

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
UNIVERSITY OF FLORIDA HEALTH
JACKSONVILLE FOR 2013 AND 2014**

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Office of Inspector General

<https://oig.hhs.gov>

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

EXECUTIVE SUMMARY

University of Florida Health Jacksonville did not fully comply with Medicare requirements for billing inpatient services, resulting in overpayments of at least \$273,000 over nearly 2 years.

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 2014, Medicare paid hospitals \$159 billion, which represents 46 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.

The objective of this review was to determine whether University of Florida Health Jacksonville (the Hospital) complied with Medicare requirements for billing inpatient services on selected types of claims.

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.

The Hospital is a 695-bed, not-for-profit hospital, located in Jacksonville, Florida. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$167 million for 11,134 inpatient claims paid from January 2013 through September 2014 (audit period).

Our audit covered \$13,858,253 in Medicare payments to the Hospital for 1,305 inpatient claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 154 paid claims with payments totaling \$1,964,826. These 154 inpatient claims had payment dates in our audit period.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 133 of the 154 inpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 21 claims, resulting in net overpayments of \$63,881 for the audit period. 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 \$273,346 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare program \$273,346 in estimated overpayments on claims incorrectly billed for our audit period;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF FLORIDA HEALTH JACKSONVILLE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital did not agree with some of our findings and recommendations. It disagreed that it improperly billed 11 of 21 inpatient claims that we identified as not fully complying with Medicare billing requirements. However, it acknowledged that it improperly billed the remaining 10 inpatient claims. The Hospital stated that human error contributed to the findings, but also stated that there was “no evidence to support systemic coding or billing concerns.” In addition, the Hospital objected to the use of statistical sampling and extrapolation to calculate the overpayment.

The Hospital stated that it consistently exercised reasonable diligence by conducting timely and good faith investigations of all credible indications of potential overpayments and by returning overpayments in accordance with the 60-day rule. The Hospital also noted the specific corrective actions that it has taken with respect to the findings included in this report. It also indicated that it plans to appeal the claims that it disagreed it improperly billed.

We used an independent medical review to assess medical necessity and coding errors. Regarding our extrapolation methodology and statistical validity, Federal courts have consistently upheld statistical sampling and extrapolation as a valid method to determine overpayment amounts in Medicare. Therefore, we maintain that all of our findings and recommendations are valid.

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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 2014, Medicare paid hospitals \$159 billion, which represents 46 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.

OBJECTIVE

Our objective was to determine whether University of Florida Health Jacksonville (the Hospital) complied with Medicare requirements for billing inpatient services on selected types of claims.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with 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 Claims at Risk for Incorrect Billing

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

- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims paid in excess of charges, and
- inpatient same-day discharges and readmissions.

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 (§ 1815(a)).

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).

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), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

University of Florida Health Jacksonville

The Hospital is a 695-bed, not-for-profit hospital located in Jacksonville, Florida. According to CMS’s National Claims History (NCH) data, Medicare paid the Hospital approximately \$167 million for 11,134 inpatient claims from January 2013 through September 2014 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$13,858,253 in Medicare payments to the Hospital for 1,305 inpatient claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 154 paid claims with payments totaling \$1,964,826. These 154 inpatient claims had payment dates in 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 54 claims to coding reviews to determine whether the services were correctly coded. 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 audit scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 133 of the 154 inpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 21 claims, resulting in net overpayments of \$63,881 for the audit period. 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.

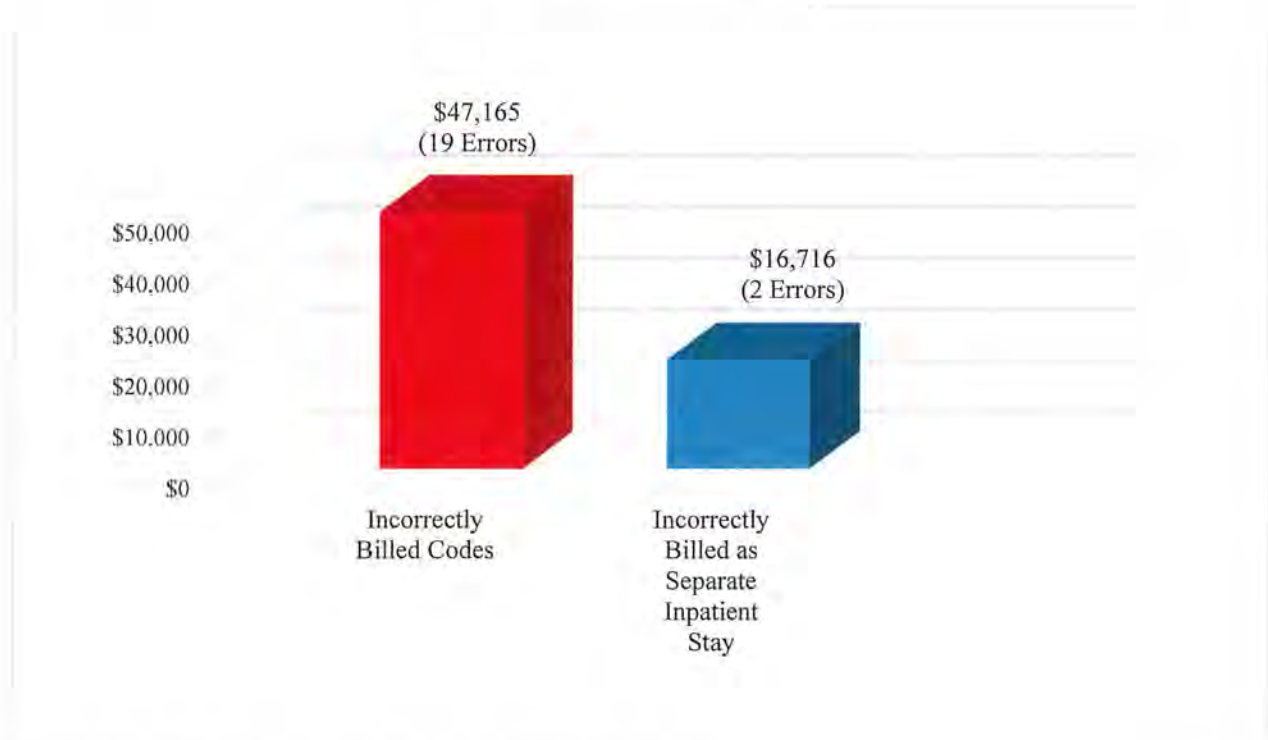
On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$273,346 for the audit period.

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

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 21 of the 154 inpatient claims that we reviewed. These errors resulted in net overpayments of \$63,881, as shown in the figure below.

Figure: Inpatient Billing Errors



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 requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (chapter 1, § 80.3.2.2).

For 19 of the 154 inpatient claims, the Hospital billed Medicare for incorrect DRG codes. For example, the Hospital submitted a claim with a secondary diagnosis code 599.0 (urinary tract infection), but the medical record indicated that the patient had no signs or symptoms of urinary tract infection. Therefore, the Hospital should not have assigned code 599.0. The Hospital stated that, for some claims, human error caused the use of incorrect DRG codes. As a result of these errors, the Hospital received net overpayments of \$47,165.

Incorrectly Billed as Separate Inpatient Stays

The Manual (chapter 3, § 40.2.5) states that, when a patient is discharged or transferred from an acute care hospital, and is readmitted to the same hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition, hospitals should adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 2 of the 154 selected claims, the Hospital incorrectly billed Medicare separately for related discharges and readmissions that occurred on the same day. The Hospital stated that human error caused the billing of both related claims. As a result of these errors, the Hospital received overpayments of \$16,716.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$273,346 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$273,346 in estimated overpayments on claims incorrectly billed for our audit period;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF FLORIDA HEALTH JACKSONVILLE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

University of Florida Health Jacksonville Comments

In written comments on our draft report, the Hospital did not agree with some of our findings and recommendations. It disagreed that it improperly billed 11 of the 21 inpatient claims that we identified as not fully complying with Medicare billing requirements. However, it acknowledged that it improperly billed the remaining 10 inpatient claims. The Hospital stated that human error contributed to the findings, but also stated that there was “no evidence to support systemic coding or billing concerns.”

In addition, the Hospital objected to the use of statistical sampling and extrapolation to calculate the overpayment. It stated:

- The OIG is not expressly authorized by law to use extrapolation, and extrapolation is generally considered inappropriate without a determination of a sustained or high payment error rate.
- The OIG did not provide sufficient documentation to validate that the sampling methods used for this audit were statistically valid or in compliance with Medicare requirements.

