Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF PARKRIDGE MEDICAL CENTER, INC., FOR 2014 AND 2015

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

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Deputy Inspector General
for Audit Services

August 2017
A-04-16-08048

Office of Inspector General

https://oig.hhs.gov

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Report in Brief
Date: August 2017
Report No. A-04-16-08048

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

Medicare Compliance Review of Parkridge Medical Center, Inc., for 2014 and 2015

Why OIG Did This Review

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2015, Medicare paid hospitals $163 billion, which represents 46 percent of all fee-for-service payments for the year.

Our objective was to determine whether Parkridge Medical Center, Inc. (Hospital) complied with Medicare requirements for billing inpatient services on selected types of claims.

How OIG Did This Review

We selected for review a stratified random sample of 100 inpatient claims with payments totaling $1.8 million for our audit period (January 1, 2014, through December 31, 2015).

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

What OIG Found

The Hospital complied with Medicare billing requirements for 88 of the 100 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 12 claims, resulting in net overpayments of $65,029.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $201,808 for our audit period. During the course of our audit, the Hospital submitted some of these claims for reprocessing that we verified as correctly reprocessed. Accordingly, we have reduced the recommended refund by this amount.

What OIG Recommends and Hospital Comments

We recommended that the Hospital refund to the contractor $191,936 ($201,808 less $9,872 that had already been repaid) in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

The Hospital did not agree with most of our findings and recommendations. Specifically, the Hospital disagreed with 8 of the 12 claim errors that we identified. We obtained independent medical review for medical necessity and coding errors, and our report reflects the results of that review. Therefore, we maintain that all of our findings and recommendations are correct.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2015, Medicare paid hospitals $163 billion, which represents 46 percent of all fee-for-service payments; accordingly it is important to ensure hospital payments comply with requirements.

OBJECTIVE

Our objective was to determine whether Parkridge Medical Center, Inc., 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 uses Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

Under the inpatient prospective payment system (IPPS), CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Inpatient Rehabilitation Prospective Payment System

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for rehabilitation facilities. CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the payment system, CMS established a Federal prospective payment rate for each of the distinct case-mix groups (CMG). The assignment to a CMG is based on the beneficiary's clinical characteristics and expected resource needs. In addition to

the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient claims billed with medical devices,
- inpatient claims billed with high-severity-level DRG codes, and
- inpatient claims billed with elective admissions.

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

Medicare Requirements for Hospital Claims and Payments

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

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

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

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

Parkridge Medical Center, Inc.

Parkridge Medical Center, Inc. (the Hospital), is composed of 5 facilities, with 645 combined beds, located in Chattanooga, Tennessee. These facilities include: Parkridge Medical Center, Parkridge East Hospital, Parkridge Valley Hospital – Child and Adolescent Campus, Parkridge Valley Hospital – Adult and Senior Campus, and Parkridge West. For purposes of Medicare billing, the Hospital submits claims to Medicare for reimbursement using one provider identification (#440156) for all five facilities. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately $101 million for 9,893 inpatient claims between January 1, 2014, and December 31, 2015 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our audit covered $11,396,043 in Medicare paid claims to the Hospital for 806 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 inpatient claims with payments totaling $1,819,073. Medicare paid these 100 claims during our audit period.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 100 claims to medical and coding review to determine whether the services met medical necessity and coding requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

