and, in particular, about Stratum 2. The estimates presented in this report, however, are statistically valid.

After our initial data extraction, the Hospital adjusted some claims through the MAC that were part of our sample items. This adjustment resulted in a payment amount that is different from the

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<sup>4</sup> See, e.g., *State of Georgia v. Califano*, 446 F. Supp. 404, 409-410 (N.D.Ga. 1977) (ruling that sampling and extrapolation are valid audit techniques for programs under Title IV of the Social Security Act); *Ratanasen v. California Dept. of Health Servs.*, 11 F. 3d 1467, 1471-72 (9th Cir. 1993) (ruling that simple random sampling and subsequent extrapolation were valid techniques to calculate Medi-Cal overpayments); *Illinois Physicians Union v. Miller*, 675 F. 2d 151, 155-56 (7th Cir. 1982) (ruling that random sampling and extrapolation were valid statistical techniques for calculating Medicaid overpayments claimed against an individual physician).

<sup>5</sup> *Illinois Physicians Union v. Miller*, 675 F. 2d 151, 155-56 (7th Cir. 1982).

<sup>6</sup> See *Puerto Rico Department of Health*, DAB (Departmental Appeals Board) No. 2385 (2011) (DAB upholding disallowance of claims based on statistical sampling and statistical methodology).

original amount in the sampling frame. For some claims, the payment amount increased; for other claims, it decreased. The net effect, however, was a decrease in the total amount of the value of our sample, which also benefitted the Hospital. The estimated overpayment is based on the value of the claim as it was in CWF at the time of the review.

In addition, the Hospital noted that our sampling frame appears to contain one duplicate claim. However, the claim to which the Hospital is referring is not a duplicate in our frame; instead, it constitutes two different records that the MAC processed and paid twice. The Hospital filed this claim twice under two different Health Insurance Claim Numbers.

We recommend that the Hospital refund to the Medicare program \$4,395,269 in estimated overpayments for CYs 2009 and 2010.

# **APPENDIXES**

## **APPENDIX A: SAMPLE DESIGN AND METHODOLOGY**

### **POPULATION**

The population is inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during CYs 2009 and 2010.

### **SAMPLING FRAME**

According to CMS's NCH data, Medicare paid the Hospital \$208,115,518 for 30,572 inpatient and 40,770 outpatient claims for services provided to beneficiaries during CYs 2009 and 2010.

We obtained a database of claims from the NCH data totaling \$143,804,498 for 10,121 inpatient and 24,534 outpatient claims in 30 risk areas.

From the 30 risk areas, we selected 5 that consisted of 4,065 claims totaling \$26,273,162. The risk areas are: Inpatient Claims for Short Stays, Inpatient Claims With High-Severity-Level DRG Codes, Outpatient Claims Greater Than \$25,000, Inpatient Claims With Same Day Discharges and Readmissions, and Inpatient Claims Paid in Excess of Charges.

We combined claims from each of the risk areas into a single database. We then removed 249 claims totaling \$1,077,183 as follows:

- all claims that were less than \$100,
- all claims that were under review by the Recovery Audit Contractor, and
- all duplicate claims.

This resulted in 3,816 unique Medicare claims remaining totaling \$25,195,979, from which we drew our sample.

### **SAMPLE UNIT**

The sample unit was a Medicare paid claim.

### **SAMPLE DESIGN**

We used simple random sampling to select the sample claims.

### **SAMPLE SIZE**

We selected 200 sample claims for review.

## SOURCE OF RANDOM NUMBERS

We generated 200 random numbers using the Office of Inspector General, Office of Audit Services, statistical software Random Number Generator.

## METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims in our sampling frame from 1 to 3,816. After generating the 200 random numbers, we selected the corresponding claims from our sampling frame.

## ESTIMATION METHODOLOGY

Post-stratification: After randomly selecting 200 sample claims from our sampling frame of 3,816 unique Medicare claims, we stratified these claims into one of three different strata:

**Sampled Claims by Stratum<sup>1</sup>**

<b>Stratum</b>	<b>Risk Area</b>	<b>Number of Claims in Sample Frame</b>	<b>Number of Claims in the Sample</b>
1	Inpatient Claims for Short Stays	2,939	150
2	Inpatient Claims With High-Severity-Level DRG Codes	730	45
3	Outpatient Claims Greater Than \$25,000	130	4
	Inpatient Claims With Same Day Discharges and Readmissions	10	1
	Inpatient Claims Paid in Excess of Charges	7	0
	<b>TOTAL</b>	<b>3,816</b>	<b>200</b>

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<sup>1</sup> Each claim can appear in only one stratum.

## APPENDIX B: SAMPLE RESULTS AND ESTIMATES

### 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	2,939	\$15,080,893	150	\$849,754	54	\$256,633
2	730	5,906,960	45	340,391	16	37,236
3	147	4,208,126	5	130,417		0
<b>Total</b>	<b>3,816</b>	<b>\$25,195,979</b>	<b>200</b>	<b>\$1,320,562</b>	<b>70</b>	<b>\$293,869</b>

### ESTIMATES

#### Estimated Value of Overpayments for CYs 2009 and 2010 *Limits Calculated for a 90-Percent Confidence Interval*

Point Estimate	\$5,632,342
Lower limit	\$4,395,269
Upper limit	\$6,869,415

**APPENDIX C: RESULTS OF REVIEW BY RISK AREA**

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Over-payments</b>	<b>Value of Over-payments</b>
<b>Inpatient</b>				
Claims for Short Stays	150	\$849,754	54	\$256,633
Claims With High-Severity-Level DRG Codes	45	340,391	16	37,236
Claims With Same Day Discharges and Readmissions	1	5,084	0	0
Claims Paid in Excess of Charges	0	0	0	0
<b>Inpatient Totals</b>	<b>196</b>	<b>\$1,195,229</b>	<b>70</b>	<b>\$293,869</b>
<b>Outpatient</b>				
Claims Greater Than \$25,000	4	\$125,333	0	\$0
<b>Outpatient Totals</b>	<b>4</b>	<b>\$125,333</b>	<b>0</b>	<b>\$0</b>
<b>Inpatient and Outpatient Totals</b>	<b>200</b>	<b>\$1,320,562</b>	<b>70</b>	<b>\$293,869</b>

Notice: The table above illustrates the results of our review 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.

