

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
MEMORIAL UNIVERSITY MEDICAL
CENTER**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Gloria L. Jarmon
Deputy Inspector General
for Audit Services**

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Office of Inspector General

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Report in Brief

Date: February 2018

Report No. A-04-17-08055

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



Why OIG Did This Review

This review is part of a series of hospital compliance reviews. 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 2016, Medicare paid hospitals \$170 billion dollars, which represents 46 percent of all fee-for-service payments for the year.

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

How OIG Did This Review

We selected for review a stratified random sample of 120 inpatient and 11 outpatient claims with payments totaling \$1.9 million for our 2-year audit period.

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

Medicare Compliance Review of Memorial University Medical Center

What OIG Found

The Hospital complied with Medicare billing requirements for 92 of the 131 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 39 claims, resulting in overpayments of \$599,530 in calendar year 2015 and 2016.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1.4 million for the audit period. During the course of the audit, the Hospital submitted some of these claims for reprocessing that we verified as correctly reprocessed. Accordingly, we have reduced the recommended refund by this amount.

What OIG Recommends and Hospital Comments

We recommended that the Hospital refund the Medicare contractor just over \$1.3 million (\$1.4 million less \$155,072 that had already been repaid) in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

The Hospital did not agree with all of our findings and recommendations. Specifically, the Hospital disagreed with 17 of the 39 claim errors that we identified as not fully complying with Medicare billing requirements. We obtained independent medical review for Inpatient Rehabilitation Facility medical necessity requirements. The independent medical reviewers were provided with all documentation necessary to sufficiently determine medical necessity for the IRF claims, and our report reflects the results of that review. Therefore, we maintain that all of our findings and recommendations are correct.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. 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 2016, Medicare paid hospitals \$170 billion, which represents 46 percent of all fee-for-service payments; accordingly it is important to ensure hospital payments comply with requirements.

OBJECTIVE

Our objective was to determine whether Memorial University Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims from January 1, 2015, through December 31, 2016.

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 (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 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 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

Our previous work at other hospitals identified these types of hospital claims at risk for noncompliance:

- inpatient claims billed with high-severity-level DRG codes,
- Inpatient claims paid in excess of charges,
- inpatient rehabilitation facility (IRF) claims, and
- outpatient medical device claims.

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 review.

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 Social Security Act (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 (§ 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)).

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

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, § 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

Under section 1128J(d) of the Social Security Act and 42 CFR part 401, subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR §§ 401.305(a)(2), and (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments.

Memorial University Medical Center

The Hospital is a 604-bed nonprofit academic medical center in Savannah, GA. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately \$193 million for 12,488 inpatient and 55,924 outpatient claims between January 1, 2015, and December 31, 2016 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$8,465,777 in Medicare payments to the Hospital for 770 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 131 claims (120 inpatient and 11 outpatient) with payments totaling \$1,946,077. Medicare paid these 131 claims during our audit period.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 30 IRF claims to medical review to determine whether the services met medical necessity requirements. 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.