- The Hospital should be allowed to correct and rebill the claims that it concurred were overpayments, which could have resulted in a lower extrapolated overpayment determination.
- The use of extrapolation is premature because the Hospital intends to dispute approximately half of the error claims; therefore, extrapolation should be postponed until the claims have been fully adjudicated.

The Hospital stated that it consistently exercises reasonable diligence by conducting timely and good faith investigations of all credible indications of potential overpayments and by returning overpayments in accordance with the 60-day rule.

The Hospital also stated that it had a strong compliance program with education, training, monitoring, and internal audits. It also noted the specific corrective actions that it has taken with respect to the findings included in this report. The Hospital also indicated that it plans to appeal the claims that it disagreed it improperly billed.

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

Office of Inspector General Response

We used an independent medical review to assess medical necessity and coding errors.

Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare. *See Momentum EMS, Inc. v. Sebelius*, 2014 WL 199061 at *9 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010). Additionally, 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. *See John Balko & Assoc. v. Sebelius*, 2012 WL 6738246 at *12 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012). 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.

Furthermore, no statutory or other authority limits our ability to recommend a recovery to CMS based upon sampling and extrapolation.

The Hospital's reference to the requirement that a determination must be made of a sustained or high level of payment error or a documented failed educational intervention before extrapolation may be used applies only to Medicare contractors. See Social Security Act § 1893(f)(3); CMS Medicare Program Integrity Manual, chapter 8.4.1.4 (effective June 28, 2011). None of the criteria cited by the Hospital in support of its argument is applicable to OIG audits.

The use of statistical sampling and extrapolation to determine overpayment amounts in Medicare does not violate due process because the auditee is given the opportunity to appeal the audit results through the Medicare appeals process. *See Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *34 (S.D. Tex. 2012).

Therefore, we maintain that all of our findings and recommendations are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$13,858,253 in Medicare payments to the Hospital for 1,305 inpatient claims during January 2013 through September 2014 (audit period) that were potentially at risk for billing errors. We selected for review a stratified random sample of 154 inpatient claims with payments totaling \$1,964,826. These 154 inpatient claims had payment dates during the 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 54 claims to coding reviews to determine whether the services were coded correctly.

We limited our review of the Hospital's internal controls to those applicable to the inpatient 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 CMS's 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 fieldwork at the Hospital during September 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient paid claims data from CMS's NCH file for the audit period;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 154 claims totaling \$1,964,826 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;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- reviewed the Hospital's procedures for inpatient coding, conditions of admission and discharge, and medical record requirements;
- used an independent contractor to determine whether 54 sampled claims met coding 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 to estimate the Medicare overpayments 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: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was inpatient claims paid to the Hospital from January 2013 through September 2014 (audit period), for services provided to Medicare beneficiaries.

SAMPLING FRAME

According to CMS's NCH data, Medicare paid the Hospital approximately \$74 million for 4,756 inpatient claims in 12 risk areas during the audit period.

From these 12 risk areas, we selected 3 consisting of 1,542 claims totaling \$17,015,124 for further refinement. We performed data filtering and analysis of the claims within each of the three risk areas. The specific filtering and analysis steps performed varied depending on the risk area, but included such procedures as removing:

- \$0 paid claims;
- claims duplicated within individual risk areas by assigning each inpatient claim that appeared in multiple risk areas to just one category based on the following hierarchy:
 - inpatient claims billed with high-severity-level DRG codes,
 - inpatient claims paid in excess of charges, and
 - inpatient same day discharges and readmissions; and
- claims under review by the Recovery Audit Contractor (RAC) as of June 22, 2015.

This data filtering resulted in a sampling frame of 1,305 unique Medicare claims totaling \$13,858,253.

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into strata on the basis of risk area and split one risk area on the basis of dollar value resulting in a total of four strata. The split risk area was Inpatient Claims Billed with High-Severity-Level DRG Codes (low and high).

SAMPLE SIZE

We selected 154 claims for review as shown in Table I.

Table 1: Strata, Risk Areas, Frame Sizes and Values, and Sample Details

Stratum	Risk Area	Frame Size	Value of Frame	Sample Size
1	Inpatient Claims Billed With High-Severity-Level DRG Codes (low dollars)	717	\$6,048,723	61
2	Inpatient Claims Billed With High-Severity-Level DRG Codes (high dollars)	237	4,758,551	50
3	Inpatient Claims Paid in Excess of Charges	347	3,017,470	39
4	Inpatient Same Day Discharges and Readmissions	4	33,509	4
	Total	1,305	\$13,858,253	154

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 1 through 3. After generating the random numbers for these strata we selected the corresponding claims in each stratum. We selected all claims in stratum 4.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments paid to the Hospital during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: 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	717	\$6,048,723	61	\$515,972	10	\$21,416
2	237	4,758,551	50	1,076,436	8	36,175
3	347	3,017,470	39	338,908	0	0
4	4	33,509	4	33,510	3	6,290
Total	1,305	\$13,858,253	154	\$1,964,826	21	\$63,881

ESTIMATES

Table 3: Estimated Value of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	\$429,491
Lower Limit	\$273,346
Upper Limit	\$585,637

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Table 4: Sample Results by Risk Area

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient Claims Billed With High-Severity-Level DRG Codes (low)	61	\$515,972	10	\$21,416
Inpatient Claims Billed With High-Severity-Level DRG Codes (high)	50	1,076,436	8	36,175
Inpatient Claims Paid In Excess of Charges	39	338,908	0	0
Inpatient Same Day Discharges and Readmissions	4	33,510	3	6,290
Totals	154	\$1,964,826	21	\$63,881

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient 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: UNIVERSITY OF FLORIDA HEALTH JACKSONVILLE
COMMENTS



UF Health Jacksonville

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December 16, 2016

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CC: Ms. Denise Novak, Assistant Regional Inspector General
CC: Mr. Brian Ritchie, Assistant Inspector General for Audit Services

UPLOADED VIA HHS OIG SECURE DELIVERY SERVER

RE: RESPONSE TO OIG DRAFT REPORT: A-04-15-07057, entitled
*Medicare Compliance Review of University of Florida Health Jacksonville
for 2013 and 2014*

Dear Ms. Pilcher:

The University of Florida Health Jacksonville (“UF Health Jacksonville” or “Hospital”) respectfully submits this letter, along with the attached Appendix (Appendix A) in response to the draft report issued by the U.S. Department of Health & Human Services, Office of Inspector General (“OIG”), entitled *Medicare Compliance Review of University of Florida Health Jacksonville for 2013 and 2014* (“Draft Report”). In accordance with the instructions in your November 8, 2016 letter, our response sets forth the Hospital's written comments regarding the Draft Report, including the Hospital's statements of concurrence or non-concurrence with the OIG's findings and recommendations.

EXECUTIVE SUMMARY:

Overall, based on its findings, OIG recommends that the Hospital refund an extrapolated amount of \$273,346 in estimated overpayments for the audit period based on twenty-one (21) claims that were alleged to have been billed incorrectly. In addition, OIG recommends that the Hospital strengthen its controls to ensure compliance with Medicare requirements.

Patient Care • Research • Education

The Hospital respectfully disagrees with approximately half of the findings in the Draft Report. While we disagree with some of the findings in the OIG's Draft Report, we would like to acknowledge the professional and courteous manner in which the OIG reviewers handled themselves throughout this process. To the extent that we concur with the OIG's findings related to specific claims that were reviewed, we will refund the appropriate amounts to our Medicare Administrative Contractor, First Coast Service Options, Inc. We intend to appeal those remaining claims, where we do not concur with the OIG's findings, but rather believe the claims were billed appropriately and in accordance with both Medicare billing rules and national coding guidelines. We would also like to note that we were not provided an opportunity to participate in peer-to-peer discussions regarding specific sampled claims reviewed by OIG external reviewers, where we would have asserted what we believe to be well understood CMS standards that contradict their findings. As a result, we not only seek guidance as to how or why certain findings were made, but respectfully request that the OIG reconsider its Draft Report findings taking into account our subsequent review, exit conference, and response documentation. We also respectfully request that overpayment estimates be recalculated based upon our assertions which align with CMS standards.