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

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

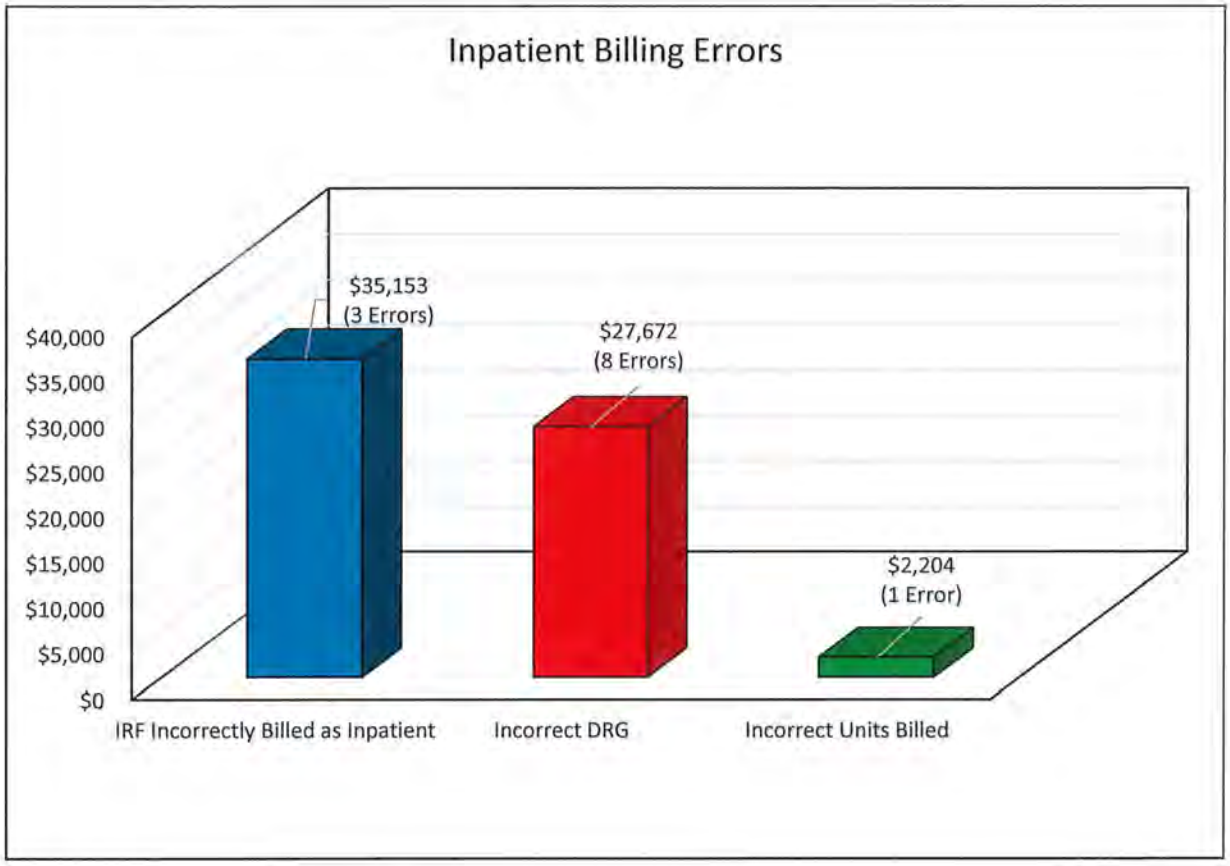
FINDINGS

The Hospital complied with Medicare billing requirements for 88 of the 100 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 12 claims, resulting in net overpayments of $65,029 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 $201,808 for the audit period. See Appendix B for sample design and methodology, Appendix C for sample results and estimates, and Appendix D for results of review by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 12 of the 100 inpatient claims that we reviewed. These errors resulted in net overpayments of $65,029 as shown below.



Incorrectly Billed Rehabilitation Facility Claims

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

The *Medicare Benefit Policy Manual* states that the IRF benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care (Pub. No. 100-02, chapter 1, § 110-110.1).

In addition, the *Medicare Benefit Policy Manual* states that a primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record must document a reasonable expectation that, at the time of admission to the IRF, the patient

generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs (Pub. No. 100-02, chapter 1, § 110.2.2).

For 3 of the 100 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation.

The Hospital did not provide a cause for the errors because officials contended that these claims met Medicare requirements. As a result of these errors, the Hospital received overpayments of $35,153.