## APPENDIX D: JFK MEDICAL CENTER COMMENTS

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June 17, 2013

### BY Federal Express and Electronic Mail

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

Re: Response to the Draft Report regarding the Medicare Compliance Review of JFK ,  
Atlantis, Florida, Report Number: A-04-12-07032

Dear Ms. Pilcher:

JFK Medical Center (“JFK” or “Hospital”)<sup>1</sup> is in receipt of the draft report from the U.S. Department of Health and Human Services, Office of the Inspector General (“OIG”) (A-04-12-07032), dated April 30, 2013, entitled “JFK Medical Center Substantially Complied with Medicare Requirements for Calendar Years 2009 and 2010” (referred to herein as “Draft Report”). As permitted by the terms of the Draft Report, this letter sets forth the Hospital’s objections to: (1) many of the OIG’s findings with respect to the actual claims at issue; and (2) the OIG’s recommendation that these findings be extrapolated for a total overpayment of approximately \$4.4 million.

### I. Background

The OIG did not audit JFK due to any perceived improper billing or compliance practices. Rather, the OIG selected JFK as part of an ongoing national auditing initiative focused on certain risk areas for hospitals across the country. Indeed, as of the date of this letter, the OIG’s national initiative has resulted in the publication of Medicare Compliance reports relating to 55 hospitals in 23 states, the District of Columbia, and Puerto.<sup>2</sup>

In this case, the OIG’s audit considered five risk areas: (1) inpatient claims for “short-stays”

<sup>1</sup> JFK is a 460-bed acute care hospital located in Atlantis, Florida.

<sup>2</sup> A summary chart of OIG Medicare Compliance Reports published to date is attached at **Tab A**.

(referred to as “Short-Stays”),<sup>3</sup> (2) inpatient claims with high-severity diagnosis-related group (“DRG”) codes, (3) inpatient claims paid in excess of charges, (4) outpatient claims greater than \$25,000 and (5) inpatient claims with same day discharges and readmissions (“Risk Areas”).<sup>4</sup>

The audit of JFK covered all paid claims involving one or more of the Risk Areas with dates of service in calendar years 2009-2010 (“Audit Period”), provided that the payment was for \$100 or more. According to the OIG, once it removed duplicate claims and claims under RAC review, it ended up with a universe of 3,816 claims (the “Universe of Claims”), representing a total of \$25,195,979 in Medicare reimbursement. Thereafter, the OIG selected a random sample of 200 claims (representing \$1,320,562 in Medicare reimbursement) for substantive review, using the OIG’s statistical software Random Number Generator.<sup>5</sup> Of the 200 claims, there were 196 inpatient claims: 150 Short-Stay, 45 high-severity level DRG codes, and one (1) inpatient same day discharge/readmission. The remaining four (4) claims were for outpatient services. Of the 200 claim sample, the OIG subjected 84 for focused medical review, either through the Medicare Administrative Contractor and/or the OIG auditors. The OIG also asked the Hospital to self-evaluate claims.

Despite JFK’s request for information and detail, the OIG has not explained why it chose to use a sample size of 200 claims. Nor has it explained why it undertook post-sampling stratification instead of building stratification into the original sample design. Certainly, the use of post-sampling stratification does not appear to have increased the reliability of the extrapolation in any meaningful sense. Moreover, after dividing the sample into three strata — Stratum 1 = “Short-Stays”, Stratum 2 = Inpatient Claims Billed With High-Severity-Level DRG Codes, and Stratum 3 = claims in the remaining Risk Categories — the OIG realized that Stratum 3 contained five (5) claims only, making it inappropriate for extrapolation and requiring the OIG to assign each of the five (5) claims a zero dollar value.

## II. Draft Report Findings

At the conclusion of the OIG’s review, it found that JFK “substantially” complied with Medicare billing requirements during the Audit Period. Specifically, the Hospital only had alleged errors in two of the five Risk Areas. More specifically, the OIG concluded that 70 claims of the 200 were allegedly billed in error, for a total alleged overpayment of \$293,869 — a claims error rate of 35 percent, but a financial error rate of 22 percent.

<sup>3</sup> It is the Hospital’s understanding that a “short-stay” for purposes of the Audit included a claim with an admission and discharge on the same calendar day and a claim in which discharge occurred on the day immediately following the day of admission.

<sup>4</sup> Draft Report, at 2.

<sup>5</sup> Id. at Appendix A, p. 2.

The more specific findings break down as follows:

- With regard to the 150 Short-Stay claims in Stratum 1, the OIG identified 54 allegedly erroneous claims, to which it ascribed an alleged overpayment value of \$256,633.<sup>6</sup>
- With regard to the 45 claims in Stratum 2 (high-severity level DRG codes), the OIG identified 16 allegedly erroneous claims, to which it ascribed an alleged overpayment value of \$37,236.<sup>7</sup>
- The OIG ascribed a zero dollar value to the five (5) claims in Stratum 3.<sup>8</sup>

The OIG proceeds to recommend — without meaningful discussion and without actually using the word “extrapolation” — that JFK refund \$4,395,269 in Medicare overpayments. For the reasons set forth below, the Hospital takes strong exception to these recommendations. It also recommends that the Hospital “strengthen controls to ensure full compliance with Medicare requirements.”