FINDINGS

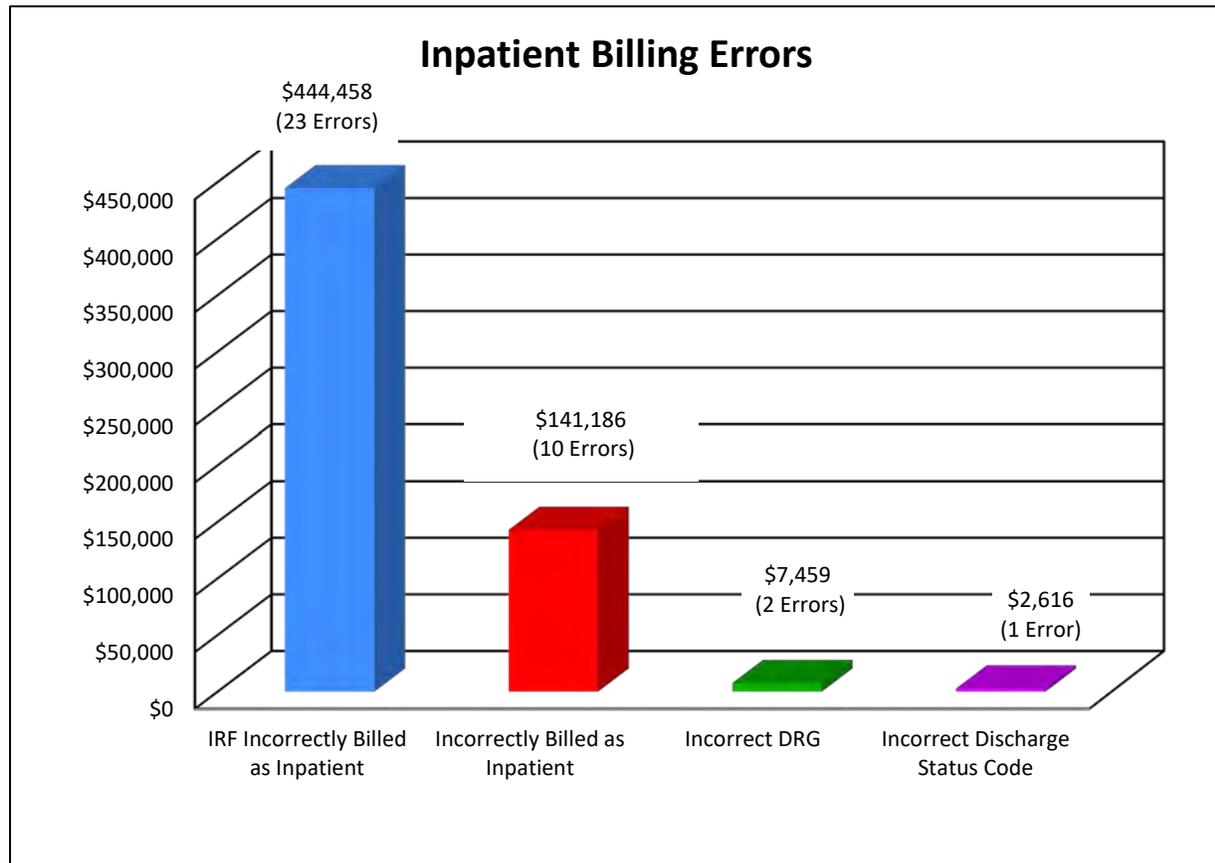
The Hospital complied with Medicare billing requirements for 92 of the 131 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare

billing requirements for the remaining 39 claims, resulting in overpayments of \$599,530 for the audit period. Specifically, 36 inpatient claims had billing errors, resulting in overpayments of \$595,719, and 3 outpatient claims had billing errors, resulting in overpayments of \$3,811. These errors occurred primarily because the Hospital did not have adequate 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 \$1,455,892 for the audit period. See Appendix B for statistical sampling methodology, Appendix C for sample results and estimates, and Appendix D for results of review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 36 of the 120 inpatient claims that we reviewed. These errors resulted in overpayments of \$595,719 as shown below.



Incorrectly Billed 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)).

The *Medicare Benefit Policy Manual* states that “the IRF benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care” (Pub. No. 100-02, chapter 1, § 110).

According to the *Medicare Benefit Policy Manual*, the patient’s medical record must include certain documentation intended to ensure that the IRF coverage requirements are met. The record must include (1) a comprehensive pre-admission screening, (2) a post-admission rehabilitation physician evaluation, and (3) an individualized overall plan of care developed by a rehabilitation physician (Pub. No. 100-02, chapter 1, § 110.1.1-110.1.3).

In order for IRF care to be considered reasonable and necessary, the *Medicare Benefit Policy Manual* states that the documentation in the patient’s IRF medical record must demonstrate a reasonable expectation that, at the time of admission to the IRF, the patient (1) required the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally required an intensive rehabilitation therapy program; (3) was expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program; (4) required physician supervision by a rehabilitation physician; and (5) required an intensive and coordinated interdisciplinary approach to providing rehabilitation (Pub. No. 100-02, chapter 1, § 110.2).

