

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF MARY HITCHCOCK
MEMORIAL HOSPITAL
FOR 2009 THROUGH 2012**

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Office of Inspector General

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EXECUTIVE SUMMARY

Mary Hitchcock Memorial Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated net overpayments of at least \$1.4 million over more than 2 years.

WHY WE 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 services that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals. We reviewed claims and line items; the term “service” in this review includes both.

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

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient 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 pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital, which is part of the Dartmouth-Hitchcock Health system, is a 396-bed teaching hospital located in Lebanon, New Hampshire. Medicare paid the Hospital approximately \$410 million for 16,758 inpatient and 399,997 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS’s National Claims History data.

Our audit covered \$13,034,401 in Medicare payments to the Hospital for 86,143 claims and line items that were potentially at risk for billing errors. We selected a stratified random sample of 115 inpatient claims, a simple random sample of 100 outpatient line items, and a judgmental sample of 230 claims (7 inpatient and 223 outpatient) for review. Overall payments for our 445 selected services totaled \$2,131,375. Of these 445 services, 440 had dates of service in CY 2011 or CY 2012 and 5 (involving inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2010.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 190 of the 445 inpatient and outpatient services we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 255 services, resulting in net overpayments of \$770,735 for CYs 2011 through 2012 (250 services) and CYs 2009 and 2010 (5 services). Specifically, 33 inpatient services had billing errors, resulting in net overpayments of \$462,232, and 222 outpatient services had billing errors, resulting in overpayments of \$308,503. These overpayment amounts include claim payment dates outside of the 3-year recovery period. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare services within the selected risk areas that contained errors.

On the basis of our statistical and judgmental sample results, we estimated that the Hospital received net overpayments of at least \$1,393,198. This overpayment amount includes claims outside of the 3-year recovery period. Of the total estimated overpayments, at least \$452,145 was within the 3-year recovery period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$452,145 in estimated overpayments (of which \$310,583 was net overpayments identified in our sample) for the incorrectly billed services that are within the 3-year claims recovery period,
- work with the contractor to return overpayments outside of the 3-year recovery period in accordance to the 60-day repayment rule, and
- strengthen controls to ensure full compliance with Medicare requirements.

MARY HITCHCOCK MEMORIAL HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital partially disagreed with our findings and recommendations but stated it intended to make the recommended refund for claims within the 3-year recovery period. For claims outside the 3-year recovery period, the Hospital stated it intends to refund amounts for the overpayment determinations with which it agrees. For the remaining claims, the Hospital stated it will await the contractor's determination regarding the use of extrapolation and the recovery of identified payments outside of the 3-year recovery period. The Hospital stated that it reserves its right to appeal these claims. The Hospital also discussed steps it had taken to strengthen controls in the areas with which it agreed with our findings.

We acknowledge the Hospital's decision to refund to the contractor the estimated overpayments within the 3-year recovery period and its efforts to implement stronger controls. We continue to recommend that the Hospital work with the contractor to return overpayments outside of the 3-

year recovery period and strengthen controls to ensure full compliance with Medicare requirements

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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 data analysis techniques, we identified hospital services that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals. We reviewed claims and line items; the term “service” in this review includes both.

OBJECTIVE

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

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

Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). 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), 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 services at risk for noncompliance:

- inpatient short stays,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient services provided during inpatient stays,
- outpatient dental services, and
- outpatient evaluation and management (E&M) services.

For the purpose 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)).

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

Mary Hitchcock Memorial Hospital

The Hospital, which is part of the Dartmouth-Hitchcock Health system, is a 396-bed teaching hospital located in Lebanon, New Hampshire. Medicare paid the Hospital approximately \$410 million for 16,758 inpatient and 399,997 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS’s National Claims History data.

¹ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$13,034,401 in Medicare payments to the Hospital for 86,143 claims and line items that were potentially at risk for billing errors. We selected a stratified random sample of 115 inpatient claims, a simple random sample of 100 outpatient line items, and a judgmental sample of 230 claims (7 inpatient and 223 outpatient) for review. Overall payments for our 445 selected services totaled \$2,131,375. Of these 445 services, 440 had dates of service in CY 2011 or CY 2012 and 5 (involving inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2010 (audit period).

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected all 122 inpatient claims to focused medical review to determine whether the services were medically necessary and properly coded. This report focused 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.

For the details of our audit scope and methodology, see Appendix A.

