Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# MEDICARE COMPLIANCE REVIEW OF WAKEMED RALEIGH CAMPUS

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**Report in Brief**
Date: July 2018
Report No. A-04-17-04057

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

# Medicare Compliance Review of WakeMed Raleigh Campus

## Why OIG Did This Review

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2016, Medicare paid hospitals $170 billion, which represented 46 percent of all fee-for-service payments to hospitals.

The objective of this review was to determine whether WakeMed Raleigh Campus (the 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 263 claims with payments totaling $3.2 million for our audit period.

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

## What OIG Found

The Hospital complied with Medicare billing requirements for 187 of the 263 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 76 claims, resulting in net overpayments of $249,954 for our audit period from September 1, 2014, through August 31, 2016. 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 $697,608 for the audit period.

## What OIG Recommends

We recommend that the Hospital refund to the Medicare program $697,608 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 identify any returned overpayments as having been made in accordance with this recommendation; and strengthen controls to ensure full compliance with Medicare requirements.

In written comments on our draft report, the Hospital disagreed with our findings on certain claims and contended that the extrapolation of our results was not justifiable or appropriate. The Hospital also disagreed with any suggestion that the audit results demonstrate deficiencies in its key controls for coding, billing, and documenting within the medical records. The Hospital stated that it would continue to assess its obligations under the 60-day rule and conduct any necessary expanded review within the time limits established under the program requirements.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We used an independent medical reviewer to determine whether certain sampled claims were appropriately billed. Additionally, we used a statistically valid sampling methodology in our sample selection and in determining the estimated Medicare overpayment.

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# INTRODUCTION

## WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2016, Medicare paid hospitals $170 billion, which represented 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 WakeMed Raleigh Campus (the Hospital) complied with Medicare requirements for billing inpatient services on selected types of claims from September 1, 2014, through August 31, 2016.

## BACKGROUND

### The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS 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 (PPS), 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 hospital claims at risk for noncompliance:

- inpatient claims with unreported discharges to home health services,
- inpatient claims paid in excess of charges, and

- inpatient claims billed with high-severity-level DRG codes.

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), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Providers who receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).[1]

**WakeMed Raleigh Campus**

The Hospital is a 720-bed hospital located in Raleigh, North Carolina. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately $198 million for 22,346 inpatient claims from September 1, 2014, through August 31, 2016 (audit period).

**HOW WE CONDUCTED THIS REVIEW**

Our audit covered $18,069,173 in Medicare payments to the Hospital for 1,913 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 263 inpatient claims with payments totaling $3,220,100. Medicare paid these 263 claims during our audit period.

[1] The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

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 submitted 146 claims to an independent medical review contractor to determine whether the services were properly 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 scope and methodology.

## FINDINGS

The Hospital complied with Medicare billing requirements for 187 of the 263 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 76 claims, resulting in net overpayments of $249,954 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 $697,608[2] for the audit period. See Appendix B for statistical sampling methodology, Appendix C for sample results and estimates, and Appendix D for results of review by risk area.

### BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 76 of the 263 inpatient claims that we reviewed. These errors resulted in net overpayments of $249,954. Seven of these claims contained errors that did not cause any overpayment, and two claims contained more than one error.[3]

#### Incorrectly Billed Diagnosis-Related-Group Codes

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

[2] To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total 95 percent of the time.

[3] For sampled claims that contained more than one type of error, we used the total claim overpayment for error estimation. We did not estimate errors on the same claim twice.

to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 41 of the 263 inpatient claims, the Hospital submitted claims to Medicare with incorrect DRG codes. The Hospital representatives disagreed that 19 of the 41 claims had errors, but they acknowledged that 22 claims may have been incorrectly coded. For these 22 claims, the Hospital representatives maintained that different reviewers can reach different opinions for a variety of reasons. For instance, reviewers could reach different conclusions because of differences of professional opinion in interpreting and applying coding guidelines to complex acute patient populations.

As a result of these errors, the Hospital received net overpayments of $192,941.

**Incorrectly Billed Patient Discharge Status Codes**

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

If a patient is discharged to home for the provision of home health services, but the continuing care is not related to the condition or diagnosis for which the individual received inpatient hospital services, the hospital can apply condition code 42 and receive the full DRG payment (65 Fed. Reg. 47054, 47081 (August 1, 2000) and Medicare Learning Network Matters SE1411). The hospital is responsible for coding the bill based on its discharge plan for the patient, or if it finds out subsequently that postacute care occurred, it is responsible for either coding the original bill as a transfer or submitting an adjustment bill (63 Fed. Reg. 40954, 40976-77, 40979-80 (July 31, 1998)).