I. BACKGROUND

Per the OIG Draft Report, the audit of UF Health Jacksonville is part of a series of hospital compliance reviews in which the OIG has utilized computer matching, data mining, and other data analysis techniques to identify hospital inpatient and outpatient claims that OIG asserts are at risk for noncompliance with Medicare billing requirements. Based on its work with other hospitals, the OIG identified certain types ("stratum" or "strata") of hospital inpatient claims that it asserts were potentially at risk for noncompliance, and focused on these as part of the review conducted at UF Health Jacksonville. These "risk areas" include:

- Inpatient claims billed with high-severity-level DRG codes;
- Inpatient claims paid in excess of charges; and
- Inpatient same day discharges and readmissions.

The OIG focused its audit of the Hospital's inpatient claims on these three risk areas for claims paid from January 2013 through September 2014 ("Audit Period"). No outpatient claims were included in the OIG's review.

For the Audit Period, the Draft Report states that the Audit covered \$13,858,253 in Medicare payments to the Hospital for 1,305 inpatient claims that were potentially at risk for billing errors. The OIG selected for review a stratified random sample of 154 paid claims with payments totaling \$1,964,826. The OIG's sample included the following, based on these "risk areas":

Stratum	Medicare Risk Area	Sample Size
1	Inpatient Claims Billed with High Severity DRG Codes (low \$)	61
2	Inpatient Claims Billed with High Severity DRG Codes (high \$)	50

3	Inpatient Claims Billed in Excess of Charges	39
4	Inpatient Same Day Discharge and Readmit Claims	4
	Total Sampled Claims	154

The OIG stated that 150 claims out of the 154 claim sample were considered “statistically selected” and as such, the results were projected to all claims in the sampling frame. The remaining 4 claims (specifically, the inpatient same day discharge and readmit claims) were “judgmentally sampled,” and therefore were not projected to all claims in the sampling frame. *Note: The Inpatient claims billed with High-Severity DRG Codes included 61 low dollar claims and 50 high dollar claims, however, these were split for purposes of the OIG’s review into two separate strata.*

Sample design: The OIG divided the sampling frame into three strata on the basis of risk area, and split one risk area on the basis of dollar value (Inpatient Claims Billed with High-Severity DRG Codes).

External review: Of the 154-claim sample, the OIG evaluated compliance with selected billing requirements and forwarded for external coding review a total of 54 claims, to determine if they were correctly coded. This included a total of 27 claims from the high-severity level DRG category (13 low dollar and 14 high dollar) and 27 claims from the claims billed in excess of charges category. These were performed at two separate review times, purportedly due to the OIG’s budget allowances.

Stratum	Medicare Risk Area	Sample Size	Externally reviewed
1	Inpatient Claims Billed with High Severity DRG Codes (low \$)	61	13
2	Inpatient Claims Billed with High Severity DRG Codes (high \$)	50	14
3	Inpatient Claims Billed in Excess of Charges	39	27
4	Inpatient Same Day Discharge and Readmit Claims	4	0
	Total Sampled Claims	154	54

II. REVIEW OBJECTIVE

The OIG stated its objective was to determine whether UF Health Jacksonville (the “Hospital”) complied with Medicare requirements for billing inpatient services for selected types of claims.

III. OIG DRAFT REPORT

In its Draft Report, the OIG reported that the Hospital complied with Medicare billing requirements for 133 of the 154 inpatient claims reviewed, but had not satisfied such requirements for the remaining 21 claims. According to the Draft Report, errors associated with the 21 claims resulted in a net overpayment to the Hospital of \$63,881 for the Audit Period. The reported errors included both underpayments to the Hospital and overpayments to the Hospital. The OIG projected its results onto the full sampling frame,

and based on the sample, the OIG estimated that the Hospital received overpayments of approximately \$273,346 for the Audit period.

According to the OIG Draft Report, the following twenty-one (21) samples reviewed contained one or more errors out of the 154-claim sample: A6, A14, A21, A34, A38, A42, A44, A47, A55, A60, B3, B8, B11, B13, B16, B32, B41, B47, D1, D2, and D3.

These findings are further explained below, and are separated in the following strata: Incorrectly Billed DRG's (high dollar and low dollar); Inpatient Claims Paid in Excess of Charges; and Incorrectly Billed as Separate Inpatient Stays.

- *Strata 1 and 2: Allegedly - Incorrectly Billed Diagnosis-Related Group Codes:* One Hundred and Eleven (111) claims were selected for this part of the review, which included 50 high dollar and 61 low dollar claims. Here, the OIG found that the Hospital billed Medicare for incorrect DRG codes for 18 of the 154 inpatient claims.

The OIG contends the Hospital received a net overpayment of \$47,165 inclusive of payments from nineteen (19) total claims, where eighteen (18) claims were incorrectly billed High Severity DRG claims (10 low dollar claims and 8 high dollar claims) appropriately reviewed in Strata 1 and 2, and one (1) additional claim, although initially sampled and reviewed in Stratum 4, was also recognized as an incorrectly billed DRG claim that totaled to an underpayment. The 18 HS-DRG claims are the following Sample #'s: A6, A14, A21, A34, A38, A42, A44, A47, A55, A60, B3, B8, B11, B13, B16, B32, B41, and B47. The additional incorrectly billed DRG claim is Sample # D3. (*D3 totaled to an underpayment value of \$10,426.46.*) (*Net overpayment value of \$47,165 results from subtracting the sample D3 underpayment of \$10,426.46 from the total value of Strata 1 and 2 overpayments of \$57,591.48.*)

- *Stratum 3: Inpatient Claims Paid in Excess of Charges:* Thirty-Nine (39) claims were selected for this part of the review. The OIG found that the Hospital correctly billed Medicare for all inpatient claims selected for review in this category (this included 100% of the selected sample). The OIG reported that no overpayment was received, and no errors were found for this category.
- *Stratum 4: Allegedly - Incorrectly Billed as Separate Inpatient Stays:* Four (4) claims were selected for this part of the review. The OIG found that the Hospital separately billed Medicare for related discharges and readmissions that should have been combined for two (2) of the four (4) inpatient claims sampled in this Stratum. Of the two (2) remaining claims, one (1) was recognized above as an incorrectly billed DRG claim, and the Hospital complied with Medicare billing requirements for the remaining claim. The incorrectly billed separate inpatient stay claims included the following sample #'s: D1 and D4. The OIG found the

Hospital received an overpayment of \$16,716. *(Note: There were a total of 3 claim findings in this category, however, Sample # D3 was included in the above Strata 1 and 2 results.)*

Based on its findings, the OIG recommended that the Hospital:

- Refund to the Medicare contractor \$274,346 in estimated overpayments for the audit period for claims that it allegedly incorrectly billed;
- Exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule; and
- Strengthen controls to ensure full compliance with Medicare requirements.

IV. HOSPITAL RESPONSE

The Hospital provides the following objections and comments in response to the Draft Report and above summary of findings. These comments are specific to: (1) The Hospital's objection to the OIG's use of extrapolation to calculate the overpayment; (2) The Hospital's concurrence or non-concurrence with the OIG's specific findings for each area reviewed; and (3) The Hospital's response to recommendations made by the OIG in its Draft Report. Included with our letter is a spreadsheet with an analysis of the claims included in our sample, to provide further information as to the payments made on these claims. This has been uploaded via the secure server, for your convenience. *Refer also to the enclosed Appendix A.*

(1) The Hospital Objects to OIG's Use of Extrapolation to Calculate Overpayment:

We respectfully object to the OIG's use of extrapolation to calculate an overpayment in this case, for the following reasons: (1) the OIG is not expressly authorized by law to use extrapolation to determine overpayment amounts, and extrapolation is generally considered inappropriate without a determination of a sustained or high payment error rate; (2) the OIG has not provided sufficient documentation to validate that the sampling methods used for this audit were statistically valid or in compliance with Medicare requirements; (3) if given the opportunity, the Hospital, in those claims where we concurred with the OIG, would have appropriately rebilled; and (4) even if extrapolation were permitted in this case, the use of extrapolation to determine an overpayment would be premature at this point since we intend to successfully dispute approximately half of the alleged claim errors, which would result in a large decrease in any extrapolated error rate.

1. The OIG is not expressly authorized by law to use extrapolation to determine overpayment amounts, and extrapolation is generally considered inappropriate without a determination of a sustained or high payment error rate.

We are unaware of any expressed authority that permits the OIG to use extrapolation to determine Medicare overpayment amounts. Under 42 U.S. Code §

1395ddd(f)(3), a Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that there is a sustained or high level of payment error, or documented educational intervention has failed to correct the payment error. This requirement is also copied in the CMS Medicare Program Integrity Manual, Chapter 8, Section 8.4.1.2 (hereinafter, referenced as “PIM,” with section).