Incorrectly Billed Diagnosis-Related Group Codes

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act, § 1862(a)(1)(A)). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 8 of the 100 selected inpatient claims, the Hospital submitted claims to Medicare with incorrectly coded claims, resulting in incorrect DRG payments to the Hospital. Specifically, certain diagnosis codes were not supported by the medical records.

The Hospital indicated that it had billed 3 of the 8 claims incorrectly because of human error. The Hospital did not provide a cause for the remaining errors because it believed that the claims were correctly coded.

As a result of these errors, the Hospital received net overpayments of $27,672. For 2 of the 8 claims, the Hospital refunded $7,668 of the overpayments after the start of our review.

Incorrectly Billed Number of Units

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

For 1 of the 100 selected inpatient claims, the Hospital submitted the claim to Medicare with the incorrect number of units. The Hospital stated that the incorrect submission occurred because of human error or lack of documentation explaining the basis for the additionally reported medical device on the claim. As a result, the Hospital received an overpayment of $2,204. The Hospital refunded the overpayment after the start of our review.

OVERALL ESTIMATE OF OVERPAYMENTS

The combined overpayments on our sampled claims totaled $65,029. On the basis of our sample results, we estimated that the Hospital received overpayments of at least $201,808 for the audit period. During the course of our audit, the Hospital submitted some of these claims for reprocessing that we verified as correctly reprocessed. Accordingly, we have reduced the recommended refund by this amount.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $191,936 ($201,808 less $9,872 that has already been repaid) in estimated overpayments for the audit period for claims that it incorrectly billed;

- exercise reasonable diligence to identify and return any additional overpayments received outside of our audit period, in accordance with the 60-day repayment rule; and

- strengthen controls to ensure full compliance with Medicare requirements.

PARKRIDGE MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

PARKRIDGE MEDICAL CENTER COMMENTS

In written comments on the draft report, the Hospital did not agree with most of our findings and recommendations. Specifically, the Hospital disagreed that it incorrectly billed 8 of 12 inpatient claims that we identified as not fully complying with Medicare billing requirements, including 3 inpatient rehabilitation facility claims and 5 incorrect DRG coded claims. The Hospital indicated that it would pursue the Medicare appeals process for these claims.

The Hospital also disagreed with extrapolation and believes that extrapolation is legally unfounded. The Hospital stated that the Social Security Act expressly limits the ability of CMS and its contractors to extrapolate alleged overpayments unless either there is a sustained or high level of payment error or documented educational intervention has failed to correct the payment error. It stated that Health and Human Services/Office of Inspector General (HHS/OIG) has not proven either of these cases and thus should not recommend extrapolation to CMS.

The Hospital stated that the use of extrapolation is inconsistent with HHS/OIG's stated purpose of Medicare compliance reviews and is fundamentally unfair. It stated that extrapolation, even if appropriate, is premature because the alleged error rate is erroneously inflated. There will be no settled "error rate" from which to extrapolate until it avails itself of its appeal rights, and

extrapolation may require the Hospital to refund overpayment amounts that have yet to be determined. Therefore, the Hospital requested the HHS/OIG abandon the extrapolation recommendation.

The Hospital also stated that it routinely examines its coding and billing practices and procedures with the objective of achieving ever-improving accuracy and completeness. The full text of comments is in Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

In response to the Hospital's disagreement that it improperly billed 8 claims, we obtained an independent medical review for medical necessity and coding errors, and our report reflects the results of that review. Prior to review of the medical records by independent medical staff and again after preliminary results were obtained, we gave the Hospital the opportunity to provide all information and documentation related to the sampled claims. The hospital provided no new specifics related to these claims in its response to our draft report, so we stand by our original error determinations.

Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[1]

Furthermore, no statutory or other authority limits our ability to recommend a recovery to CMS based upon sampling and extrapolation. Regarding our extrapolation methodology, the requirement that a determination of a sustained or high level of payment error or documented failed educational intervention must be made before extrapolation applies only to Medicare contractors.[2] 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.[3]

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

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[1] *See Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 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).