FINDINGS

The Hospital complied with Medicare billing requirements for 190 of the 445 inpatient and outpatient services we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 255 services, resulting in net overpayments of \$770,735 for CYs 2011 through 2012 (250 services) and CYs 2009 and 2010 (5 services). Specifically, 33 inpatient services had billing errors, resulting in net overpayments of \$462,232, and 222 outpatient services had billing errors, resulting in overpayments of \$308,503. These overpayment amounts include claim payment dates outside of the 3-year recovery period.² These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare services within the selected risk areas that contained errors.

² Our audit report represents the results for all claims within our audit period. Section 1870(b) of the Act governs the recovery of excess payments. This section provides that excess payments identified are barred from recovery 3 years after the year in which the original payment was made. In addition, the Hospital is responsible for reporting and returning overpayments they identified to their Medicare administrative contractor. The 2010 Patient Protection and Affordable Care Act requires the reporting and return of Medicare overpayments along with written notice of the reason for the overpayment within 60 days after the overpayment was identified (60-day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

On the basis of our statistical and judgmental sample results, we estimated that the Hospital received net overpayments of at least \$1,393,198. This overpayment amount includes claims outside of the 3-year recovery period. Of the total estimated overpayments, at least \$452,145 was within the 3-year recovery period.

See Appendix B for our inpatient sample design and methodology, Appendix C for our inpatient sample results and estimates, Appendix D for our outpatient sample design and methodology, Appendix E for our outpatient sample results and estimates, and Appendix F for the results of our review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT SERVICES

The Hospital incorrectly billed Medicare for 33 of 122 selected inpatient services, which resulted in net overpayments of \$462,232.

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)).

For 22 (claims) of 122 selected inpatient services, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have billed as outpatient or outpatient with observation services. Hospital officials did not provide a cause for the errors identified because they disagreed with this finding. As a result of these errors, the Hospital received overpayments of \$377,113.³

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

For 10 (claims) of the 122 selected inpatient services, the Hospital billed Medicare with incorrectly coded claims that resulted in incorrect DRG codes. Hospital officials did not provide a cause for the errors identified because they disagreed with this finding. As a result of these errors, the Hospital received overpayments of \$77,537.

³ 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 and adjudicated by the Medicare administrative contractor before issuance of our report.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require a reduction in the IPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of the device, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89(a)). The Manual states that to correctly bill for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50 (which identifies the replacement device) and value code FD (which identifies the amount of the credit or cost reduction received by the hospital for the replaced device) (chapter 3, § 100.8).

For 7 (claims) of 122 selected inpatient services, the Hospital received reportable credits from manufacturers for replaced devices but did not adjust its inpatient claims with the proper condition and value codes to reduce payments. Hospital officials stated that these errors occurred because their clinical section responsible for device implants did not have adequate administrative processes in place to meet the Medicare requirements for crediting the rebates. As a result of these errors, the Hospital received overpayments of \$7,582.⁴

BILLING ERRORS ASSOCIATED WITH OUTPATIENT SERVICES

The Hospital incorrectly billed Medicare for 222 of 323 selected outpatient services, which resulted in overpayments of \$308,503.

Incorrectly Billed Outpatient Services Provided During Inpatient Stays

Medicare Part A covers certain items and nonphysician services provided to inpatients; consequently, the IPPS rate covers these services (the Manual, chapter 3, § 10.4).

For 200 (claims) of 323 selected outpatient services, the Hospital incorrectly billed Medicare Part B for outpatient services provided during inpatient stays that should have been included on its inpatient (Part A) claims to Medicare. Hospital officials stated that these errors occurred because the billing system did not recognize the outpatient charge as being subject to a bill-stop instruction if the charge was entered into the system after the inpatient stay was billed. As a result of these errors, the Hospital received overpayments of \$229,905.

Incorrect Billing for Dental Services

The Act states: “No payment may be made under Medicare Part A or Part B for any expenses incurred for items or services where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth ...” (§ 1862(a)(12)).

⁴ Six of the claims for “manufacturer credits for replaced medical devices not reported” had multiple types of errors that we have reported in the sections above. Five claims were incorrectly billed as inpatient, and one claim contained an incorrectly billed DRG code. To avoid double counting, we included only inpatient unreported credit overpayments of \$7,582 for two of the seven claims with errors. For the remaining unreported credit errors, we included these as overpayments in the “incorrectly billed as inpatient” section of this review.

For 10 (claims) of 323 selected outpatient services, the Hospital incorrectly billed Medicare for the treatment or removal of teeth. Hospital officials stated that these errors occurred because their billing operations did not have adequate administrative processes in place to avoid billing noncovered dental services to Medicare. As a result of these errors, the Hospital received overpayments of \$45,213.