In this case, the OIG did not provide any evidence or even allege that the Hospital had a sustained or high level of payment error. For the strata that the OIG subjected to extrapolation, the OIG’s audit results actually reflect the contrary: stratum 1 alleges a 4.15% payment error rate; stratum 2 alleges a 3.36% payment error rate; and stratum 3 alleges a 0% error rate. For these strata that were subjected to the extrapolation, the net audit results allege that 97.02% of those payments were accurate (\$1,873,725 of the \$1,931,316 amounts sampled for strata 1 through 3). These results do not demonstrate a sustained or high level of payment errors. Also, there is no evidence to suggest that documented educational intervention has failed to correct payment errors. Therefore, it is our position that the OIG’s use of extrapolation in this case to determine any overpayment is inappropriate.

While the extrapolation requirements cited above specifically apply to Medicare contractors, they reflect the industry standard for the use of sampling and extrapolation to determine Medicare overpayment amounts. It does not appear appropriate for the OIG to calculate overpayment amounts in a manner that is expressly prohibited for Medicare contractors, when the OIG has no express authority to do so. This is especially noteworthy since it is the Medicare Administrative Contractor (First Coast Service Options, Inc.) that will be involved in recouping any overpayment amount that is calculated as a result of the OIG’s audit. First Coast Service Options, Inc. would be tasked with recouping an overpayment that the contractor itself would not have been permitted to calculate.

2. The OIG has not provided sufficient documentation to validate that the sampling methods used for this audit were statistically valid or in compliance with Medicare requirements.

Section 8.4.1.5 of the PIM states that, *“the sampling methodology used to project overpayments must be reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimation methods. This is done to ensure that a statistically valid sample is drawn and that statistically valid methods for projecting overpayments are followed.”* Section 8.4.4.1 of the PIM further provides that, *“Sufficient documentation shall be kept so that the sampling frame can be re-created, should the methodology be challenged.”*

The OIG has not provided the Hospital with the detailed documentation necessary to confirm whether the sampling methods used were statistically valid as required by Medicare, or the documentation necessary to re-create the sampling frame in order to have a meaningful opportunity to challenge the methodology. However, as explained

below, the limited information that was provided raises concerns regarding whether the sampling methods used were in fact statistically valid.

A statistically valid sample is generally supposed to be selected from a sampling frame/population that ideally, “*covers the target universe completely.*” (See Section 8.4.3.2.3 of the PIM). However, per page 1 of the OIG’s Draft Report, the OIG used computer matching, data mining, and other data analysis techniques to identify hospital claims that were at risk for noncompliance. It seems that the OIG’s sampling frame did not cover the target universe completely, but was selected in a biased manner in order to establish a frame that only included claims that were already identified as being at risk for noncompliance. By removing the claims that had less risk for noncompliance, the sampling frame was altered such that a selected sample would result in a higher probability of payment errors, and thereby increase the error rates.

Section 8.4.4.3 of the PIM provides that the sample size has a direct impact on the precision of any estimated overpayment. The sample sizes that were selected in this case by the OIG for each stratum are not proportionately consistent. For stratum 2, a sample size of 50 claims was selected from a frame size of 237 claims. This equates to a sample that was approximately 21.1% of the size of the frame. However, for stratum 1, a sample size of 61 claims was selected from a frame size of 717 claims (equals only 8.5% of the frame). Also, for stratum 3, a sample size of only 39 claims was selected from a frame of 347 claims, which is a larger frame size than stratum 2, yet fewer claims were selected for the stratum 3 sample. This lack of consistency raises questions about whether the OIG’s selection of sample sizes meets the requirements for statistically valid samples.

3. If given the opportunity, the Hospital, in those claims where we concurred with the OIG, would have appropriately rebilled.

The Hospital recognizes that claims were outside of the timely filing limits when the OIG identified them as incorrect. If, however the Hospital had been provided the opportunity to correct and appropriately reprocess the claims it is likely that the calculated overpayment may have been reduced thus decreasing any extrapolated overpayment determination.

4. The use of extrapolation to determine an overpayment would be premature at this point since we intend to successfully dispute approximately half of the alleged claim errors, which would result in a large decrease in any extrapolated error rate.

As explained above, we object to the use of extrapolation to determine an overpayment in this case, since the OIG lacks the express authority to do so. However, even if extrapolation were permitted, it would be premature to extrapolate an error rate to the sampling frames at this point since our hospital intends to successfully dispute approximately half of the alleged claim errors. Assuming that we are successful in our challenges, this will result in a large decrease to the error rates, and therefore, will result

in a large decrease in any extrapolated overpayment determination. Any extrapolation should at least be postponed until the associated claims have been fully adjudicated.

(2) Hospital Response: Concurrence and Non-Concurrence with OIG Findings:

The Hospital agrees with ten (10) of the twenty-one (21) OIG findings, and respectfully disagrees with the remaining eleven (11).

The ten (10) claims the Hospital agrees with were self-identified and disclosed to the OIG at the start of the review, and therefore, the Hospital fully intended to refund to the Medicare Administrative Contractor (First Coast Service Options) all overpayments associated with these claims. The Hospital disputes the remaining eleven (11) claims principally upon the OIG's application of both CMS standards and well established Medicare billing and coding guidelines. In addition, there was no finding of a pattern in coding errors (*even in high volume areas reviewed*), there was no finding of evidence to suggest that documented educational intervention failed to correct payment errors, or any evidence suggesting a lack of a proactive compliance program. Therefore, the Hospital intends to challenge on appeal all findings it disputes, and will refund to the Medicare Administrative Contractor (First Coast Service Options, Inc.) all overpayments on claims where its challenges are deemed unsuccessful.

Strata 1 and 2: Allegedly - Incorrectly Billed Diagnosis-Related Group Codes (high dollar and low dollar):

OIG findings summary: The OIG found that the Hospital billed Medicare for incorrect DRG codes for a total of 19 of the 154 inpatient claims. Eighteen (18) claims were reviewed in Strata 1 and 2 as incorrectly billed High Severity DRG claims (10 low dollar claims and 8 high dollar claims), and one (1) claim, although initially sampled and reviewed in Stratum 4, was determined on review as an incorrectly billed DRG claim. These claims included the following Sample #'s: A6, A14, A21, A34, A38, A42, A44, A47, A55, A60, B3, B8, B11, B13, B16, B32, B41, and B47. (*D3**, *Refer to Stratum 4 Response*).

Hospital response: During the course of the review and as part of the initial self-audit, the Hospital performed a multi-level review of all claims in the sample and communicated such findings to the OIG. Regarding OIG findings for Strata 1 and 2:

Concurrence:

The Hospital concurs with 8 of the OIG's findings regarding coding on high-severity DRGs, where the OIG reported that "for 19 claims the principal or secondary diagnosis codes were not substantiated by the medical records resulting in incorrect DRG codes". These claims include: Sample #'s A6, A21, A34, A44, A60, B3*, B8, and B16. These findings were self-identified by the Hospital during the initial self-audit, were voluntarily reported to the OIG, and were not further challenged or commented on by the auditors. The OIG agreed with the findings and included them within the Draft Report, as "errors".

*Refer to Strata 4, “Allegedly - Incorrectly Billed as Separate Inpatient Stays”, regarding Sample # D3.

**Sample # B3*, the hospital disagreed with based on review and official coding guidelines, and additional information/rationale was provided. Refer to Appendix A for details.*

Non-concurrence:

The Hospital does not concur with eleven (11) of the OIG's findings regarding coding on high-severity DRGs, where the OIG reported that “for 19 claims the principal or secondary diagnosis codes were not substantiated by the medical records resulting in incorrect DRG codes.” Please note that for one (1) of these claims (D3*) the hospital concurs with the DRG coding change but does not concur with the claims inclusion in the Stratum 4 sample. These claims include: Sample #'s A14, A38, A42, A47, A55, B11, B13, B32, B41, and B47. (D3*, Refer to Stratum 4 Response)

The Hospital holds that the coding was appropriate and consistent with published Medicare coding guidelines for these claims, and that the claims/records accurately reflect the services performed and billed. During the OIG’s review the Hospital provided both information and its rationale based upon the Medicare rules and coding guidance it relied upon. (Relevant information is included in Appendix A).

Additionally, the Hospital self-reported 8 of these claims to the OIG at the start of the review (Samples # A6, A21, A34, A44, A60, B3*, B8, and D3*), and the findings of the self-audit were accepted by the OIG (with no further auditor comments/findings).