[2] *See* Social Security Act § 1893(f)(3); CMS Medicare Program Integrity Manual, chapter 8.4.1.4 (effective June 28, 2011).

[3] *See Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *34 (S.D. Tex. 2012).

We acknowledge the Hospital's commitment to operate in compliance with applicable rules and regulations and its objective of ever-improved accuracy and completeness.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $11,396,043 in Medicare payments to the Hospital for 806 claims that were potentially at risk for billing errors. We selected a stratified random sample of 100 inpatient claims with payments totaling $1,819,073 for review. Medicare paid these 100 claims during our audit period.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 100 claims to medical and coding review to determine whether the services met medical necessity and coding requirements.

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

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

We conducted our fieldwork from August 2016 through April 2017.

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 analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 100 inpatient claims totaling $1,819,073 for detailed review (Appendix B);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;

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

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

- reviewed the Hospital's procedures for assigning DRG and admission status codes for Medicare claims;

- used an independent medical review contractor to determine whether 100 claims met medical and 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 review to calculate the estimated Medicare overpayment to the Hospital (Appendix C); and

- discussed the results of our review with Hospital officials.

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

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

TARGET POPULATION

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

SAMPLING FRAME

According to CMS's NCH data, Medicare paid the Hospital $101 million for 9,893 inpatient claims during the audit period.

We obtained a database of claims from the NCH data totaling $68,685,667 for 6,041 inpatient claims in 22 risk areas. From these 22 areas, we selected 3 consisting of 3,134 claims totaling $38,147,345 for further review.

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

- claims with certain discharge status and diagnosis codes,
- paid claims less than $3,000, and
- claims under review by the Recovery Audit Contractor as of July 11, 2016.

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: Inpatient Claims Billed With Medical Devices, Inpatient Claims Billed With High-Severity-Level DRG Codes, and Inpatient Claims Billed With Elective Admissions.

This assignment hierarchy resulted in a sample frame of 806 Medicare paid claims in 3 risk areas totaling $11,396,043 from which we drew our sample (Table 1).

Table 1: Risk Areas

Medicare Risk Area	Frame Size	Value of Frame
Inpatient Claims Billed With Medical Devices	202	$5,274,020
Inpatient Claims Billed With High Severity Level DRG Codes	313	2,555,174
Inpatient Claims Billed With Elective Admissions	291	3,566,849
Total	**806**	**$11,396,043**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into three strata on the basis of Medicare risk area and amount paid. All claims were unduplicated, appearing in only one area and only once in the entire sampling frame.

SAMPLE SIZE

We selected a stratified random sample of 100 claims for review as shown in Table 2.

Table 2: Claims by Stratum

Stratum	Medicare Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Claims Billed With Medical Devices	202	40
2	Inpatient Claims Billed With High-Severity-Level DRG Codes	313	30
3	Inpatient Claims Billed With Elective Admissions	291	30
	Total	**806**	**100**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

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

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Net Overpayments in Sample
1	202	$5,274,020	40	$1,098,625	6	$26,221
2	313	2,555,174	30	255,776	5	36,363
3	291	3,566,849	30	464,672	1	2,445
Total	**806**	**$11,396,043**	**100**	**$1,819,073**	**12**	**$65,029**

ESTIMATES

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

Point Estimate	$535,521
Lower limit	$201,808
Upper limit	$869,233

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Table 5: Sample Results by Risk Area

Inpatient Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Under/Over Payments	Value of Net Overpayments
Inpatient Claims Billed With Medical Devices	40	$1,098,625	6	$26,221
Inpatient Claims Billed With High-Severity-Level DRG Codes	30	255,776	5	36,363
Inpatient Claims Billed With Elective Admissions	30	464,672	1	2,445
Inpatient Totals	**100**	**$1,819,073**	**12**	**$65,029**

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.

DENTONS

July 13, 2017

[redacted]

Office of Inspector General - The redacted information contains sensitive information.