Manufacturer Credits for Replaced Medical Devices Not Reported

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)). For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier -FB and reduces charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.⁵

For 6 (claims) of 323 selected outpatient services, the Hospital received full credits for replaced devices but did not report the -FB modifier and reduced charges on its claims. Hospital officials stated that these errors occurred because the clinical section responsible for device implants did not have adequate administrative processes in place to meet the Medicare requirements for crediting the rebates. As a result of these errors, the Hospital received overpayments of \$32,979.

Incorrectly Billed Evaluation and Management Services

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). Additionally, for beneficiary visits involving global surgery procedure, the Manual states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure (chapter 12, § 30.6.6(B)).

For 6 (line items) of 323 selected outpatient services, the Hospital incorrectly billed Medicare for E&M services that were either insufficiently documented or were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of certain procedures. Hospital officials indicated that five of these errors occurred because the treating physicians did not fully understand the Medicare requirements for separately billing an E&M service from certain procedures. Hospital officials did not provide a cause for the remaining error because they initially disagreed with our findings specific to this sampled service.⁶ As a result of these errors, the Hospital received overpayments of \$406.

⁵ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

⁶ In written comments on our draft report, the Hospital subsequently agreed with our findings for all six incorrectly billed E&M services.

OVERALL ESTIMATION OF OVERPAYMENTS

On the basis of our statistical and judgmental sample results, we estimated that the Hospital received net overpayments of at least \$1,393,198.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$452,145 in estimated overpayments (of which \$310,583 was net overpayments identified in our sample) for the incorrectly billed services that are within the 3-year claims recovery period,
- work with the contractor to return overpayments outside of the 3-year recovery period in accordance to the 60-day repayment rule, and
- strengthen controls to ensure full compliance with Medicare requirements.

MARY HITCHCOCK MEMORIAL HOSPITAL COMMENTS

In written comments on our draft report, the Hospital partially disagreed with our findings and recommendations but stated it intended to make the recommended refund for claims within the 3-year recovery period. For claims outside the 3-year recovery period, the Hospital stated it intends to refund amounts for the overpayment determinations with which it agrees. For the remaining claims, the Hospital stated it will await the contractor's determination regarding the use of extrapolation and the recovery of identified payments outside of the 3-year recovery period. The Hospital stated that it reserves its right to appeal these claims. The Hospital also discussed steps it had taken to strengthen controls in the areas with which it agreed with our findings.

The Hospital's response is included in its entirety as Appendix G.

CONTESTED DETERMINATION OF CLAIMS

The Hospital agreed with 223 (222 outpatient and 1 inpatient) of the 255 inpatient and outpatient services identified in our draft report as being improperly billed. The Hospital disagreed with our determination that it did not correctly bill the remaining inpatient 32 services.⁷ Specifically, for 22 services identified in our draft report as incorrectly billed as inpatient, the Hospital stated that the decision to admit each patient was based on the judgment of the attending physician and confirmed by the Utilization Management Committee at the point of care. For 10 services identified in our draft report as billed with incorrect inpatient DRG codes, the Hospital stated that

⁷ For the six claims with multiple types of errors, the Hospital agreed with the part of our findings where it received a reportable credit from the manufacturer for a replaced device but did not correctly adjust the claim.

it believed that the DRG code assigned was the appropriate code for each of these claims based upon control processes that the Hospital believed worked as designed.

STATISTICAL VALIDITY

The Hospital disagreed with our methodology and the statistical validity of the inpatient and outpatient amounts extrapolated. Specifically, the Hospital stated that the inpatient population contained inappropriate claims (i.e., claims already reviewed by the Recovery Audit Contractor, claims for managed care services, and claims that matched Medicare Part B physician claims for inpatient-only procedures performed on the same date of service). The Hospital also stated that the types of claims in the population varied widely in reimbursement amount and types of service, which made the claim samples unrepresentative of the population. Finally, the Hospital stated that our methodology overestimated the overpayment amount because it failed to offset the inpatient stay overpayment amount by the available Medicare Part B payments. The Hospital also disagreed with our use of extrapolation for incorrectly billed evaluation and management services.⁸

OFFICE OF INSPECTOR GENERAL RESPONSE

CONTESTED DETERMINATION OF CLAIMS

We subjected all inpatient claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Each case that was denied was reviewed by qualified personnel—including a licensed physician for services identified as incorrectly billed as inpatient and a certified coding specialist for services identified as billed with incorrect DRG codes. We continue to stand by those determinations and we acknowledge the Hospital's rights to appeal.