### III. JFK’s Response to the Draft Report

#### A. All claims paid in 2009 are time barred and, as such, there may be no recoupment of any alleged overpayments

In addition to disagreeing substantively with the OIG’s findings as noted above, JFK notes that all 2009 claims are time barred and, as such, these claims may not form the basis of errors much less extrapolation. Specifically, 34 of the 70 claims identified by the OIG are for dates of service in 2009, which claims may not be recouped as they are time barred as explained below.<sup>9</sup> This represents approximately 49 percent of the alleged erroneous claims at issue.

There are two separate laws that, when read together, determine the period of time a provider is subject to recovery of an overpayment: (1) Social Security Act (“SSA” or “the Act”) § 1869(b)(1)(G), which governs when claims may be reopened (“Reopening Rules”); and (2) SSA § 1870, which governs when overpayments may be recovered (“Recovery Rules”). Notably, Section 638 of the American Tax Payer Relief Act (“ATPRA”) only amended Section 1870 of the SSA, but even this expansion still leaves these 2009 claims beyond recoupment.

<sup>6</sup> Id.

<sup>7</sup> Id. Note, there is one claim for inpatient discharge/readmission within the 196 set of inpatient claims at issue, but the OIG found no error in this regard. The OIG grouped this one inpatient claim, and the four outpatient claims, together in Stratum 3, discussed above.

<sup>8</sup> Id.

<sup>9</sup> These 34 claims are Sample Numbers 1, 18, 23, 24, 25, 26, 31, 36, 38, 63, 64, 67, 71, 72, 74, 93, 110, 116, 117, 124, 125, 127, 134, 148, 153, 157, 158, 159, 160, 164, 179, 184, 189 and 193.

## 1. Reopening Rules

The Reopening Rules, and implementing regulations found at 42 C.F.R. § 405.980, prescribe the relevant time frames and requirements for revising Medicare claims decisions.<sup>10</sup> Specifically, a contractor's decision to pay a claim, (referred to as an "initial determination") is binding upon all parties to the claim (*i.e.*, the provider and the contractor) unless a party reopens and revises the initial determination.<sup>11</sup> A claim may only be reopened: (1) within one-year of payment for any reason; (2) within four years of payment if the contractor establishes "good cause," or (3) anytime if the contractor has "reliable evidence ... that the initial determination was procured by fraud or similar fault."<sup>12</sup> Given that the 2009 claims are beyond one-year from payment, and that the OIG has in no way intimated any evidence of "fraud or similar fault," we are left with only the four-year rule to consider.

As noted above, the four-year reopening time frame does not give the contractor unfettered access to those claims. Rather, only a showing of "good cause" will afford a contractor (not the OIG) access to these claims. We respectfully submit that even if the contractor sought to reopen these claims at some point (indeed even 2010 claims), there would be no ability to do so as there is not "good cause."

In order to establish "good cause," the contractor would have to establish either: (1) that the evidence that was considered in making the initial determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision;<sup>13</sup> or (2) that there is "new and material evidence" that was not available or known at the time of the initial determination and may result in a different conclusion.<sup>14</sup> "Good cause" does not exist, however, if a provider complied with all pertinent regulations, made full disclosure of all material facts, and on the basis of the information available, had a reasonable basis for assuming that the payment was correct.<sup>15</sup>

The vast majority of the 70 OIG identified claims relate to "medical necessity," or Short-Stay, denials. JFK respectfully submits that, despite the OIG's contention, JFK had "a reasonable basis for assuming payment was correct" because it complied with the Medicare Benefit Policy Manual ("MBPM"), Ch. 1 § 10. Specifically, the MBPM provides that "a patient is considered an

<sup>10</sup> The Reopening Rules also govern the proper reopening of Medicare cost reports, at 42 C.F.R. § 405.1885. However, these are not at issue in this case.

<sup>11</sup> *Id.* § 405.928(b). Note, JFK also argues that CMS or its contractor, not the OIG, is the party to the claim that may reopen such claim.

<sup>12</sup> 42 C.F.R. § 405.980(b)(1), (2) and (3).

<sup>13</sup> *See Id.* § 405.986(a)(2).

<sup>14</sup> *See Id.* § 405.986(a)(1).

<sup>15</sup> *See* Medicare Financial Management Manual ("MFMM"), CMS-Pub. 100-06, Ch. 3, § 90.

inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.”<sup>16</sup> Thus, as long as there is an “expectation” of an overnight stay, whether the patient is — in fact — discharged after six, 12 or 18 hours (for example) is irrelevant: the patient was properly treated as a inpatient. Moreover:

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient...the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.<sup>17</sup>

In other words, there should be deference afforded to the patient’s physician and this critical, complex medical decision should not be summarily second-guessed by the OIG after-the-fact. Given that JFK provided care and treated the patient in the status as ordered by his/her physician, and given the clinical presentation of the patient at the time of service, JFK submits that it acted in accordance with Medicare policy and had no understanding that the payment of the claims were improper. Thus, there is no good cause with regard to these claims 54 claims, and they may not be reopened.

Even if, for the sake of argument, though not conceding the point, these claims may be reopened by the contractor, a number of the 34 claims for 2009 dates of service are beyond the four-year time frame. As such, these may not be reopened even if there were “good cause.” Therefore, as of the filing of this letter, only claims that were paid on or after June 17, 2009 may be reopened by the Medicare contractor (not the OIG).

## 2. Recovery Rules

If, and only if, an initial determination has been reopened, contractors (not the OIG) may then seek to recover the overpayment. Section 1870 of the Act governs the recovery of overpayments and the timing of the same. Specifically, § 1870 prohibits recovery of overpayments from providers that are “without fault.” Prior to January 2, 2013 and the passage of the ATPRA, § 1870 deemed providers to be “without fault” beginning three years after the year in which a claim was paid, unless there was evidence of provider fault.<sup>18</sup> In essence, this created a rebuttable

<sup>16</sup> Medicare Benefit Policy Manual (“MBPM”), Ch. 1, § 10.