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

Re: Response to the Draft Report regarding the Medicare Compliance Review of Parkridge Medical Center, Chattanooga, Tennessee, Report Number: A-04-16-08048

Dear Ms. Pilcher:

On behalf of Parkridge Medical Center ("Parkridge" or "Hospital"), we respectfully submit this letter in response to the U.S. Department of Health and Human Services, Office of Inspector General ("HHS-OIG") draft report number A-04-16-08048), dated June 15, 2017, entitled "Medicare Compliance Review of Parkridge Medical Center, Inc., for 2014 and 2015" (referred to herein as "Draft Report"). As permitted by the terms of the Draft Report, this letter sets forth the Hospital's objections to: (1) several of the HHS-OIG's findings with respect to the actual claims at issue; and (2) the HHS-OIG's recommendation that these findings be extrapolated for a total overpayment of approximately $201,000.

I. Background

The Draft Report is a product of an audit (the "Audit"), which was undertaken by HHS-OIG as part of a national auditing initiative designed to determine whether hospitals were complying with Medicare billing requirements for certain types of claims that HHS-OIG believed were at risk for noncompliance.

The HHS-OIG's Draft Report focused on the following three claim error categories with dates of service in calendar years 2014 and 2015 ("Audit Period"): (1) inpatient claims for inpatient rehabilitation facility ("IRF") services, (2) inpatient claims billed with incorrect DRG codes, and (3) inpatient claims with incorrectly billed number of units.[1] The HHS-OIG focused on particular categories of inpatient claims because they were deemed areas at risk for incorrect billing based on previous work at other hospitals. ("Risk Areas").[2]

The audit covered 806 Medicare paid claims with dates of service during the Audit Period, and payments totaling $11,396,043. From this universe, the HHS-OIG selected a stratified random sample of 100 paid inpatient claim with dates of service during the Audit Period, representing a total of $1,819,073

[1] The categories of billing errors the OIG identified in its Draft Report for Parkridge differ from the "risk areas" that the OIG identified through its work with other hospitals. The original "risk areas" were: (1) inpatient claims billed with medical devices, (2) inpatient claims billed with high severity DRG codes, and (3) inpatient claims billed with elective admissions. See Draft Report, at 2.

[2] See id.

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in Medicare reimbursement. The HHS-OIG's audit of this sample focused on the Risk Areas identified as a result of prior HHS-OIG reviews at other hospitals by subjecting the 100 claims to medical and coding review to determine whether the services met medical necessity and coding requirements.

II. Draft Report Findings

The HHS-OIG's audit found that Parkridge complied with Medicare billing requirements for 88 of the 100 inpatient claims reviewed. The remaining 12 claims that were allegedly billed in error resulted in alleged net overpayments of $65,029 for the Audit Period. Without actually using the word "extrapolation," the HHS-OIG proceeds to recommend that Parkridge refund an estimated alleged overpayment of $191,936 ($201,808 for the audit period less $9,872 that has already been repaid by the Hospital).

A. IRF Claims

The HHS-OIG audit found three (3) of the 100 selected inpatient claims were incorrectly billed because the stay did not meet Medicare criteria for inpatient rehabilitation, resulting in alleged overpayments of $35,153. Discussed in more detail below.

B. Incorrectly Billed DRGs

The HHS-OIG audit found eight (8) of the 100 selected inpatient claims were incorrectly coded resulting in incorrect DRG payments to the Hospital, resulting in alleged overpayments of $27,672.

The Draft Report acknowledges that Parkridge had already indicated that three (3) of the eight (8) claims were incorrectly billed due to human error, and Parkridge already refunded $7,668 in overpayments associated with these claims. Discussed in more detail below.

C. Billed Number of Units

For only one (1) of the 100 selected inpatient claims, the HHS-OIG found that the hospital submitted the claim to Medicare with the incorrect number of units.

The Draft Report recognizes that Parkridge conceded that this one (1) claim was incorrectly billed due to human error. As Parkridge has refunded $2,204 associated with this claim, this is not discussed in more detail below.