Finally, the *Medicare Benefit Policy Manual* states that a primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient’s IRF medical record must document a reasonable expectation that, at the time of admission to the IRF, the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs (Pub. No. 100-02, chapter 1, § 110.2.2).

For 23 of the 120 selected inpatient claims (23 of the 30 selected IRF claims), the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation. In addition, for 6 of the 23 incorrectly billed claims, the Hospital billed IRF claims that did not comply with Medicare documentation requirements. Specifically, the Hospital’s medical records did not include sufficient documentation to support the following required elements:

- for four errors, documentation that a rehabilitation physician performed a post-admission evaluation within the first 24 hours of the IRF admission;

- for one error, documentation that a comprehensive preadmission screening occurred within the 48 hours immediately preceding the admission; and
- for one error, documentation that a rehabilitation physician developed and documented an individualized overall plan of care within 4 days of the IRF admission.

The Hospital indicated that it had billed 6 of the 23 claims incorrectly because of human and system errors. However, it did not provide a cause for the remaining 17 errors because officials contended that these claims met Medicare requirements. As a result of these errors, the Hospital received overpayments of \$444,458.²

Incorrectly Billed as Inpatient

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)).

A payment for services furnished to an individual may be made only to providers of services that are eligible and only if, “with respect to inpatient hospital services . . . , which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual’s medical treatment . . .” (the Act, § 1814(a)(3)). Federal regulations state that Medicare Part A pays for inpatient hospital services only if a physician certifies and recertifies, among other things, the reasons for continued hospitalization (42 CFR § 424.13(a)). In addition, the regulations provide that an inpatient admission, and subsequent payment under Medicare Part A, is generally appropriate if the ordering physician expects the patient to require care for a period of time that crosses two midnights (42 CFR 412.3(d)(1)).³ Furthermore, the *Medicare Benefit Policy Manual* states that “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 (Pub. No. 100-02, chapter 1 § 10).”

For 10 of the 120 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation. The Hospital identified all 10 of these errors during their self-review of our sample claims after the start of our review. Hospital officials stated that these incorrect billings occurred because of human error during the utilization review process and a billing error in the hospital’s previous billing system.

² The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status). Until the Hospital bills these Medicare Part B services and its MAC adjudicates them, we do not have enough information to determine the effect on the overpayment amount. The Hospital should contact its MAC for rebilling instructions.

³ As amended by 80 Fed. Reg. 70298, 70602 (2015). Prior to CY 2016, the 2-midnight rule was codified at 42 CFR 412.3(e)(1).

As a result of these errors, the Hospital received overpayments of \$141,186. For all 10 claims, the Hospital refunded \$141,186 of the overpayments after the start of our review.

Incorrectly Billed Diagnosis-Related Group Codes

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 Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For 2 of the 120 selected inpatient claims, the Hospital submitted claims to Medicare that were incorrectly coded, resulting in incorrect DRG payments to the Hospital. Specifically, certain diagnosis codes were not supported by the medical records. Hospital officials stated that these errors occurred because of human error.

As a result of these errors, the Hospital received overpayments of \$7,459. For the two claims, the Hospital refunded \$7,459 of the overpayments after the start of our review.

Incorrectly Billed Discharge Status Codes

A discharge of a hospital inpatient is considered to be a transfer when the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient’s stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 1 of the 120 sampled claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers. For this claim, the Hospital should have coded the discharge status as a transfer to home under a written plan of care for the provision of home health services. However, the Hospital incorrectly coded the discharge status as to home. Thus the Hospital should have received the per diem payment instead of the full DRG payment. Hospital officials stated that this incorrect coding occurred because of human error.

As a result of this error, the Hospital received an overpayment of \$2,616. For this claim, the hospital refunded \$2,616 of the overpayment after the start of our review.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 3 of the 11 outpatient claims that we reviewed. These errors resulted in overpayments of \$3,811.