<sup>17</sup> Id.

<sup>18</sup> See 42 U.S.C § 1395gg(b) (2003) (amended 2013); see also MFMM, Ch. 3, §§ 80, 90.

presumption that a provider was “without fault” (and hence no recovery) after the passage of three calendar years following the calendar year of initial determination.<sup>19</sup> Thus, under the old law, a contractor could reopen a claim determination going back four years under the Reopening Rules (discussed in Section III.A.1 above); but, the contractor could not actually recover an overpayment for this entire period if the provider was deemed to be “without fault” beyond three years from payment.

For example: July 1, 2009, Hospital bills Medicare for a claim with valid documentation of the service. On August 1, 2009, Medicare Contractor pays the claim. On May 1, 2013, Medicare Contractor determines that this claim was paid in error. Even with good cause that would allow the Contractor to reopen the payment/initial determination made on August 1, 2009, because the Hospital was without fault, and because the Recovery Rule “three calendar years after the year in which the claim was paid” window closed as of January 1, 2013, this August 1, 2009 payment amount may not be recovered.

Under the new law, effective January 2, 2013, the “without fault” provision was expanded to five years after a claim’s payment. In other words, a provider is only protected from recovery now after the expiration of five calendar years after the year in which a claim was paid, not three. This, coupled with the four-year Reopening Rule will mean that for claims paid on or after January 2, 2013, all claims subject to the Reopening Rule likely will also be subject to the Recovery Rules. However, no recovery is possible for the entire expanded five-year period because the law did not modify SSA § 1869, thus a claim is still limited to a four-year reopening period with “good cause.”

Given that (1) the Recovery Rules operate on a calendar year basis, (2) all 2009 claims ceased to be subject to recovery as of 12:00 a.m., January 1, 2013, which was beyond three calendar years in which the 2009 claims were paid, and (3) the ATPRA was not implemented until January 2, 2013, thus the five calendar year expansion cannot apply to claims that expired under the old law as of January 1, 2013, JFK is “without fault” in this matter and no 2009 claims are subject to the Recovery Rules.

Even if one were to argue that the ATPRA applied retroactively such that the change in the law to the “fifth calendar year” after payment is retroactive, JFK would strenuously oppose this argument based on the law and legislative intent. Courts presume a law to operate prospectively from its date of enactment unless Congress expressly states that it is to be applied retroactively. Nothing in the ATPRA indicates an intent that this particular amendment apply retroactively. In addition, any application of this provision retroactively arguably is a violation of due process.

Finally, as noted above, even assuming the new “fifth calendar year” limitations period were to apply retroactively to reach earlier claims, a large portion of the 2009 claims still cannot be

<sup>19</sup> Mt. Sinai Hospital of Greater Miami, Inc. v. Weinberger, 517 F.2d 329, 342 (5th Cir. 1975).

recovered under federal law because these claims are beyond the SSA § 1869 Reopening Rules, as noted above in Section III.A.1.

#### **B. JFK contests numerous substantive findings in the Draft Report**

Specifically, the OIG concluded that 70 inpatient claims were billed incorrectly and these were in two Risk Areas: (1) Short-Stay; and (2) incorrect diagnosis-related codes.

Separate and apart from the 34 claims that are time-barred as noted above, JFK argues that the OIG is wrong with respect to 39 of these 70 claims on the clinical merits, or over half of the OIG's conclusions.

In other words, JFK had these claims re-reviewed by independent third party reviewers who were physician experts in Medicare rules and regulations. These independent physician experts concluded that, on the merits, JFK was actually right in 24 of the alleged 54 cited errors with respect to Short-Stay claims. Thus, only 30 (not 54) of 150 Short-Stay claims were in error. (Notably, based on discussions with OIG auditors, it is our understanding that the OIG did not utilize physician reviewers.)

Moreover, even though JFK agrees with the OIG as to 30 of the Short-Stay claims at issue, we note that 14 of these claims are time-barred as they are 2009 claims.<sup>20</sup> Thus, of the 54 claims identified by the OIG as erroneous, JFK only agrees that 16 are both erroneous and subject to reopening and recovery.<sup>21</sup>

With regard to DRG coding issues, JFK identified only one (1) of the OIG's identified 16 claims to be in error.<sup>22</sup> Moreover, even if the OIG refuses to concede the 15 remaining DRG claims, JFK notes that four (4) of these 15 claims are time-barred for the reasons set forth above.<sup>23</sup>

JFK is, and has always been, committed to operating in compliance with applicable rules and regulations. While JFK fundamentally disagrees with the OIG's findings with respect to over half of the 70 claims as issue, the Hospital takes any finding of potential errors seriously. JFK will redouble its efforts to attend to any opportunities for improvements, including continuing its efforts on patient status/Short-Stay cases.

#### **C. JFK objects to the application of extrapolation**

JFK respectfully challenges the OIG's recommendation that its findings with respect to the

<sup>20</sup> These claims are Sample Numbers 1, 18, 24, 38, 63, 67, 72, 74, 110, 124, 134, 148, 153, and 159.

<sup>21</sup> These claims are Sample Numbers 2, 4, 5, 28, 44, 47, 85, 89, 94, 96, 155, 156, 172, 186, 191 and 195.

<sup>22</sup> This claim is Sample Number 120.

<sup>23</sup> These claims are Sample Numbers 23, 71, 117 and 189.

70 randomly selected claims be extrapolated to the Universe of Claims. Such extrapolation is erroneous as a matter of law, statistical integrity and fundamental fairness.