Stratum 3: Inpatient Claims Paid in Excess of Charges:

OIG findings summary: The OIG found that the Hospital billed Medicare correctly for all 39 claims reviewed by the OIG, and those 27 claims reviewed by the external auditors for Stratum 3.

Hospital response: The Hospital concurs with the OIG’s findings from the Draft Report, as no errors were found for the claims in Stratum 3. As part of the self-review and expanded review, the Hospital performed a multi-level review of all claims in the sample and communicated to the OIG that no errors were identified.

Stratum 4: Allegedly - Incorrectly Billed as Separate Inpatient Stays:

OIG findings summary: The OIG found that the Hospital separately billed Medicare for related discharges and readmissions that should have been combined for 2 of the 154 inpatient claims, which included the following sample #'s: D1 and D4.

Hospital response: During the course of the review and as part of the initial self-audit, the Hospital performed a multi-level review of all claims in the sample, and the findings were communicated to the OIG. *(Note: There were a total of 4 claims in this category, however, one (1) claim fully complied with Medicare billing requirements, and one (1) claim (Sample # D3*) although initially included in Stratum 4, was added to Strata 1 and 2 as an Incorrectly Billed DRG claim. For purposes of this section of the Response, Sample D3* will be discussed with Stratum 4 claims.)*

Regarding OIG findings for Stratum 4:

Concurrence:

The Hospital concurs with the OIG's findings regarding same day discharges and readmissions which should have been combined as they appeared to be medically related, where the OIG reported that "for 2 of the 154 Hospital incorrectly billed for related discharges and readmissions that occurred on the same day". These claims include: Sample #'s D1 and D4. These findings were self-identified by the Hospital during the initial self-audit, were voluntarily reported to the OIG, and were not further challenged or commented on by the auditors. The OIG agreed with the findings and included them within the Draft Report, as "errors".

Non-Concurrence:

* Sample # D3 was initially included and reviewed in this category (Stratum 4), however upon review, the OIG agreed with the Hospital's request that this Sample be removed and labeled a "non-error" due to it not being a readmission case. The Hospital conducted a coding and billing review of the full sample and determined a coding change was required (self-reported). In its Draft Report, the OIG included Sample # D3 as part of the overall coding findings – and did not include it in this section. After further review, the Hospital respectfully requests that for purposes of the sample results and calculated overpayments, Sample # D3 should be moved from Stratum 4 to the more appropriate Strata 1 or 2. If the OIG declines this request to move Sample # D3, we request the sampling results to reflect that this claim was a "non-error" in Stratum 4, and to still include the claim in the net calculated overpayments. (Sample # D3 was an underpayment.)

(3) Hospital Response to OIG Recommendations:

Based on its findings, the OIG recommended that the Hospital: (1) Refund to the Medicare contractor \$274,346 in estimated overpayments for claims that it allegedly incorrectly billed during the audit period; (2) exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule; and (3) Strengthen controls to ensure full compliance with Medicare requirements. The Hospital's response to these recommendations are included below:

1. Refund to the Medicare Contractor estimated overpayments (\$273,346) per the Draft Report:

The OIG estimated that the overpayment of \$63,881.36 when projected onto the sampling frame is approximately \$273,346. As previously stated, the Hospital does not concur with over half of the findings within the OIG's Draft Report. For the claims where we concur, we will refund the appropriate amounts to our Medicare Administrative Contractor, First Coast Service Options. The Hospital intends to appeal the claims where we do not concur with the OIG's findings. Further, we request that the OIG reconsider its results and adjust its findings as per our Response estimations. The Hospital calculates the net overpayment as \$24,104.00, represented by (11) claims of which the Hospital either self-identified or otherwise concurs with the OIG findings. *This includes 10 claims from Strata 1 and 2, and 3 claims from Stratum 4.* Additionally, the Hospital objects to the use of extrapolation for the reasons set forth above.

2. Exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule:

In accordance with the 60-day rule, the Hospital consistently exercises reasonable diligence by conducting timely and good faith investigations of all credible information that may result in a potential overpayment. Our internal controls entail conducting multiple levels of billing and coding reviews, and routine education and training. Not only do we proactively monitoring claims for billing and coding quality and compliance, we conduct reactive investigations in response to any questionable billing or coding information we identify through our efforts, and in all instances remit payment in accordance with the 60-day rule.

Although human error was an identified source of the OIG's findings during this audit, there was no evidence to support systemic coding or billing concerns. Furthermore, no additional information was supplied by the OIG during this audit or identified otherwise that we would consider to be credible information of potential overpayments beyond the scope of this audit period that would warrant further investigation. Based upon this rationale, we strongly believe we have maintained, and continue to maintain reasonable diligence such that we would have, and will consistently identify credible information of potential overpayments and appropriately return them in accordance with the 60-day rule.

3. Strengthen Controls to ensure full compliance with Medicare requirements:

The mission of UF Health Jacksonville is to provide excellent patient care, to collaborate in improving community health, and to create an environment that supports education and research in the health sciences. As part of our mission for excellence, we seek to provide the best medical care and education while upholding the highest legal and ethical standards. Our Compliance Program is based on the OIG's Compliance Program Guidance, the Seven Elements of an Effective Compliance Program, and industry best practice models. We are dedicated to ensuring compliance with policies, rules, and regulations. We aim to prevent and detect fraud by monitoring, conducting routine audits and reviews, and effective internal controls. We routinely examine our coding and billing practices and procedures to continually improve accuracy and completeness. We strive to ensure that all activity by or on behalf of UF Health Jacksonville is in compliance with the organization's policies and procedures, as well as local, state, and federal laws.

In September 2016, we responded to the OIG's Internal Controls Questionnaire, which provided a response to each identified error, along with a statement on controls and actions taken as a result. A brief summary detailing our internal controls related to the OIG's review findings, is included below.

UF Health Jacksonville has adopted numerous policies to prevent and detect fraud, waste, and abuse. These require compliance with federal and state laws and our Code of Conduct, and were designed to ensure staff follow proper procedures. Billing and coding staff adhere to Medicare billing and payment rules, and Official Guidelines for Coding and Reporting. As a result of the review, we have adjusted applicable policies to provide further clarification on issues found to be in error and have educated staff on these revised policies and procedures.

UF Health Jacksonville staff are trained at hire and annually on the importance of compliance, and on performing their duties in a legal and ethical manner. Additionally, our coding and billing staff complete continuous training on billing and coding. As a result of this review, we have re-trained our coding and billing staff to provide specific education on proper coding and billing, with respect to the findings within the OIG's Draft Report.

The Hospital has a robust coding, billing, and claims audit process, with quality controls to monitor the accuracy of its coding and billing. Our process includes proactive monitoring and auditing for coding quality, along with routine education and training, including training on issues identified where it appears that specific policies and procedures have not been followed. Our training helps ensure that all persons responsible for coding or billing functions have a complete understanding of the defined processes and associated regulatory, coding, and billing requirements. The Hospital holds that coding and billing errors were not the result of any deficiency in its coding or billing capabilities.

Although the Hospital acknowledges some errors in the claims reviewed, these errors are limited to cases where, for example, an anomalous human error occurred which

resulted in claims not being combined in our systems, or where the Hospital was unaware of a prior inpatient admission from another facility. Importantly, there was no pattern found in coding errors, even in high volume review areas, and no evidence suggests payment errors resulted from failed documented educational intervention or an incomplete understanding of the current rules and regulations, and no evidence to support the absence of a proactive compliance program.

In summary, the Hospital believes that OIG's Draft Report does not reflect any fundamental flaw in the Hospital's systems or processes. Accordingly, the corrective actions noted by the Hospital are focused on continuing our commitment to existing compliance efforts.

Thank you for allowing us this opportunity to respond to your Draft Report, and for your consideration of our submission. As we have been throughout this process, we are willing and available to respond to your questions or concerns. You may contact me by email at heather.bokor@jax.ufl.edu or by phone at (904) 244-1979 or (904) 244-1219.