Federal Regulations

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of a replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45(a)). The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements in additional detail (Pub. No. 15-1).⁴ For services furnished on or after January 1, 2014, the Manual states that, when a hospital furnishes a replacement device received without cost or with a credit of 50 percent or more of the cost of a replacement because of a warranty, recall, or field action, the hospital must report the amount of the device credit in the amount portion for value code “FD” and report either condition code 49 or 50.

Manufacturing Credits for Replaced Medical Devices Not Reported

For 3 of the 11 outpatient claims, the Hospital incorrectly billed Medicare for medical devices that were under warranty. For these three claims, the Hospital received a full credit for replaced devices but did not report value code “FD” indicating that it received a full warranty. Hospital officials stated that this incorrect reporting occurred because of human error and the lack of a formal written policy and process to issue medical device credits. As a result of these errors, the Hospital received overpayments of \$3,811. For all three claims, the Hospital refunded \$3,811 of the overpayments after the start of our review.

OVERALL ESTIMATE OF OVERPAYMENTS

The combined overpayments on our sampled claims totaled \$599,530. On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,455,892 for the audit period. During the course of our audit, the Hospital submitted some of these claims for reprocessing that we verified as correctly reprocessed. Accordingly, we have reduced the recommended refund by this amount.

⁴ The PRM states: “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service” (part I, § 2102.1). Section 2103 further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example: “Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.”

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$1,300,820 (\$1,455,892 less \$155,072 that has already been repaid) in estimated overpayments for the audit period for claims that it incorrectly billed;
- exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day repayment rule; and
- strengthen controls to ensure full compliance with Medicare requirements.

MEMORIAL UNIVERSITY MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

MEMORIAL UNIVERSITY MEDICAL CENTER COMMENTS

In written comments on the draft report, the Hospital did not agree with all of our findings and recommendations. The Hospital disagreed that it incorrectly billed 17 of the 39 claims that we identified as not fully complying with Medicare billing requirements. Specifically, the Hospital said that the IRF claims were not audited by the OIG, but were instead audited by the independent medical reviewer and the medical reviewer did not allow the hospital to submit additional documentation regarding these findings that would show that these 17 IRF claims met medical necessity requirements for the services provided. The Hospital further said that it would pursue the Medicare appeals process for these claims. The Hospital agreed with our remaining findings and recommendations. See Appendix E for the auditee's comments.

OFFICE OF INSPECTOR GENERAL RESPONSE

After review and consideration of the Hospital's comments, we maintain that our findings and recommendation are correct. We obtained an independent medical review to determine the medical necessity for all IRF claims in our sample, which included the 17 claims that the Hospital says met medical necessity requirements. The independent medical reviewers were provided with all documentation necessary to sufficiently determine medical necessity for the IRF claims. Although the Hospital indicated in its response to our draft report that the medical reviewers did not allow it to submit additional documentation, at the time we discussed the medical results with the Hospital, the Hospital indicated that it did not have additional medical records, but instead questioned the medical reviewer's interpretation of the information already provided. After consultation with the medical reviewers, the medical reviewers declined to reevaluate the same information that they had been previously provided, although they acknowledged that the same documentation could be reviewed during the appeals process. Our report reflects the results of the determinations that the independent medical reviewers made. The Hospital retains its full appeal rights for these claims.

OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to HHS action officials. Action officials at CMS, acting through a Medicare Administrative Contractor (MAC) or other contractor, will determine whether an overpayment exists and will recoup any overpayments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Parts A and B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a hearing before an Administrative Law Judge. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$8,465,777 in Medicare payments to the Hospital for 770 claims that were potentially at risk for billing errors. We selected a stratified random sample of 120 inpatient and 11 outpatient claims with payments totaling \$1,946,077 for review. Medicare paid these 131 claims during our audit period.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 30 IRF claims to medical review to determine whether the services met medical necessity 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 from April 2017 through October 2017.