### 1. Extrapolation is unjust and arbitrary as a matter of law

The Act provides very limited circumstances under which either the Centers for Medicare & Medicaid Services (“CMS”) or its contractors may extrapolate results for overpayment purposes.<sup>24</sup> And, as is set forth below, none of these circumstances are at issue in this case.

Specifically, § 1893(f)(3) of the Act provides that “a Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise *unless the Secretary determines that ... there is a sustained or high level of payment error...*”<sup>25</sup> Note, however, there is “no administrative or judicial review . . . of determinations by the Secretary of sustained or high levels of payment errors under this paragraph.”<sup>26</sup>

With regard to what constitutes the requisite “sustained or high level of payment error,” neither the Act nor any regulation, preamble or other CMS published guidance defines this standard either by numeric threshold or otherwise.<sup>27</sup> Indeed, during regulatory implementation of this statutory provision, one commenter requested that CMS “define the phrase ‘sustained or high levels of payment errors’” and requested that CMS specify how such determinations will be made.<sup>28</sup> Without ever specifically answering the commenter’s question, CMS noted that, in 2005, it issued Program Integrity Manual (“PIM”) instructions on “determining when a provider or supplier has a sustained or high level of payment error,”<sup>29</sup> and as such it discussed this issue no further in the preamble.

In reviewing the aforementioned Manual instructions,<sup>30</sup> one concludes that they are as vague

<sup>24</sup> Given that the OIG has no recoupment authority, but rather must make recommendations to CMS, and/or its contractors, to recoup such funds, the statutory limitations related to a contractor’s right to extrapolate its findings are germane to this issue. See 42 U.S.C § 1395ddd(f)(3) (emphasis added). This provision also provides a second factor supporting extrapolation, which is “documented educational intervention has failed to correct the payment error,” which is not at issue here. Congress added this provision through Section 935(a) of the Medicare Prescription Drug Improvement, and Modernization Act of 2003. Pub. L. 108-173, § 935(a), 117 Stat. 2066, 2407-2411 (2003).

<sup>26</sup> *Id.*

<sup>27</sup> Given that there is no allegation of educational intervention and the failure thereof, we focus on the first statutory standard that must be met to support extrapolation.

<sup>28</sup> 74 Fed. Reg. 65296, 65303–04 (Dec. 9, 2009).

<sup>29</sup> *Id.*

<sup>30</sup> CMS Pub. 100-08, Program Integrity Manual, Transmittal 114, June 10, 2005 (CR 3734); see Chapter 3, § 3.10 et seq.

as the preamble language with regard to what conduct or error rate would support extrapolation. Although PIM, Ch. 3, § 3.10.1.4 provides a variety of means by which a contractor may find the requisite high error rate, *e.g.*, probe samples, data analysis or audits/evaluations by the OIG, there is no guidance as to what error rate triggers the statutory predicate of a “sustained or high...error.”

We find that case law, too, is unhelpful in this regard as the majority of cases seeking clarity on the definition of “sustained or high level of payment errors” have been dismissed because CMS’ finding of a high rate of error is precluded from judicial review.<sup>31</sup> However, in at least one case, Cabarrus Podiatry Clinic, a Medicare Administrative Contractor (“MAC”) reversed an overpayment calculation based on extrapolation where neither the contractor nor CMS could produce *any documentation* concerning a finding of a high error rate or a documented failure of education.<sup>32</sup> Thus, at a bare minimum, the MAC, CMS or OIG must document its findings that there exists a high rate of error before extrapolating the findings of a statistical sample to a broader universe of claims.

The need for a specific finding, and the basis for such a finding, is underscored by CMS’ own discussion in § 3.10.4.2 of the PIM in which CMS notes, “that before using extrapolation to determine overpayment amounts to be recovered by recoupment, offset or otherwise, there must be a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error.”<sup>33</sup>

Notably, any such articulated finding, or the basis for such finding, is lacking in this case. Indeed, how could there be such a finding when of the 55 similar OIG reviews published to date, 26 of the hospitals under review had error rates higher than JFK’s and the OIG did not extrapolate in any of those cases.<sup>34</sup> Moreover, extrapolation subjects JFK to punitive measures, which contravenes the Secretary’s stated purpose of extrapolation, which is to be a method of calculation, not an unchecked sanction.<sup>35</sup>

Thus, the OIG must at the *very least* remain consistent in its application of the “high rate of error” criterion. Such consistency is seriously called into question if providers presenting nearly double the error rate of the Hospital are not found to have a “high rate of error” or are not, for some other undocumented reason, subject to extrapolation.

<sup>31</sup> See Anghel v. Sebelius, No. 10-CV-4574, 2012 WL 6212843 (E.D.N.Y. Dec. 13, 2012); Gentiva Healthcare Corp. v. Sebelius, 857 F. Supp.2d 1, 13 (D.D.C. 2012); Morgan v. Sebelius, No. 11 Civ. 0300, 2012 WL 1231960, at \*1 (S.D.W.Va. Apr. 12, 2012); John Balko & Assocs. v. Sebelius, No. 12-CV-0572, 2012 WL 6738246 (W.D. Pa. Dec. 28, 2012).

<sup>32</sup> Cabarrus Podiatry Clinic (Appellant) (Beneficiaries) Claim for Part B Benefits, ALJ Appeal No. 1-127356701 (Dec. 14, 2007).

<sup>33</sup> Id. at § 3.10.1.2.

<sup>34</sup> See **Tab A**.

<sup>35</sup> 74 Fed. Reg. at 65303–04.