STATISTICAL VALIDITY

The use of statistical sampling to determine overpayment amounts is well established and has been upheld repeatedly on administrative appeal within the Department and in Federal courts.⁹

Regarding the Hospitals objections to our statistical sampling and extrapolation methodology, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.¹⁰ We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

⁸ We did not recommend recovery of the extrapolated overpayments in this area because most of the incorrectly billed services were outside of the 3-year recovery period.

⁹ *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

¹⁰ *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transynd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

We acknowledge that certain claims in our inpatient sample were either already reviewed by the Recovery Audit Contractor (one claim) or contained managed care services (five claims). Accordingly, our analysis effectively estimates the total value of these types of claims in our sampling frame and excludes the resulting total from our overpayment estimate. This adjustment ensures a fair and unbiased treatment of claims that were reviewed by the Recovery Audit Contractor or that contained managed care services.

We also agree that our inpatient sampling methodology was designed to remove claims that matched Medicare Part B physician claims for inpatient-only procedures performed on the same date of service. However, certain claims related to inpatient-only procedures were included in our sampling frame because the Hospital's physicians did not order an admission until at least 1 day after the inpatient-only procedure was performed, but prior to the patient's discharge. We considered these claims to be technical errors and did not recommend recovery of the overpayments or extrapolate the payment amounts associated with these claims.

We account for the variability in the sampling frame by recommending recovery at the lower-limit of a two sided 90 percent confidence interval. The more the claims in the population vary, the smaller our lower limit will tend to be. This approach ensures that the variability in the sampling frame is handled in a manner that is both statistically valid and fair to the auditee.

Finally, our draft report acknowledged in a footnote that Medicare Part B rebilling may affect the final overpayment amount. However, CMS is ultimately responsible for administering Medicare and contracts with Medicare contractors to process and pay claims. We cannot judge the value or allowability of Part B claims that have yet to be submitted. Consequently, providing an offset to the Part A overpayment with Part B reimbursement figures is not within the scope of this review. Should CMS determine that the Part B offset is a viable option, we will work with CMS to offset the Part A overpayments accordingly and use RAT-STATS to determine a new extrapolation.

We acknowledge the Hospital's decision to refund to the contractor the estimated overpayments within the 3-year recovery period and its efforts to implement stronger controls in the areas with which it agreed with our findings. We continue to recommend that the Hospital work with the contractor to return overpayments outside of the 3-year recovery period, and strengthen controls to ensure full compliance with Medicare requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$13,034,401 in Medicare payments to the Hospital for 86,143 claims and line items that were potentially at risk for billing errors. We selected a stratified random sample of 115 inpatient claims, a simple random sample of 100 outpatient line items, and a judgmental sample of 230 claims (7 inpatient and 223 outpatient) for review. Overall payments for our 445 selected services totaled \$2,131,375. Of these 445 services, 440 had dates of service in CY 2011 or CY 2012, and 5 (involving inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2009 or CY 2010.

We focused our review on the risk areas identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected all 122 inpatient claims to focused medical and coding review to determine whether the services were medically necessary and properly coded.

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 National Claims History 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.

Our fieldwork included contacting the Hospital in Lebanon, New Hampshire, from September 2013 through September 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2011 and 2012;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2009 through 2012;
- used computer matching, data mining, and other data analysis techniques to identify claims and line items potentially at risk for noncompliance with selected Medicare billing requirements;

- selected a stratified random sample of 115 inpatient claims for detailed review (Appendix B);
- selected a simple random sample of 100 outpatient line items for detailed review (Appendix D);
- judgmentally selected a sample of 230 claims (7 inpatient and 223 outpatient) for detailed review;
- 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 selected samples;
- requested that the Hospital conduct its own review of the selected samples to determine whether they were billed correctly;
- used an independent medical review contractor to determine whether 122 selected inpatient claim samples met medical necessity requirements and were properly coded;
- discussed the incorrectly billed samples with the Hospital to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those samples requiring adjustments for our audit period;
- calculated the overpayments that were within the 3-year recovery period;
- used the results of the sample review to calculate the estimated Medicare overpayment to the Hospital (Appendix C and E) for our audit period;
- used the results of the sample to estimate the Medicare overpayments to the Hospital (Appendix C) for our audit period that are within the 3-year recovery period; 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: INPATIENT SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population contained inpatient short-stay claims paid to the Hospital for services provided to Medicare beneficiaries during CYs 2011 and 2012.

SAMPLE FRAME

We downloaded claims from the National Claims History database totaling \$46,373,097 for 4,443 inpatient short-stay claims. We performed data analysis of these claims for further review and development and removed the following:

- claims that matched Medicare Part B physician claims for inpatient-only procedures performed on the same date of service,
- claims with patient discharges/transfers to hospice-home or a hospice-medical facility,
- hospital psychiatric facility claims,
- claims that did not begin in observation status or that did not have dates of service on the weekend,
- claims identified as under review by the Recovery Audit Contractor, and
- claims with payments less than \$1,378.