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 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 120 inpatient and 11 outpatient claims totaling \$1,946,077 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;
- reviewed the Hospital's procedures for assigning DRG and admission status codes for Medicare claims;
- used an independent medical review contractor to determine whether 30 IRF claims met medical necessity requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare 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 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.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population contained inpatient and outpatient claims paid to the Hospital during the audit period for selected services provided to Medicare beneficiaries.

SAMPLING FRAME

According to CMS's NCH data, Medicare paid the Hospital \$193 million for 12,488 inpatient and 55,924 outpatient claims during the audit period.

We obtained a database of claims from the NCH data totaling \$116 million for 6,796 inpatient and 37,963 outpatient claims in 30 risk areas. From these 30 areas, we selected 4 consisting of 2,280 claims totaling \$34,607,059 for further review.

We performed data filtering and analyses of the claims within each of the 4 high risk areas. The specific filtering and analyses steps performed varied depending on the Medicare issue but included such procedures as removing:

- claims with certain discharge status and diagnosis codes,
- paid claims less than \$0, and
- claims under review by the Recovery Audit Contractor as of March 23, 2017.

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: Inpatient Claims Billed With High-Severity-Level DRG Codes, Inpatient Claims Paid in Excess of Charges, and Inpatient Rehabilitation Facility Claims.

This assignment hierarchy resulted in a sample frame of 770 Medicare paid claims in 4 risk areas totaling \$8,465,777 from which we drew our sample (Table 1).

Table 1: Risk Areas

Medicare Risk Area	Frame Size	Value of Frame
Inpatient Claims Billed With High Severity Level DRG Codes	494	\$4,704,802
Inpatient Claims Paid in Excess of Charges	200	2,293,728
Inpatient Rehabilitation Facility Claims	65	1,299,827
Outpatient Medical Device Claims	11	167,420
Total	770	\$8,465,777

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 four strata on the basis of Medicare risk area and then split one risk area on the basis of amount paid. Paid claims less than \$11,137 are in stratum 1 and paid claims \$11,137 or greater are in stratum 2. The split risk area was Inpatient Claims Billed with High-Severity-Level DRG Codes (low and high). All claims were unduplicated, appearing in only one area and only once in the entire sampling frame.

We selected 131 claims for review as shown in Table 2.

Table 2: Claims by Stratum

Stratum	Medicare Risk Area	Claims in Sampling Frame	Value of Frame	Claims in Sample
1	Inpatient Claims Billed With High-Severity-Level DRG Codes (low dollar)	369	\$2,513,990	30
2	Inpatient Claims Billed With High-Severity-Level DRG Codes (high dollar)	125	2,190,812	30
3	Inpatient Claims Paid in Excess of Charges	200	2,293,728	30
4	Inpatient Rehabilitation Facility Claims	65	1,299,827	30
5	Outpatient Medical Device Claims	11	167,420	11
	Total	770	\$8,465,777	131

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 4. After generating the random numbers, we selected the corresponding claims in each stratum. We selected all claims in stratum 5.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate our estimates. We used the lower-limit of the 90-percent confidence interval to estimate the amount of improper Medicare payments in our sampling frame during the audit period.

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	369	\$2,513,990	30	\$199,956	2	\$12,999
2	125	2,190,812	30	545,455	3	45,676
3	200	2,293,728	30	396,825	8	92,586
4	65	1,299,827	30	636,421	23	444,458
5	11	167,420	11	167,420	3	3,811
Total	770	\$8,465,777	131	\$1,946,077	39	\$599,530

Table 4: Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	\$1,934,251
Lower limit	1,455,892
Upper limit	2,412,609

APPENDIX D: RESULTS OF REVIEW 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
Inpatient Claims Billed With High-Severity-Level DRG Codes (low dollar)	30	\$199,956	2	\$12,999
Inpatient Claims Billed With High-Severity-Level DRG Codes (high dollar)	30	545,455	3	45,676
Inpatient Claims Paid in Excess of Charges	30	396,825	8	92,586
Inpatient Rehabilitation Services	30	636,421	23	444,458
Inpatient Totals	120	\$1,778,657	36	\$595,719
Outpatient Medical Device Claims	11	\$167,420	3	\$3,811
Outpatient Totals	11	\$167,420	3	\$3,811
Inpatient and Outpatient Totals	131	\$1,946,077	39	\$599,530