Indeed, a high error rate does not seem to be the basis for the OIG's extrapolation. Rather, the decision to extrapolate seems to have been made before the OIG's review was barely underway. On February 6, 2012, JFK received its first notice that it was selected for OIG review. On or about March 9, 2012, JFK received a list of 200 claims to be reviewed. JFK began pulling the corresponding charts in response to the list. Then, on March 13, 2012, the OIG Auditor emailed JFK indicating that "HQ may change the sample design," and explained in subsequent telephonic communications that this meant changing the sample because of the OIG's intention to extrapolate the results. JFK objected to the changed sample because the Hospital had started compiling the charts and such a mid-stream change would be overly burdensome on the Hospital. Thereafter, on or about March 15, 2012, the OIG Auditor emailed the Hospital CFO to indicate that the Hospital may proceed with its self-audit on the original list of 200 charts. The Hospital understood that the OIG then would not be extrapolating the results. Indeed, it was not until September 27, 2012, after the exit conference and several conferences between the Hospital and the OIG auditors, that extrapolation was ever mentioned.

Given its failure to make the requisite showing of a high payment error rate, and the apparent OIG decision pre-audit to extrapolate such errors for the simple sake of efficiency, the Hospital respectfully submits that no extrapolation may follow as there are statutory infirmities to such a finding.

## 2. Statistical Deficiencies

Even if, for the sake of argument, one were to assume that extrapolation of the 70 claims were legally appropriate, the decision to engage in post-sampling stratification, after initially selecting a simple random sample of 200 claims, coupled with a series of other material irregularities (discussed below) raises genuine concerns about the validity of the extrapolated numbers.

The OIG's preoccupation with recoupment efficiency appears to have caused the agency to lose sight of other critically important objectives in conducting and reporting on industry audits. Principal among these is the need for the OIG to proceed in a manner that is not only fair, but has the appearance of fairness — an objective that is discussed in Section III.C.i. above. Of equal importance, is the objective of reliability. In a nutshell, the OIG's processes and findings must be transparent (i.e., readily accessible and understandable) and reliable.

These objectives notwithstanding, the OIG has never articulated its rationale for using a sample size of 200 claims. Moreover, it has not provided an explanation of why, in all but one reported case thus far, the audited hospitals have been asked to make a straightforward refund while JFK, which we believe has better processes, practices and outcomes, are subjected to extrapolation to a seven-figure monetary demand.

JFK also respectfully notes that it appears that the OIG has not given appropriate thought to the sample design (and hence sample reliability) as reflected in the numerous errors identified by independent statistical experts retained to review the OIG's work in this case. For example, even a cursory review of Universe of claims makes it patently clear that there is a decided lack of claim homogeneity — with radical swings in the amounts at issue on a claim-by-claim basis<sup>36</sup> — thereby heightening the importance of a carefully constructed sample design. The OIG seems to have recognized the lack of claim homogeneity in the sample and attempted, post hoc, to bolster the reliability of its contemplated extrapolations by post-sampling stratification, that is dividing the sample into three strata. Post-sampling stratification, however, is rarely a substitute for careful sample design or a “fix” for poorly designed statistical samples as evidenced by the fact that Stratum 3 (which was associated with claims representing approximately 16 percent of the Medicare payments in the Universe of Claims) contained only five (5) claims (or 2.5 percent of the sample), rendering it statistically useless for extrapolation.

Instead of acknowledging the inherent flaws in its sample design and abandoning either its post-stratification efforts or extrapolation in its entirety, OIG appears to have attributed a zero value to the five (5) Stratum 3 claims. The OIG claims that it persisted with post-sampling stratification in order to enhance reliability. We, respectfully, argue that this approach: (1) did not achieve a precise and thus highly reliable estimate of the overall extrapolated amount (overall point estimate of \$5,632,342), achieving a 90 percent confidence interval and a 21.96 percent precision level; nor (2) did it enhance the precision level beyond what would have been achieved by a non-stratified approach.

JFK's review has concluded that the OIG's purported precision level is approximately 22 percent. We respectfully argue that this precision level is artificially enhanced by the OIG's treatment of Stratum 3, that is setting claims in these Stratum claims to zero in an effort to address sample design errors. At a 90 percent confidence level, JFK calculates Stratum 1 at a 24 percent precision level and Stratum 2 with approximately 45 percent precision level. Thus, the overall precision level of approximately 22 percent may only be achieved because of the “fix” related to Stratum 3.

Independent of this issue, we note that Stratum 2's precision level at the 90 percent confidence interval was an unacceptably high 44.92 percent — essentially 20 percentage points worse than the twenty-five (25) percent precision threshold established by the OIG in its 1998 voluntary self disclosure protocol and widely used by Independent Review Organizations (“IRO”) auditing entities under OIG Corporate Integrity Agreements. JFK notes that, at the very least, the OIG must conclude that there can be no statistically sound basis to extrapolate in any way based on these findings alone.

<sup>36</sup> Claims in the Universe have a payment range of \$100 to \$48,381.07.

In addition, it appears that had the OIG run the exact same 200-claim data that were used in the post-stratified variable appraisal in a non-stratified manner, it would have achieved an overall point estimate of \$5,607,016 with a lower limit at the 90 percent confidence interval of \$4,363,113 — an alleged overpayment amount that is \$32,156 lower than the overpayment amount calculated by OIG with a precision level that is only .22 percent less reliable than the artificially obtained stratified 21.96 precision level. As such, clearly post-stratification did not achieve the goal articulated by the OIG in enhancing the precision level. The negligible difference between a precision level of 22.18 and 21.96 illustrates yet again that the OIG's post-stratification efforts failed, essentially achieving (and artificially so) no additional precision or reliability.

JFK identified additional errors in the OIG's sampling and extrapolation exercises. In further attempts to assure JFK that it need not be concerned with the problems with Stratum 3, the OIG states that "errors associated with claims outside of Strata 1 and 2 were not extrapolated."<sup>37</sup> This statement, however, is incorrect. Statistical testing unequivocally demonstrates that all 200 sampling units were used in the post-stratified appraisal.

JFK has also identified errors in the OIG's Summary Review Sheets that call into question (if not outright undermine the integrity of) the OIG's stated overpayment figure, and by extension, its extrapolation to the Universe.