Sincerely,

Heather Noughton Bokor
Senior Director of Compliance
Compliance Services
UF Health

CC: Elizabeth Rusczyk, Vice President of Compliance and Privacy, UF Health
Russell Armistead, Chief Executive Officer, UF Health Jacksonville
William "Bill" Ryan, Chief Financial Officer, UF Health Jacksonville
James Roberts, Senior Vice President and General Counsel, UF Health
Jon DeBardeleben, Vice President and Senior Counsel, UF Health Jacksonville
Dean Cocchi, Associate Vice President of Finance, UF Health Jacksonville

/ Enclosure /

UF HEALTH JACKSONVILLE - HOSPITAL RESPONSE TO OIG DRAFT REPORT - MEDICARE COMPLIANCE REVIEW [APPENDIX A]

SAMPLE #	DRG or Billing CHANGE	OIG Review Findings	Concurrene or Nonconcurrence	Hospital Comments/Supporting Statements	Supporting Documentation/References
STRATA 1: IP (LOW DOLLAR) HIGH SEVERITY DRG					
A6	Yes	OIG agreed with Hospital self-audit which included # A6 as an error, due to a DRG recommended change.	Hospital Concurs.	The Hospital completed a review of the claim/record for this Sample. Hospital provided to the OIG during the review, that # A6 required a DRG change. OIG reported as an error. Hospital agrees with the draft report/findings.	N/A
A14	No	OIG recommende "re-evaluating principal Dx 584.9 and changing to 276.51 (dehydration). Discharge summary indicates severe dehydration as the primary condition and acute-on-chronic kidney disease secondary to dehydration."	Hospital disagrees with OIG findings.	The Hospital completed a multi-level review of the claim/record for this Sample (A14). Hospital provided to the OIG a statement that no issues were identified. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and holds that it does not agree with the draft report/findings. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG and its contracted auditors were not following proper coding guidelines.	<p>Sequencing guidelines for Acute Renal Failure due to dehydration were well established.</p> <p>*Reference - AHA Coding Clinic 3Q 2002: Question: A patient is admitted with acute renal failure (ARF) due to severe dehydration. The patient is treated with IV fluids, and a renal ultrasound reveals atrophic right kidney. The patient slowly improves; however, the family does not want an aggressive workup and the patient is discharged to a hospice. What is the principal diagnosis in this case, ARF or dehydration? Answer: Assign code 584.9, Acute renal failure, unspecified, as the principal diagnosis. Acute renal failure was the reason for the admission. Code 276.5, Volume depletion, should be assigned as an additional diagnosis.</p> <p>*Reference: AHA Coding Clinic 1Q 2003: There are some issues with regard to the question in Coding Clinic, Third Quarter 2002, page 21, on acute renal failure due to dehydration, where the only treatment is IV hydration, and BUN and creatinine return to normal. The answer contains the final sentence, "The fact that renal function was not investigated or worked up does not affect code assignment." This was misleading, in that the renal function in fact would be followed based on close monitoring of the fluid intake and output, as well as the BUN and creatinine. Fluid monitoring requires nursing resources. Even though the only treatment for the acute renal failure is IV hydration, no procedures are done to image or evaluate the kidneys, and treatment with dialysis is not required, it is still appropriate to assign the code for acute renal failure as the principal diagnosis. In most instances, when dialysis is not required, rehydration corrects the acute renal failure. This would be consistent whether the acute renal failure was due to dehydration or another condition. * Reference: AHA Coding Clinic 1Q 2003 pg. 3 directs if the patient is admitted in Acute Renal Failure due to Dehydration or another condition, it is appropriate to code to the Acute Renal Failure as the Principal Diagnosis: Fluid monitoring requires nursing resources. Even though the only treatment for the acute renal failure is IV hydration, no procedures are done to image or evaluate the kidneys, and treatment with dialysis is not required, it is still appropriate to assign the code for acute renal failure as the principal diagnosis. In most instances, when dialysis is not required, rehydration</p>

					corrects the acute renal failure. This would be consistent whether the acute renal failure was due to dehydration or another condition.
SAMPLE #	DRG or Billing CHANGE	OIG Review Findings	Concurrere or Nonconcurrency	Hospital Comments/Supporting Statements	Supporting Documentation/References
A21	Yes	OIG agreed with Hospital self-audit which included # A21 as an error, due to a DRG recommended change.	Hospital Concurs.	The Hospital completed a review of the claim/record for this Sample (A21). Hospital provided to the OIG during the review, that # A21 required a DRG change. OIG reported as an error. Hospital agrees with the draft report/findings.	N/A

A34	Yes	OIG agreed with Hospital self-audit which included # A34 as an error, due to a DRG recommended change.	Hospital Concur.	The Hospital completed a review of the claim/record for this Sample (A34). Hospital provided to the OIG during the review, that # A34 required a DRG change. OIG reported as an error. Hospital agrees with the draft report/findings.	N/A
A38	No	OIG recommend "removing secondary Diagnosis of 514, Pulmonary congestion and hypostasis. Pulmory edema is mentioned in the discharge summary and progress notes but not listed as a definite condition. Discharge summary only states "Chest x-ray revealed some interstitial reticular densities, may be due to some chronic changes superimposed pulmonary edema".	Hospital disagrees with OIG findings.	The Hospital completed a multi-level review of the claim/record for this Sample (A38). Hospital provided to the OIG a statement that no issues were identified. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and holds that it does not agree with the draft report/findings. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG and its contracted auditors were not following proper coding guidelines.	<p>*Reference: ICD-9-CM Official Guidelines, Section II.H directs: If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.</p> <p>*Supporting documentation: Discharge Summary and Progress Notes all document 'chronic changes with possible superimposed pulmonary edema'. Additionally, the History and Physical documents the patient was in Acute Respiratory Distress - which codes to 518.82 - Other Pulmonary Insufficiency, Not Elsewhere Classified, which is also a CC (Co-morbidity). Recommend adding this additional diagnosis. Although the 4/17/13 Chest X-Ray impression of "possible superimposed pulmonary edema" is re-stated on the H&P, Progress Notes, and Discharge Summary, no follow-up x-rays were performed to assess the resolution or progression, and the physician does not comment on its clinical significance. The pulmonary edema appears to be an incidental radiology finding.</p>
SAMPLE #	DRG or Billing CHANGE	OIG Review Findings	Concurrere or Nonconcurrere	Hospital Comments/Supporting Statements	Supporting Documentation/References

A42	No	OIG reported that "Acute renal failure is justified as a diagnosis given the renal note, however, this does not appear to be the principal diagnosis. Discharge summary indicates "acute kidney injury: Pre-renal in nature due to dehydration". Severe hyponatremia due to dehydration is the main Dx. Recommend changing principal Dx to 276.1 (Hyposmolality and/or hyponatremia)."	Hospital disagrees with OIG findings.	The Hospital completed a multi-level review of the claim/record for this Sample (A42). Hospital provided to the OIG a statement that no issues were identified. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and holds that it does not agree with the draft report/findings. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG and its contracted auditors were not following proper coding guidelines.	<p>* Supporting documentation: Both conditions were present on admission, both conditions were due to dehydration, both were treated with IV hydration. ICD-9-CM Official Guidelines, Selection of Principal Diagnosis: Section II.C directs: when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first. Sequencing guidelines for Acute Renal Failure due to dehydration are well established. Dehydraton with hyponatremia is a combination code (276.1) so although the altered mental status was attributed to severe hyponatremia, the Coding Clinic guidance cited below applies.</p> <p>*Reference - AHA Coding Clinic 3Q 2002: Question: A patient is admitted with acute renal failure (ARF) due to severe dehydration. The patient is treated with IV fluids, and a renal ultrasound reveals atrophic right kidney. The patient slowly improves; however, the family does not want an aggressive workup and the patient is discharged to a hospice. What is the principal diagnosis in this case, ARF or dehydration? Answer: Assign code 584.9, Acute renal failure, unspecified, as the principal diagnosis. Acute renal failure was the reason for the admission. Code 276.5, Volume depletion, should be assigned as an additional diagnosis. *</p> <p>Reference: AHA Coding Clinic IQ 2003: There are some issues with regard to the question in Coding Clinic,Third Quarter 2002, page 21, on acute renal failure due to dehydration, where the only treatment is IV hydration, and BUN and creatinine return to normal. The answer contains the final sentence, "The fact that renal function was not investigated or worked up does not affect code assignment." This was misleading, in that the renal function in fact would be followed based on close monitoring of the fluid intake and output, as well as the BUN and creatinine. Fluid monitoring requires nursing resources. Even though the only treatment for the acute renal failure is IV hydration, no procedures are done to image or evaluate the kidneys, and treatment with dialysis is not required, it is still appropriate to assign the code for acute renal failure as the principal diagnosis. In most instances, when dialysis is not required, rehydration corrects the acute renal failure. This would be consistent whether the acute renal failure was due to dehydration or another condition.</p>
A44	Yes	OIG agreed with Hospital self-audit which included # A44 as an error, due to a DRG recommended change.	Hospital Concurs.	The Hospital completed a review of the claim/record for this Sample (A44). Hospital provided to the OIG during the review, that # A44 required a DRG change. OIG reported as an error. Hospital agrees with the draft report/findings.	N/A
SAMPLE #	DRG or Billing CHANGE	OIG Review Findings	Concurrene or Nonconcurrency	Hospital Comments/Supporting Statements	Supporting Documentation/References