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 E: MEMORIAL UNIVERSITY MEDICAL CENTER



November 29, 2017
Report number: A-04-17-08055

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

Re: Memorial Health University Medical Center's Response to the OIG Draft Report A-04-17-08055 (Medicare Compliance Review of Memorial University Medical Center).

Dear Ms. Pilcher:

Memorial Health University Medical Center (Memorial) is in receipt of the November 3, 2017, U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled *Medicare Compliance Review of Memorial University Medical Center*. As requested by the OIG, Memorial is providing written comments specific to our views on the validity of the facts, reasonableness of the recommendations, and a statement of concurrence or non-concurrence for each recommendation. Memorial appreciates the opportunity to submit this response.

The OIG's Recommendations:

The Draft Audit Report includes three recommendations. Memorial responds as follows to each recommendation.

1. OIG Recommendation: We recommend that the Hospital refund to the Medicare contractor \$1,315, 931 (\$1,467,934 less \$152,003 that has already been repaid) in estimated overpayments for the audit period for claims that it incorrectly billed.

Memorial does not concur with this recommendation.

The recommended refund, \$1,315,931, to the Medicare Contractor represents amounts due for billing errors for thirty-nine (39) claims. Memorial does not agree with the OIG's findings for seventeen (17) of these claims, which represent \$335,199.84 in potential overpayments. These 17 claims are specific to Inpatient Rehabilitation Services, for which Memorial will appeal, to the Medicare Contractor.

During the audit process, Memorial was allowed the opportunity to submit additional documentation to the OIG on the medical records originally submitted, with the exception of the Inpatient Rehabilitation medical records. These Rehabilitation medical records were not audited by the OIG, as were all others, but were instead audited by the Medicare Contractor, Cahaba. Unlike the OIG, Cahaba did not permit Memorial to submit additional documentation or to have any discussion regarding their findings during the audit process. Instead, Cahaba is requiring all communication to be during the post audit period and requires Memorial to formally appeal Cahaba's findings. Memorial believes the additional documentation for these 17 claims that Memorial was prepared to submit to the OIG until it was instructed to submit such additional documentation to Cahaba (which refused to accept any additional documentation) clearly supports the patients' eligibility for and the medical necessity of the services provided. As a result, Memorial will appeal the findings, once the Demand Letter is received from the Medicare Contractor, and is confident that with the additional documentation, the services will be found to have been medically necessary.

Memorial agrees with the findings for the remaining twenty-two (22) claims. We are in the process of re-filing all claims with the Medicare Contractor and anticipate completion by end of November 2017. Memorial appreciates the opportunity to re-file a corrected claim.

2. OIG Recommendation: We recommend that the Hospital exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day repayment rule.

Memorial is in concurrence with this recommendation.

Prior to the issuance of the Draft Report, Memorial began this process. Memorial anticipates it will complete its' review and refund any identified overpayments by 2017 year-end.

3. **OIG Recommendation:** We recommend that the Hospital strengthen controls to ensure full compliance with Medicare requirements.

Memorial is in concurrence with this recommendation.

Prior to the issuance of the Draft Report, Memorial began a review of the processes and associated controls; strengthening those already in existence and creating new ones as needed. For example: Policies and processes to specific to appropriate assignment of patient status were updated and re-education provided. Additionally, the Medical Device process was revised to include tracking of the claim adjustment notification from the Medicare Administrative Contractor.

Please do not hesitate to contact me if you would like to discuss Memorial's response to the OIG Draft Report at 912-350-8551 or shirlal1@memorialhealth.com.

Sincerely,

Alysia Shirley

Alysia F. Shirley
Vice President, Compliance and Audit Services
Memorial Health, Inc.