At JFK's request, the OIG did provide various documents. In examining those documents, JFK noted that in the OIG summary review sheet (*JFK-200\_Sample Findings\_Summary new.xlsx*), the OIG ascribed payment amounts for 13 of the 200 claims in the sample (i.e., 6.5 percent) that simply do not match the payment amounts reported in the Universe of Claims (See *12-07032 Sampling Frame.xlsx* and *12-07032 Random Numbers.xlsx*). For example, when reporting its post-audit findings, OIG reports and uses a claim payment amount of \$4,210.49 for sample claim number 142. Yet, as best as could be determined, this same claim is reported in the Universe of Claims as having a claim payment amount of \$2,551.21. This raises an inevitable question: How did a claim payment amount increase by approximately \$1,660? The other 12 such discrepancies are captured in the Chart attached hereto at **Tab B**.

The existence of these payment data discrepancies — coupled with how difficult the OIG's work papers make it for an independent statistician to try match the Universe, random numbers and review sheet with the actual sample — are exceedingly troubling. They suggest a pattern of unexplained, but undeniable, non-sampling errors in parts of the sample data and seriously undermine the claimed reliability of OIG's recommended overpayment amount.

In addition, the OIG's workpapers appear to include a duplicate claim in the Universe of Claims, further eroding any remaining confidence in the validity of the process and resulting process.

<sup>37</sup> OIG Response to JFK Inquiry Regarding Sampling Methods (May 28, 2013), attached at **Tab C**.

Specifically, FI\_DOC\_CLM\_CNIL\_NUM - 20927400671302NTA 01 appears twice in the frame with the same date of birth, payment amount, date of service, but different HCIN (See CLM\_NUM 2797 and 2799).

Based on all of the errors above, including but not limited to, (1) identified apparent errors in the OIG's stated overpayment, and by extension its extrapolation, (2) unexplained bases for favoring extrapolation in lieu of such issues, (3) the unacceptably high precision level for Stratum 2, which exceeds the OIG's own accepted threshold; and (4) the artificially enhanced precision level at the 90 percent confidence interval, JFK respectfully submits that not only should the overpayment findings be questioned, but extrapolation should be rejected.

### 3. Extrapolation is inconsistent with the OIG's stated purpose of the Medicare Compliance Reviews and is fundamentally unfair

The OIG has indicated that the purpose of these specific reviews is to "use them to instruct the hospital on best practices and prevent any future problems."<sup>38</sup> We respectfully submit that this goal is not advanced by applying extrapolation in this case. Indeed, there is nothing instructive about extrapolation.

Moreover, to extrapolate in JFK's case would be fundamentally unfair. This is the case because, as referred to above and set forth in **Tab A**, the OIG has released 55 Medicare Compliance Review audits involving the same Risk Areas at issue in this case, but has not extrapolated its findings in 54 of the 55 reported cases. Moreover, 26 facilities had error rates higher than JFK with 16 of those facilities having error rates in excess of 50 percent; and in none of those cases did the OIG recommend extrapolation.<sup>39</sup> We strenuously object to extrapolation for a facility with an "error rate" performance that is significantly lower than most other facilities reviewed by the OIG.

Finally, extrapolation, even if it were appropriate, is premature because the OIG's alleged error rate is erroneously inflated. There will be no settled "error rate" from which to extrapolate until JFK has had the opportunity to avail itself fully of its appeal rights. As noted above, JFK contests 39 of the OIG's 70-claim findings.

JFK's appeal history is the best evidence of the premature nature of any extrapolation. With regard to the Universe of Claims, the RAC has identified 297 claims for complex review (that is Short-Stay and DRG-related coding). Of this 297-claim total, 261 claims relate to Short-Stay cases. Of those, JFK has appealed 100 claims and of the 19 appeal decisions rendered thus far, JFK has prevailed on all of these cases. Moreover, of these 261 claims, the RAC agreed with JFK on 59 Short-Stay cases. Clearly, this is a fluid process that affords JFK appeal rights that have yet to be

<sup>38</sup> Modern Healthcare, *Audits said to put hospitals on track*, pp. 17-21 (Oct. 22, 2012).

<sup>39</sup> See Tab A.

fully exercised. Given its appeal history, clearly some number, indeed perhaps a significant number, of cases will be found to be proper. As such, utilizing a 70-claim error rate is patently premature and imprecise and may require JFK to refund amounts as overpayments that have yet to be determined to be such. Accordingly, JFK requests that OIG abandon the extrapolation recommendation in its entirety.

**4. The OIG's "overpayment" amount is inflated because it claims the entire DRG amount as an "overpayment" when the OIG concedes JFK can rebill those claims to recover, at least, the Part B payment**

The Draft Report does not dispute the medical necessity of any services rendered. Thus, even for the 54 Short-Stay cases the OIG finds to be in error, it concedes that these claims may be eligible for Part B payment.<sup>40</sup> As such, JFK should be permitted to calculate and deduct from the Part A overpayment the amount that which should have been paid under Medicare Part B.

Even if, for the sake of argument, JFK agreed that all 54 Short-Stay cases were incorrect, JFK's preliminary review estimates the overpayment to be approximately \$169,688, and not \$256,633 as noted in Appendix A of the Draft Report. Moreover, if JFK's appeal history holds and it continues to prevail at the ALJ level on all 24 Short-Stay claims it plans to appeal on the merits, thus keeping the DRG payments for these 24 claims, the Part B payment amount of the remaining 30 Short-Stay claims is approximately \$55,700, which would mean an overpayment amount of only \$75,900 and not \$256,633 as noted in the Draft Report.