This resulted in a sampling frame of 601 unique Medicare short-stay claims totaling \$5,603,221 from which we drew our sample.

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into three strata based on the claim payment amounts.

SAMPLE SIZE

We selected 115 claims for review as follows:

Stratum	Risk Area	Payment Amount Range for Claims in Sampling Frame	Claims in Sampling Frame	Claims in Sample
1	Inpatient Short Stays	\$1,378 to \$9,998	419	50
2	Inpatient Short Stays	\$9,998 to \$24,251	167	50
3	Inpatient Short Stays	\$24,251 to \$54,852	15	15
	Total	\$1,378 to \$54,852	601	115

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata one and two. After generating the random numbers for these two strata, we selected the corresponding frame items. We selected all claims in stratum three.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate the estimated Medicare overpayments in our inpatient sampling frame. We used the lower-limit of the 90 percent confidence interval for this estimate.

APPENDIX C: INPATIENT SAMPLE RESULTS AND ESTIMATES

OVERALL SAMPLE RESULTS

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Claims in Sample	Value of Net Claim Overpayments in Sample
1	419	\$2,691,331	50	\$325,360	14	\$83,990
2	167	2,442,809	50	711,712	9	89,729
3*	15	469,081	15	469,081	3	104,759
Total	601	5,603,221	115	\$1,506,153	26	\$278,478

ESTIMATES

Estimates of Inpatient Overpayments for the Audit Period
Limits Calculated for a 90 Percent Confidence Interval

Point Estimate	\$1,108,290
Lower Limit	\$ 783,578
Upper Limit	\$1,433,002

SAMPLE RESULTS WITHIN THE 3-YEAR RECOVERY PERIOD

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Claims in Sample	Value of Net Claim Overpayments in Sample
1	419	\$2,691,331	50	\$325,360	7	\$28,410
2	167	2,442,809	50	711,712	6	53,824
3*	15	469,081	15	469,081	1	29,077
Total	601	5,603,221	115	\$1,506,153	14	\$111,311

*We reviewed all sample units in this stratum.

ESTIMATES

Estimates of Inpatient Overpayments Within the 3-Year Recovery Period
Limits Calculated for a 90 Percent Confidence Interval

Point Estimate	\$446,925
Lower Limit	\$252,874
Upper Limit	\$640,976

APPENDIX D: OUTPATIENT SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population contained outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during CYs 2011 and 2012.

SAMPLE FRAME

We downloaded claims from the National Claims History database, which included 101,102 outpatient claims and their corresponding 102,764 line items totaling \$8,627,603 that were billed with a modifier 25, for further review and development. We performed data analysis of these line items, which included removing the following:

- line items that were not for evaluation and management services;
- line items with payments less than or equal to \$20;
- evaluation and management line items coded for new patient, emergency department, or critical care visits; and
- line items paid as part of a composite rate.

This resulted in a sampling frame of 85,312 unique Medicare line items totaling \$6,813,754 from which we drew our sample.

SAMPLE UNIT

The sample unit was a Medicare paid line item.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected 100 sample line item services for review as follows:

Risk Area	Line Items in Sampling Frame	Line Items in Sample
Outpatient Evaluation and Management Services	85,312	100

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the line item services, and after generating the random numbers, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate the estimated Medicare overpayments in our outpatient sampling frame. We used the lower-limit of the 90 percent confidence interval for this estimate.

APPENDIX E: OUTPATIENT SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Frame Size (Line Items)	Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Line Items in Sample	Value of Net Line Item Over- payments in Sample
85,312	\$6,813,754	100	\$7,796	6	\$406

ESTIMATES

Estimates of Outpatient Overpayments for the Audit Period *Limits Calculated for a 90-Percent Confidence Interval*

Point Estimate	\$346,614
Lower Limit	\$117,769
Upper Limit	\$575,459

Notice: We did not re-extrapolate the incorrectly billed line items that are within the 3-year recovery period. For these line items, we added the actual overpayments to our combined statistical and judgmental 3-year recovery period estimates.