A47	Yes	Recommend removing secondary Dx 428.32. Chronic diastolic heart failure is not mentioned in the discharge summary nor in the progress notes.	Hospital disagrees with OIG findings.	The Hospital completed a multi-level review of the claim/record for this Sample (A47). Hospital provided to the OIG a statement that no issues were identified. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and holds that it does not agree with the draft report/findings. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG and its contracted auditors were not following proper coding guidelines.	<p>* Supporting Documentation: History and Physical documents under Assessment and Plan, patient has Diastolic Heart Failure. Being treated with Lisinopril 10mg daily and Metoprolol 50mg daily. ("past medical history of diastolic heart failure. No acute CHF decompensation"). ED Note includes Past Medical History of CHF.</p> <p>* Reference: AHA Coding Clinic 3Q 2007 pg. 13 directs: Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded. This applies to Inpatient coding.</p> <p>*Reference: Official Guidelines, Reporting of Additional Diagnoses directs: For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring.</p> <p>Additionally, Consultation by Dr. J. Cury as well as Progress Notes by Dr. S. Po and Dr. A Singh document:Hemoptysis due to right lower lobe pneumonia: Likely due to aspiration. Hemoptysis is blood mixed with sputum, not frank blood. Recommend adding 786.30 - Hemoptysis, Unspecified as secondary diagnosis, which is also a CC.</p> <p>*Reference: AHA Coding Clinic 1Q 2014 - regarding Documentation: Question: Can you clarify whether advice on documentation issues that do not appear to be specifically tied to a particular coding system (ICD-9-CM nor ICD-10- CM/PCS) are still valid for ICD-10-CM or ICD-10- PCS? Answer: Coding Clinic advice regarding documentation issues over the years has focused on what documentation can be used and was not specific to a coding system. For clarification purposes, the following information is being republished. Provider Documentation - Code assignment may be based on other physician (i.e., consultants, residents, anesthesiologist, etc.) documentation as long as there is no conflicting information from the attending physician. Medical record documentation from any physician involved in the care and treatment of the patient, including documentation by consulting physicians, is appropriate for the basis of code assignment. Documentation is not limited to the face sheet, discharge summary, progress notes, history and physical, or other report designed to capture diagnostic information. This advice refers only to inpatient coding.</p>
SAMPLE #	DRG or Billing CHANGE	OIG Review Findings	Concurrence or Nonconcurrence	Hospital Comments/Supporting Statements	Supporting Documentation/References

A55	No	OIG stated that "The progress note stated that the acute renal failure as improved after IV fluids and that it was a prerenal condition due to dehydration. Medical records support acute kidney failure (584.9) secondary to dehydration (276.51)."	Hospital disagrees with OIG findings.	The Hospital completed a multi-level review of the claim/record for this Sample (A55). Hospital provided to the OIG a statement that no issues were identified. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and holds that it does not agree with the draft report/findings. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG and its contracted auditors were not following proper coding guidelines.	<p>Sequencing guidelines for Acute Renal Failure due to dehydration are well established.</p> <p>*Reference - AHA Coding Clinic 3Q 2002: Question: A patient is admitted with acute renal failure (ARF) due to severe dehydration. The patient is treated with IV fluids, and a renal ultrasound reveals atrophic right kidney. The patient slowly improves; however, the family does not want an aggressive workup and the patient is discharged to a hospice. What is the principal diagnosis in this case, ARF or dehydration? Answer: Assign code 584.9, Acute renal failure, unspecified, as the principal diagnosis. Acute renal failure was the reason for the admission. Code 276.5, Volume depletion, should be assigned as an additional diagnosis.</p> <p>*Reference: AHA Coding Clinic IQ 2003: There are some issues with regard to the question in Coding Clinic, Third Quarter 2002, page 21, on acute renal failure due to dehydration, where the only treatment is IV hydration, and BUN and creatinine return to normal. The answer contains the final sentence, "The fact that renal function was not investigated or worked up does not affect code assignment." This was misleading, in that the renal function in fact would be followed based on close monitoring of the fluid intake and output, as well as the BUN and creatinine. Fluid monitoring requires nursing resources. Even though the only treatment for the acute renal failure is IV hydration, no procedures are done to image or evaluate the kidneys, and treatment with dialysis is not required, it is still appropriate to assign the code for acute renal failure as the principal diagnosis. In most instances, when dialysis is not required, rehydration corrects the acute renal failure. This would be consistent whether the acute renal failure was due to dehydration or another condition.</p> <p>*Supporting Documentation: H&P Assessment & Plan: Acute renal failure. Give IV fluids. Repeat BMP. Discharge Summary Discharge Diagnosis: Acute kidney injury. Placed on gentle hydration.</p>
A60	Yes	OIG agreed with Hospital self-audit which included # A60 as an error, due to a DRG recommended change.	Hospital Concurs.	The Hospital completed a review of the claim/record for this Sample (A60). Hospital provided to the OIG during the review, that # A60 required a DRG change. OIG reported as an error. Hospital agrees with the draft report/findings.	N/A
SAMPLE #	DRG or Billing CHANGE	OIG Review Findings	Concurrence or Nonconcurrence	Hospital Comments/Supporting Statements	Supporting Documentation/References

STRATA 2: IP (HIGH DOLLAR) HIGH SEVERITY DRG					
B3	Yes	OIG agreed with Hospital self-audit which included # B3 as an error, due to a DRG recommended change. Additionally, OIG recommended "removing the secondary diagnosis 867.0 (bladder and urethra injury without mention of open wound into cavity) because the hematuria was not treated. Urology was consulted and recommended no intervention. The hematuria resolved by POD 1."	Hospital Concur with initial DRG change (self-reported), however, does not concur with OIG findings/recommended changes from their review.	The Hospital completed a review of the claim/record for this Sample (B3). Hospital provided to the OIG during the review, that # B3 required a DRG change. OIG reported as an error. OIG did not send this Sample to the external auditors. Hospital agrees with the recommended DRG change (self-reported), however, does not agree with the OIG's findings subsequently provided. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG was not following proper coding guidelines regarding their assessment.	*Supporting documentation: Patient had Hematuria secondary to foley manipulation and consult was requested and performed. Urinalysis done, and the condition was monitored. Urology Consult documentation includes, "a 59 y.o. male who was referred secondary to hematuria after foley was pulled at OR when pt was waking up from anesthesia." and "recent gross hematuria due to foley catheter trauma." Discharge Summary documentation includes - Complications: "Hematuria after foley manipulation while patient was waking up from anesthesia." Hospital Course: "After the procedure, the patient experienced hematuria while he was waking up from anesthesia. Urology was consulted and recommended no intervention. The hematuria resolved by POD 1. On POD 2 the foley was removed" Per 3/21/14 Labs, Urinalysis revealed large (abnormal) amount of blood and RBCs were high with a value of 97. *Reference: Coding Clinic 1Q 2014 pg. 12 directs to code the condition to 867.0 - Injury To Pelvic Organs; Bladder And Urethra, Without Mention Of Open Wound Into Cavity.
B8	Yes	OIG agreed with Hospital self-audit which included # B8 as an error, due to a DRG recommended change.	Hospital Concur.	The Hospital completed a review of the claim/record for this Sample (B8). Hospital provided to the OIG during the review, that # B8 required a DRG change. OIG reported as an error. Hospital agrees with the draft report/findings.	N/A
SAMPLE #	DRG or Billing CHANGE	OIG Review Findings	Concurrere or Nonconcurrere	Hospital Comments/Supporting Statements	Supporting Documentation/References