DENTONS

III. Parkridge's Response to the Draft Report

A. Parkridge Intends to Contest Claims on the Merits

Parkridge continues to object to the HHS-OIG audit's findings with respect to eight (8) of the 12 claims that the Draft Report concludes were billed incorrectly. Out of the eight (8) claims that were allegedly billed in error, Parkridge believes that three (3) of the IRF claims and five (5) of inpatient claims billed with incorrect Medicare Severity Diagnosis Related Group ("MS-DRG") or ("DRG") Codes, were billed correctly. The Hospital will pursue the Medicare appeals process with respect to these claims.

1. IRF Claims

Parkridge disagrees with the HHS-OIG Report finding that three (3) claims did not meet Medicare criteria for IRF services. The Hospital's review of these claims found that contrary to the OIG's assertions, the medical record clearly supports that the inpatient hospital level of care was medically necessary for each of the patients, and their complex medical and functional needs could not be met in a less intense setting.

Additionally, the medical record indicates that the beneficiaries were able to fully participate and benefit from a 24-hour therapeutic environment. The physicians treating each of the patients developed individualized overall plans of care for each of the patients taking into account their medical needs and determined that the high risk nature of these cases necessitated IRF level care. These plans of care were executed, and each patient received and benefitted from 24 hour rehabilitation nursing, an interdisciplinary care team, and more than 900 minutes per week of an intensive rehabilitation therapy program. When these three (3) claims were reviewed and re-reviewed, the billing and coding experts were confident that the all criteria for medically necessary IRF admissions were satisfied.

2. Incorrectly Billed DRG Codes

The Hospital also disagrees with the HHS-OIG Audit's findings with respect to five (5) of the inpatient claims determined to be billed with incorrect DRG codes. Parkridge's review revealed that the DRGs billed were supported by the medical record. The Hospital's responses to the OIG's requests in connection with this audit provided specific references in documentation substantiating each diagnosis reported and utilized by the facility to support the MS-DRG coded. Given the clear evidence in the medical record, these claims should not be considered erroneously billed, and Parkridge will pursue the Medicare appeals process with respect to each of the five disputed claims.

B. Extrapolation is Legally Unfounded and Premature

The Hospital respectfully disagrees with HHS-OIG's extrapolation on several grounds, two of which are addressed in this submission. The Hospital does not have the detail associated with the full universe and strata considered by the HHS-OIG in this matter. Once that information is made available, the Hospital may rely on additional grounds for arguing extrapolation is inappropriate in this matter.

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1. Extrapolation Is Legally Unfounded

The Social Security Act expressly limits the ability of CMS and its contractors to extrapolate alleged overpayments: "a Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise *unless the Secretary determines that* (A) *there is a sustained or high level of payment error*, or (B) *documented educational intervention has failed* to correct the payment error."[3] HHS-OIG has not met this burden, and thus should not recommend extrapolation to CMS. As initial matter, an alleged error of rate of 12 percent simply is not a high error rate. Indeed, HHS self-reported its own 11 percent error rate by various CMS contractors to fee-for-service providers. (See GAO-17-290 "Oversight of Efforts to Reduce Improper Billing Needs Improvement," (March 2017)). Numerous hospitals nationwide have had much higher error rates and, yet, were not subjected to extrapolation. Moreover, if you remove the claims that Parkridge believes were correctly billed (a total of eight (8) claims in total), the Hospital would only have four (4) of 100 claims at issue, (*i.e.*, a four (4) percent error rate),[4] all of which are attributable to human error. Four human errors out of 100 (i.e., less than 4 percent) could not be construed as indicative of systemic billing issues that could be characterized as a "sustained or high level of payment error."[5]

Similarly, HHS-OIG cannot maintain that previous educational attempts have failed to remedy the payment error for the simple reason that there has been no prior governmental educational initiative, at least not prior to the Audit. And, when it comes to the Audit itself, the Hospital cooperated with the initiative in full and, ultimately, performed very well, *i.e.*, achieved a very low error rate.