APPENDIX F: RESULTS OF REVIEW BY RISK AREA

Risk Area	Sampled Services	Value of Sampled Services	Sampled Services With Under/Over-payments	Value of Net Overpayments for Sampled Services (Before Statistical Calculations)	Total Estimated Over-payments (After Statistical Calculations)	Total Estimated Over-payments (Within the 3-Year Recovery Period)
Inpatient						
Short Stays	115 †	\$1,506,153	26	\$278,478	\$783,578 **	\$252,874**
Manufacturer Credits for Replaced Medical Devices	7 †	264,008	7	183,754	183,754	3,529
Inpatient Totals	122	\$1,770,161	33	\$462,232	\$967,332	\$256,403
Outpatient						
Services Provided During Inpatient Stays	202	\$233,275	200	\$229,905	\$229,905	\$159,019
Dental Services	15	73,789	10	45,213	45,213	25,857
Manufacturer Credits for Replaced Medical Devices	6	46,354	6	32,979	32,979	10,733
Evaluation and Management Services	100	7,796	6	406	117,769 **	133
Outpatient Totals	323	\$361,214	222	\$308,503	\$425,866	\$195,742
Inpatient and Outpatient Totals	445	\$2,131,375	255	\$770,735	\$1,393,198	\$452,145

† We submitted these inpatient claims to a focused medical review to determine whether the services met medical necessity and coding requirements.

** The total estimated overpayments for the inpatient short stays and outpatient evaluation and management services risk areas both depict their corresponding statistical estimates calculated for a lower limit 90-percent confidence interval, as shown in Appendixes C and E. For the remaining judgmentally sampled risk areas, and for the outpatient evaluation and management services within the 3-year recovery period, the total estimated overpayments reflect the dollar-for-dollar value of net overpayments for these sampled services.

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient sample units by 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 G: MARY HITCHCOCK MEMORIAL HOSPITAL COMMENTS



Mary Hitchcock Memorial Hospital

One Medical Center Drive

Lebanon, NH 03756-0001

Dartmouth-Hitchcock.org

MARY HITCHCOCK MEMORIAL HOSPITAL

May 11, 2015

VIA FEDERAL EXPRESS

David Lamir
Regional Inspector General for Audit Services
Office of Audit Services, Region I
Office of the Inspector General
U.S. Department of Health and Human Services
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Re: Response to OIG Draft Report No. A-01-13-00513

Dear Mr. Lamir:

Thank you for providing us with a copy of the draft report entitled "Medicare Compliance Review of Dartmouth-Hitchcock Medical Center for 2011 and 2012." We appreciate the opportunity to review the draft report and provide comments prior to its finalization and publication.

During the compliance review, the Office of Inspector General (OIG) sampled 445 inpatient and outpatient services provided at Mary Hitchcock Memorial Hospital (MHMH) with dates of service from calendar years 2009 through 2012. Accordingly, we request that the title of the audit report be changed to "Medicare Compliance Review of Mary Hitchcock Memorial Hospital for 2009 through 2012."

The audit concluded that 255 of the sampled claims were billed incorrectly, resulting in identified and estimated overpayments of \$1,393,198. This amount consists of \$462,232 in identified overpayments for 33 incorrectly billed inpatient claims and \$308,503 in identified overpayments for 222 incorrectly billed outpatient claims. The balance of the amount was determined based on an extrapolation of the results from a statistical sample of certain categories of claims.

The full estimated overpayment is based, however, on claims that fall outside the three-year recovery period. The OIG has not identified in its draft report which claims are included in the recommended refund and which claims fall outside the statutory three-year recovery period,

but has calculated an estimated overpayment amount based only on those claims with dates of service falling inside that window. The total estimated overpayment tied to claims within the three-year recovery period is only \$452,145.

We take the OIG's findings and recommendations very seriously. With respect to the OIG's first recommendation—to refund \$452,145 to our Medicare Administrative Contractor (MAC)—we intend to make the recommended refund. We nonetheless continue to disagree with certain of the OIG's determinations and the OIG's use of extrapolation to estimate the total overpayment due, as explained in more detail below.

For the OIG's second recommendation regarding identified overpayments that are outside the three-year recovery window, to the extent that we agree with the OIG's determinations, we intend to make an additional refund to our MAC. As with the claims within the three-year recovery period, however, we also disagree with certain of the OIG's determinations covered by this recommendation. Specifically, as explained in more detail below, we disagree at least partially with the OIG's determination on the identified inpatient claim billing errors. We also disagree with the OIG's use of extrapolation to estimate the overpayment made to MHMH and the OIG's methodology for selecting the statistical samples. We have explained our objections below. We plan to refund amounts tied to specifically identified overpayment determinations with which we agree. To preserve our appeal rights as to the other claims, we will await the MAC's determination as to whether it will recoup any additional amounts. We reserve our right to appeal the remaining claims if the MAC proceeds with such recoupment.