This position is consistent not only with the OIG's own Draft Report, but also with CMS' own: (1) proposed rule, entitled "Medicare Program; Part B Billing in Hospitals" addressing the policy of billing under Medicare Part B following the denial of a Medicare Part A hospital inpatient claim ("Inpatient Part B Proposed Rule");<sup>41</sup> (2) CMS Ruling 1455 (issued March 13, 2013, referred to as "CMS-1455-R") on the same topic; (3) CMS' Technical Decision Letter (issued July 13, 2012);<sup>42</sup> and (4) numerous Administrative Law Judge and Medicare Appeals Council decisions.<sup>43</sup>

<sup>40</sup> See Draft Report at p. 5, n.3.

<sup>41</sup> 78 Fed. Reg. 16632 (Mar. 18, 2013).

<sup>42</sup> This TDL is not publicly released, but JFK understands that such a document provides that: There have been a number of Administrative Law Judge ("ALJ") decisions in recent months that uphold a claims administration contractor's denial of inpatient services as not reasonable and necessary, but require the contractor to pay for the services on an outpatient basis and/or at an "observation level of care." ... Medicare pays for observation services under the outpatient prospective payment system ("OPPS"). However, observation services are generally bundled and not paid separately.

<sup>43</sup> See In the case of O'Connor Hospital, Med & Med GD (CCH) P 122133 (H.H.S. Feb. 1, 2010), 2010 WL 425107, consistent with In the case of UMDNJ - University Hospital, 2005 WL 6290383 (H.H.S.

With regard to the recently issued CMS-1455-R, the CMS Administrator specifically referred to the plethora of ALJ decisions declaring that providers should be paid “under Medicare Part B following a denial of a Medicare Part A hospital inpatient claim . . . [if] an inpatient admission was [found] not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act.”<sup>44</sup>

Notably, CMS-1455-R was issued as somewhat of a bridge while CMS works to finalize the Inpatient Part B Proposed Rule. In this proposed rule, CMS acknowledged that the Medicare statute and regulations require CMS to pay hospitals under Medicare Part B for reasonable and necessary services furnished to beneficiaries. Specifically, CMS provides:

Having reviewed the statutory and regulatory basis of our current Part B inpatient payment policy, we believe that, under section 1832 of the [Social Security] Act, Medicare should pay all Part B services that would have been reasonable and necessary (except for services that require an outpatient status) if the hospital had treated the beneficiary as a hospital outpatient rather than treating the beneficiary as an inpatient[.]<sup>45</sup>

CMS-1455-R is effective until the Inpatient Part B Proposed Rule.<sup>46</sup> Thus, the CMS Ruling applies to Part A inpatient claims that were denied because inpatient admission was not reasonable and necessary, as long as the denial was made: (1) while CMS-1455-R is in effect; (2) prior to the effective date of the Ruling, but for which there is still a timely appeal; or (3) prior to the effective date of CMS-1455-R, but for which an appeal is pending.<sup>47</sup> CMS “acquiesce[d] to the approach taken in the aforementioned ALJ and Appeals Council decisions” and found that that when a Part A inpatient admission is denied because the inpatient admission was not reasonable and necessary, a provider may submit a Part B inpatient claim for the Part B services that would have been payable had the beneficiary been treated as an outpatient, rather than admitted as an inpatient, except when those services specifically require an outpatient status.<sup>48</sup>

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Mar. 14, 2005) (directing the CMS contractor to reimburse the hospital for outpatient services pursuant to Medicare Part B after payment was denied for inpatient services pursuant to Medicare Part A); In the case of Indiana University Health Methodist Hospital, Docket No. M-12-872 (H.H.S. May 17, 2012), 2012 WL 3067987, at \*10; see also In the case of Montefiore Medical Center, Docket No. M-10-1121 (H.H.S. May 18, 2011), 2011 WL 6960290, at \*22. Copies of all referenced cases are included at **Tab D**.

<sup>44</sup> Centers for Medicare & Medicaid Services, Ruling No. CMS-1455-R (Mar. 13, 2013) (hereinafter, “CMS Ruling”), at 1.

<sup>45</sup> Id. at 16636.

<sup>46</sup> CMS Ruling, at 2-3.

<sup>47</sup> Id. at 14.

<sup>48</sup> Id. at 4, 6.



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In short, consistent with the ALJ and Medicare Appeals Council Rulings and the recent CMS Ruling, OIG should (or recommend that CMS) calculate the overpayment at issue by determining the difference between the inpatient reimbursement received and the outpatient reimbursement the Hospital would have received. A recommendation that does not provide for this to be done prior to extrapolation, if any, will give rise to a logistical nightmare because once the Part A payments are extrapolated there will be no practical way to determine the Part B set-off. This would be inconsistent with the current state of the law and patently unfair.

#### IV. JFK's Internal Controls

JFK is a responsible provider of healthcare items and services with a deep commitment to operating in compliance with applicable rules and regulations. As part of this commitment, the Hospital routinely examines its coding and billing practices and procedures with the objective of achieving ever-improved accuracy and completeness.

JFK notes that currently, in order to ensure that patients are properly categorized as either inpatients or outpatients, the Hospital uses outside clinical consultants to undertake a concurrent review of the medical record and the presence of medical necessity, thereby enabling adjustments before patient discharge. The OIG's determinations notwithstanding, as noted above even with regard to 2009-2010 Short-Stay cases the Hospital has an impressive record in connection with appealing and reversing RAC findings of error. This strongly suggests that the Hospital's internal controls are fully operational and highly efficient. That said, JFK will always seek to capitalize on opportunity for improvement and it will redouble its efforts on enhancing compliance with regard to the Risk Areas in the Draft Report.

\* \* \*

On behalf of JFK, we thank you in advance for your consideration of our various arguments and concerns. We, and our client, will make ourselves available to you in the event that you have any questions or require further information.

Sincerely,

/Holley Thames Lutz/

Holley Thames Lutz  
Partner

cc: James Leamon  
D. McCarty Thornton