While HHS-OIG may *recommend* to CMS a recovery based upon sampling and extrapolation, there are real, and here insurmountable, legal obstacles to implementing this recommendation.

2. Extrapolation is inconsistent with the HHS-OIG's stated purpose of the Medicare Compliance Reviews and is fundamentally unfair

The HHS-OIG has indicated that the purpose of these specific reviews is to "use them to instruct the hospital on best practices and prevent any future problems."[6] We respectfully submit that this goal is not advanced by applying extrapolation in this case. Indeed, there is nothing instructive about extrapolation.

Extrapolation, even if it were appropriate, is premature because the HHS-OIG's alleged error rate is erroneously inflated. There will be no settled "error rate" from which to extrapolate until Parkridge has had the opportunity to avail itself fully of its appeal rights. As noted above, Parkridge contests 8 of the HHS-OIG's 12-claim findings. Given its appeal history, clearly some number, indeed perhaps a significant number, of cases will be found to be proper. As such, utilizing a 12-claim error rate is patently premature and imprecise and may require Parkridge to refund amounts as overpayments that have yet to be determined to be such. Accordingly, Parkridge requests that HHS-OIG abandon the extrapolation recommendation in its entirety.

3 See 42 U.S.C. § 1395ddd(f)(3) (emphasis added).

4 While there was one claim with incorrectly billed units, the OIG did not specifically identify this as a Risk Area at the outset of this audit.

5 See 42 U.S.C. § 1395ddd(f)(3).

6 Modern Healthcare, *Audits said to put hospitals on track*, pp. 17-21 (Oct. 22, 2012).

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IV. Parkridge's Internal Controls

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

Parkridge's overall compliance program is aligned with applicable federal and state requirements to ensure the delivery of high quality services and its commitment to compliant billing practices. The hospital's highly qualified staff receive regular feedback and education on performance as well as updates on current regulations and sub-regulatory guidance.

With respect to IRF admissions, Parkridge conducts a preadmission screening assessment to evaluate the patient's ability to tolerate an intensive rehabilitation program as well as determine if the functional gains expected would be significant enough to warrant this level of care. Parkridge also requires that a rehabilitation physician review and approve the assessment and the patient's admission to the IRF prior to and within 48 hours of the patient's admission to the IRF. In addition, Parkridge reviews documentation to determine whether the individualized overall plan of care for the patient is completed within four days of admission, whether the rehabilitation physician is completing the face to face visit requirements, the patients are receiving the required minutes of therapy a week, as well as ensuring that interdisciplinary team conferences are held weekly.

In the context of DRG coding, DRG validation is part of Parkridge's overall commitment to compliance. All personnel responsible for performing, supervising or monitoring the coding of inpatient services have access to the 3M Encoder, AHA Coding Clinic and other authoritative references in support of code selection and the application of coding guidelines. All coding personnel also are required to obtain a minimum of 30 coding continuing education (CE) hours annually.

Parkridge's Coding Quality program includes ongoing medical record reviews performed by a dedicated quality team. Focus DRG topics are selected based on an assessment of benchmarking ratios, findings from internal reviews and industry topics. Parkridge claims are subject to periodic reviews as part of the Coding Quality program by internal audit. These reviews, which are part of Parkridge's overall compliance efforts and internal monitoring activities, assess medical record documentation to validate a coder's accuracy of billed services. The coding staff is educated on any coding errors and are subject to performance improvement plans, which can lead to termination, and expanded pre-bill reviews for results that are consistently below standards. Through its ongoing processes of pre-bill and post-bill reviews, Parkridge continues its long-standing efforts to enhance the accuracy and completeness of billing and coding processes and practices.

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

Sincerely,

// Holley Thames Lutz //

Holley Thames Lutz
Partner

cc: Thomas W. Jackson