Finally, as explained below, we acknowledge that certain administrative and billing controls were unsuccessful in preventing some of the errors identified by the OIG. We have taken steps to strengthen these controls, as described below. Otherwise, we believe that we have strong controls in place to identify and prevent overpayments tied to inpatient and outpatient services provided to patients of MHMH and we will continue to examine and improve our processes as warranted going forward.

1. Billing Errors Associated with Inpatient Claims

1.1 Claims Incorrectly Billed as Inpatient

We disagree with the OIG's findings on 22 claims, worth \$377,113. Based on the medical records available for review, we believe that each of these patients was properly admitted as an inpatient for medical care. The decision to admit a patient is clinically complex and requires the careful consideration of a licensed physician. Each of these patients was admitted based on the judgment of the attending physician, after considering the patient's condition and needs at the point of care. The decision to admit the patient was then reviewed by the Utilization Management (UM) Committee. These reviews typically occurred within 24 hours after admission and always before discharge. The practice of the UM Committee is that, if it identifies a potential admission error, the Committee consults with the admitting physician and the patient's status is corrected as needed. The UM Committee followed its customary practice for these patients, and no changes were made. The audit provides no basis for us to second-guess the decision of the attending physician, as confirmed by the UM Committee, at the point of care. Therefore, we maintain that the 22 claims for inpatient admissions that were identified as overpaid by the OIG were

reasonable and necessary. Nevertheless, for those claims falling within the three-year recovery period, we will refund the amount recommended by the OIG to avoid the expense and delay of an appeal. We will await a determination from the MAC as to claims falling outside the three-year recovery period and use of extrapolation so as to preserve our appeal rights.

1.2 Claims Billed with Incorrect Diagnosis-Related Group Codes

We disagree with the OIG's findings on ten claims, worth \$77,537. Based on the medical records reviewed, we believe that the diagnosis-related group (DRG) code assigned in each of these claims was the appropriate code. While we believe that all ten inpatient claims identified by the OIG as overpaid due to incorrect DRG assignment were properly billed, with respect to those claims falling within the three-year recovery period, we will refund the amount recommended by OIG.

We have extensive controls in place to ensure proper DRG code assignments. These controls include use of official coding guidelines based on patient type, examining the entire medical record for each patient to establish the appropriate code assignment, use of coding software to ensure proper code selection, secondary reviews for claims with codes that have a high risk of error, quarterly reviews of coding guidance, and continuing education for all coders. We believe these controls worked as designed for the ten claims at issue, and that each claim was correctly coded based upon the actual facts and circumstances of the admission.

1.3 Unreported Manufacturer Credits for Replaced Medical Devices

We agree with the OIG findings for seven claims in which MHMH received a reportable credit from the manufacturer for a replaced device but did not correctly adjust the associated Medicare claim. We will refund the claims within the three-year recovery period, as recommended. We will also refund the remaining claims identified as overpaid by the OIG but falling outside of the recovery period.

In addition to making this refund, we have updated our processes for reconciling the medical device credits we receive with the clinical coding, patient billing, and financial systems. We have also begun requesting that manufacturers provide us with a list of medical device credits paid to MHMH on at least a monthly basis. We have implemented steps to compare these credits with our system records to ensure that the credits are captured and appropriately allocated to Medicare claims within the 12-month Medicare billing window.

For six out of the seven claims involving unreported manufacturer credits, the OIG also identified other errors on the claims. Five out of the six claims were determined to be overpaid on the basis of an incorrect inpatient admission and one out of the six was found to be overpaid based on an incorrect DRG code assignment. We understand that these claims were included in the findings addressed in Sections 1.1 and 1.2. As noted above, we disagree with the OIG's findings related to these issues.

2. Billing Errors Associated with Outpatient Services

2.1 Outpatient Services Incorrectly Billed When Provided During an Inpatient Stay

We agree with the OIG's findings for 200 claims in which an outpatient service was provided during a patient's inpatient stay and subsequently billed to Medicare. We will refund the claims, including those outside the recovery period.

These claims resulted from patient visits to MHMH's outpatient clinic during an inpatient stay. Although these types of visits occurred infrequently, when they did occur, the charge for the clinic visit often was entered into the billing system after the inpatient stay was billed. Because the system had already billed the inpatient stay, the system did not recognize the outpatient charge as being subject to a bill-stop instruction.

In addition to refunding the claims, we have changed the billing system to capture any outpatient charges for services provided during the date span of an inpatient admission, whether or not the outpatient charge appears before or after the inpatient stay is billed.

2.2 Incorrect Billing for Dental Services

We agree with the OIG's findings for ten claims in which dental services were incorrectly billed to Medicare. We will refund the claims, including those outside the recovery period.