B11	No	OIG stated that "According to the medical record the dietary supplement was canceled due to the pt being discharged. Recommend removing the secondary dx 261 due to no treatment while in hospital."	Hospital disagrees with OIG findings (for removing code 261, resulting in no DRG change), but commented on the validity of the code. Official guidelines are referenced.	The Hospital completed a multi-level review of the claim/record for this Sample (B11). Hospital provided to the OIG a statement that no issues were identified. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and holds that it does not agree with the draft report/findings as DRG change is not required, however, questioned the validity of the code. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG and its contracted auditors were not following proper coding guidelines.	*Supporting documentation: The documentation is conflicting regarding patient's nutritional status and question whether the diagnosis of malnutrition was based upon low prealbumin level - Although "moderate to severe malnutrition: dietary supplements" is documented in the Discharge Summary and Progress Note documentation, it appears the dietary nutrition supplement order was canceled. Labs revealed low Prealbumin which could be an indicator of malnutrition. Anthropometrics indicates patient's BMI is in the normal range. Physical Exam on Urology Consult describes patient as "well-developed, well-nourished". No order for Dietitian Consult. *Reference: Official Guidelines, Reporting of Additional Diagnoses directs: For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring. Therefore, it is appropriate to code this condition.
B13	No	OIG stated that "The pt BMI of 17.33 signifies slightly underweight. However, the hospital did not treat the pt for malnutrition. Malnutrition not diagnosis not mentioned in the discharge summary. Recommend removing secondary dx 263 Malnutrition of moderate degree."	Hospital disagrees with OIG findings.	The Hospital completed a multi-level review of the claim/record for this Sample (B13). Hospital provided to the OIG a statement that no issues were identified. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and holds that it does not agree with the draft report/findings as DRG change is not required. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG and its contracted auditors were not following proper coding guidelines.	* Supporting documentation: Documentation of BMI 17.33, A Query was sent to the physician with the confirming diagnosis of Moderate Malnutrition. With this physician documentation, the BMI can be coded, as well at the Malnutrition. * Reference: Coding Clinic 2Q 2000 pg. 17 - 18 directs: If there is evidence of a diagnosis within the medical record, and the coder is uncertain whether it is a valid diagnosis because the documentation is incomplete, vague, or contradictory, it is the coder's responsibility to query the attending physician to determine if this diagnosis should be included in the final diagnostic statement. All diagnoses should be supported by physician documentation. Documentation is not limited to the face sheet, discharge summary, progress notes, history and physical, or other report designed to capture diagnostic information. This advice refers only to inpatient coding.
SAMPLE #	DRG or Billing CHANGE	OIG Review Findings	Concurrence or Nonconcurrency	Hospital Comments/Supporting Statements	Supporting Documentation/References

B16	Yes	OIG stated that "The patient was diagnosed with UTI prior to the surgery. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay should be excluded. Patient started on antibiotics for UTI by her urologist and has been on them for several days. Recommend removing Dx code 599.0."	Hospital Concurs.	The Hospital completed a multi-level review of the claim/record for this Sample (B16). Hospital provided to the OIG a statement that no issues were identified upon initial review. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and agrees with the OIG findings from the draft report.	The Hospital provides the following as a result of follow-up review: In this case, the UTI did not impact the stay as the physician continued with the surgery. Additionally, unable to find documentation of when the patient was diagnosed, or when antibiotics started or stopped.
B32	No	The OIG recommend "removing secondary Dx 556.9 Ulcerative colitis, unspecified. Medical records show previous Hx of ulcerative colitis but no active problems/complications during current inpatient stay due to this condition. The medical records stated that the carotid artery was caused by diabetes mellitus (DM) not ulcerative colitis."	Hospital disagrees with OIG findings.	The Hospital completed a multi-level review of the claim/record for this Sample (B32). Hospital provided to the OIG a statement that no issues were identified. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and holds that it does not agree with the draft report/findings. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG and its contracted auditors were not following proper coding guidelines.	* Supporting documentation: History and Physical and Consultation document the patient has Ulcerative Colitis, treated with Azulfidine 1,000mg three times a day. * Reference: Coding Clinic 3Q 2007 pg. 13 directs: Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded. * Reference: Per the Official Guidelines, Reporting of Additional Diagnoses directs: For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring.
SAMPLE #	DRG or Billing CHANGE	OIG Review Findings	Concurrence or Nonconcurrency	Hospital Comments/Supporting Statements	Supporting Documentation/References

B41	No	The OIG stated "Acidosis listed as ED clinical impression but later ruled out and the patient symptoms resulted from a hernia that was surgically removed during the hospital stay. Also, further blood work did not indicate acidosis. Therefore, secondary dx 276.2 should be removed."	Hospital disagrees with OIG findings.	The Hospital completed a multi-level review of the claim/record for this Sample (B41). Hospital provided to the OIG a statement that no issues were identified. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and holds that it does not agree with the draft report/findings. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG and its contracted auditors were not following proper coding guidelines.	<p>* Supporting documentation: ED documents Acidosis with Anion Gap of 18 on 03/20, Anion Gap of 23 on 03/21 and Anion Gap of 18 again on 03/22; finally normal again on 03/23. This supporting the Reporting of this diagnosis for monitoring/evalutaion.</p> <p>* Reference: Official Guidelines, Reporting of Additional Diagnoses directs: For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring. Therefore, it is appropriate to code this condition.</p>
B47	No	The OIG stated "The patient was admitted because of a fall and due to altered mental status not acute myocardial infarction. After further workup it was determined that the patient had a mechanical fall. Therefore, secondary dx 410.71 not supported and should be removed. Fall was ruled likely mechanical."	Hospital disagrees with OIG findings.	The Hospital completed a multi-level review of the claim/record for this Sample (B47). Hospital provided to the OIG a statement that no issues were identified. OIG completed its review and sent to the external auditors, who assessed an error and recommended a DRG change. Hospital reviewed OIG findings and holds that it does not agree with the draft report/findings. Supporting information from official coding guidelines and supporting documentation from within the medical record was provided (see next cell). Hospital contends that the OIG and its contracted auditors were not following proper coding guidelines.	<p>* Supporting documentation: Patient admitted for Lumbar fracture secondary to fall on 3/23. On 3/24 patient's Troponin started increasing, peaking at .122 documented in progress note by Dr. B. Mourad on 3/26; Dr. R. Brown signed off on and added to the resident's note by documenting: 'Patient dx with NSTEMI. Cardiac enzymes are currently trending down. Patient do not have any chest pain. Will continue plavix and heparin at this time. Possible discharge tomorrow.' This case extened the length of the hospital stay, evlauated, monitored and treatment performed, therefore based on Official guidelines, this is a reportable condition.</p> <p>* Reference: Official Guidelines, Reporting of Additional Diagnoses directs: For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring.</p>
SAMPLE #	DRG or Billing CHANGE	OIG Review Findings	Concurrere or Nonconcurrere	Hospital Comments/Supporting Statements	Supporting Documentation/References

STRATA 3: IP PAID IN EXCESS OF CLAIMS:*No claims were identified as being in error, per Hospital and OIG review.***STRATA 4: IP (HIGH DOLLAR) HIGH SEVERITY DRG**

D1	Yes	OIG reported that this was medically related and should be combined.	Hospital Concur s that the account was to be combined, however, notes error.	The Hospital completed a review of the claim/record for this Sample (D1). Hospital provided to the OIG during the review, that # D1 was in error as the patient was never discharged in error, which resulted in the error. Hospital agree that the accounts should be combined. OIG reported as an error. Hospital agrees with the draft report/findings (given the self-disclosed error).	Refer to "Hospital Comments" section.
D3	Yes	OIG agreed with Hospital findings that this case was not a readmission and should not have been included in the sample. OIG agreed with Hospital findings which included a coding error, resulting in a DRG change.	Hospital agrees with DRG change, however, disagrees with appropriateness of review inclusion. No error reported for Strata 4 regarding readmissions.	The Hospital completed a review of the claim/record for this Sample (D3). Hospital provided to the OIG during the review, that # D3 required a DRG change due to coding error, however, was not a readmission case and should be removed from the sample as it was not appropriate for the review selection related to Strata 4. Additional information was requested by Hospital for proper review, as the Hospital does not have information on the patient's "original stay", and the patient expired upon the "subsequent stay". Hospital initially requested this to be a non-error. OIG reported as an error. Hospital agrees with DRG change (self-reported), however, disagrees with review inclusion.	Refer to "Hospital Comments" section.
D4	Yes	OIG reported that this was medically related and should be combined.	Hospital Concur s.	The Hospital completed a review of the claim/record for this Sample (D4). Hospital provided to the OIG during the review, that # D4 was in error as it was medically related and should have been a combined visit. OIG reported as an error. Hospital agrees with the draft report/findings.	Refer to "Hospital Comments" section.