Because MHMH is a multi-disciplinary organization and a component of D-H as a medical system, a dental patient at MHMH may also be a patient of MHMH or D-H for other Medicare-covered services. The billing system identified these ten patients as Medicare beneficiaries and automatically generated a claim to Medicare for the dental services provided. We did not have adequate administrative processes in place to identify these dental services as being not covered by Medicare. To address this issue, we have implemented customized software to capture all Medicare dental services for review prior to billing. The new software helps ensure that only covered dental services are being billed to Medicare.

2.3 Unreported Manufacturer Credits for Replaced Medical Devices

We agree with the OIG's findings for six claims in which MHMH received a reportable credit from the manufacturer for a replaced device but did not correctly adjust the associated Medicare claim. We will refund the claims, including those outside the recovery period.

As with manufacturer credits for inpatients, we have updated our processes for reconciling the medical device credits we receive with the clinical coding, patient billing, and financial systems. We have also begun requesting manufacturers to provide a list of medical device credits paid to MHMH on at least a monthly basis. We have implemented steps to compare these credits with our system records to ensure that the credits are captured and appropriately allocated to Medicare claims within the 12-month Medicare billing window.

2.4 Incorrectly Billed Evaluation and Management Services

We agree with the OIG's findings for six claims in which evaluation and management (E&M) services were incorrectly billed. We will refund the claims, including those outside the recovery period.¹

We routinely train healthcare providers who bill E&M services on the importance of clinical documentation and E&M coding criteria, with additional education available upon request or when a need is identified. Routine reviews are conducted on samples of provider E&M documentation and feedback is provided. In addition, educational tips and tools such as E&M pocket cards are made available to providers in electronic and hard copy. Despite these efforts, misunderstandings about the requirements for billing E&M services occasionally occur. The six claims identified by the OIG as overpaid are the result of isolated misunderstandings of the Medicare billing requirements for separately billable E&M services. We have addressed these isolated errors through additional education and training of the physicians involved.

3. Extrapolation

The OIG used statistical sampling methods to review two categories of claims: inpatient stays and billing of E&M services. The OIG extrapolated the results of the audit of these statistical samples to estimate an additional \$622,463 in overpayments. After limiting its refund recommendation to claims that fall within the statutory three-year recovery period, the OIG continues to estimate an additional \$141,563 in overpayments. We disagree with the OIG's extrapolation because (1) the sampling methodology was flawed, and (2) the OIG failed to offset the inpatient stay overpayment amount by available Part B payments.

The sampling methodology used by the OIG for inpatient stays was flawed from the outset. The claims population used by the OIG for its sampling contained inappropriate claims, such as claims already reviewed by the Recovery Audit Contractor (and decided in our favor) and Medicare claims associated with managed care-covered services. As noted in the OIG's Appendix C, the sampling was designed to exclude claims that matched Medicare Part B physician claims for inpatient-only procedures performed on the same date of service, but such claims were ultimately included in the sampled claims. Furthermore, the types of claims in the population varied widely in reimbursement amount and types of service, which made the claim samples unrepresentative of the population, and the extrapolation a poor measure of the potential error rate.

¹ We disagree with the OIG's use of extrapolation for this category of claims, so we will wait for the MAC's determination regarding recoupment and extrapolation of claims outside the recovery period in order to preserve our appeal rights.

Furthermore, under the applicable Medicare Part B rebilling rules set forth in Ruling 1455-R,² a provider is entitled to seek Part B payment for the claims that are denied under Part A because of the inpatient setting. At a minimum, the value of each denied Part A claim in the sample should be reduced to the difference between the Part A and Part B payments. Because the OIG failed to take this offset into account, the extrapolated repayment amount is dramatically overstated.

* * * * *

We would like to thank the OIG's audit staff who conducted the compliance review of MHMH for their open communication and willingness to work with us during the review process. We take our compliance obligations seriously and are committed to ensuring continued compliance with Medicare billing rules and requirements.

If you have any additional questions or need additional information, please contact me at your convenience.

Sincerely,



Robin F. Kilfeather-Mackey, CPA, MBA
Chief Financial Officer

² Ruling 1455-R remains effective for all Part A claims with an admission date prior to October 1, 2013 that are subsequently denied because the inpatient admission was not medically reasonable and necessary (though the care provided was) as long as the denial is issued after September 30, 2013. As the MAC will not issue denials on the claims included in the OIG's findings until after the OIG's report is issued in final, and the dates of service all occur prior to January 1, 2013, we presume that the claims are covered by the provisions of Ruling 1455-R.