For 37 of the 263 inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to home health services. For example, the Hospital coded a discharge status as to "home" instead of to "home health."

For 30 of the 37 inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to home health services, and the services were related to the hospital stay. The Hospital received the full DRG payments instead of the graduated per diem payments that it would have received if it had correctly coded the patients' discharge statuses.

For 7 of the 37 inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers to home health services, but the home health services

were not related to the hospital stays. For these seven claims, the Hospital could have applied condition code 42 and still have received the full DRG payment. There were no overpayments because of the incorrectly billed patient discharge status codes for these seven claims.

The Hospital disagreed that 27 of the 37 claims were coded incorrectly. Specifically, the Hospital representatives stated that these 27 claims did not include a physician order for home health services in the discharge planning instructions and therefore were coded correctly based on the Hospital's discharge plan. However, we noted that the medical records indicated the intention or possibility that the patient would start or resume home health services after discharge in 32 of the 37 claims.[4] The Hospital representatives stated that 10 claims may have errors and noted that there will always be room for improvement with internal controls because of the human element involved in coding and billing.

As a result of these errors, the Hospital received overpayments of $57,013.

**OVERALL ESTIMATE OF OVERPAYMENTS**

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $697,608 for the audit period.

## RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program $697,608 in estimated overpayments for the audit period for claims that it incorrectly billed;[5]

- 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 identify any returned overpayments as having been made in accordance with this recommendation; and

- strengthen controls to ensure full compliance with Medicare requirements.

[4] We used home health claims data to identify instances in which patients received home health services within 3 days of discharge for all 37 claims.

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

## HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital disagreed with our findings on certain claims and contended that the extrapolation of our results was not justifiable or appropriate. The Hospital also disagreed with any suggestion that the audit results demonstrate deficiencies in its key internal controls for coding, billing, and documentation processes. The Hospital stated that it would continue to assess its obligations under the 60-day rule and conduct any necessary expanded review within the time limits established under the program requirements.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We used an independent medical reviewer to determine whether certain sampled claims were appropriately billed. Additionally, we used a statistically valid sampling methodology in our sample selection and in determining the estimated Medicare overpayment.

The Hospital's comments are included in their entirety as Appendix E.

### INCORRECTLY BILLED CLAIMS

#### Hospital Comments

The Hospital contended that there was a dramatic difference in our error rate and the error rate calculated by their internal and external review. The Hospital intends to exercise its statutory appeal rights to obtain a final determination of the total number of claims billed in error.

Regarding the 41 claims with DRG errors, the Hospital contended that, at most, 22 had errors. The Hospital said that its internal and external reviews of the medical records indicated that 19 of these 41 claims were billed correctly.

Regarding the 37 claims with discharge status errors, the Hospital contended that, at most, 10 claims had errors. The Hospital disagreed with our determination for 27 of the claims. The Hospital stated that there cannot be a true "transfer" of care from a hospital to a home health agency if the patient's attending physician does not order a specific home health intervention. The Hospital also noted that the Health Care Financing Administration (HCFA), the predecessor to CMS, specifically rejected a suggestion that any home health care beginning within 3 days of an inpatient discharge constitutes a transfer in 63 Fed. Reg. 40954, 40976 (July 31, 1998). Since these 27 claims did not include an order for home health services in the discharge instructions, the Hospital asserted that it billed these claims correctly based on the discharge instructions and information available at the time of service. The Hospital further stated that whether these patients ultimately received home health care within 3 days of discharge does not change this fact nor would any argument that the medical records indicated the intention or possibility that the patient would start or resume home health services after discharge.

**Office of Inspector General Response**

We acknowledge that the Hospital disagrees with and plans to appeal many of our findings. As we indicate in Appendix A, during our audit, we used an independent medical review contractor to determine whether certain claims in our sample were properly coded. The contractor examined all of the medical records submitted for these claims, including home health records when applicable, and determined that the Hospital incorrectly billed Medicare Part A for these claims. On the basis of the contractor's conclusions, we maintain that the Hospital billed the disputed claims incorrectly. We provided our contractor's conclusions and rationales to the Hospital.

Specifically, regarding the disputed claims with incorrect patient discharge status codes, we did not consider a claim to have an overpayment based only on the presence of home health services within 3 days of discharge. Instead, we identified an overpayment if the beneficiary had home health services within 3 days of discharge and our contractors determined that the home health services were related to the inpatient stay. We provided our contractors with the criteria referenced in the body of the report and asked them to assess the claims based on that criteria. We noted claims in which the Hospital records indicated an intention or possibility of starting or resuming home health services to merely point out that more than 10 claims had reference to the home health services in the Hospital record.

Insofar as the Hospital is asserting that the attending physician who treated the beneficiary during his or her inpatient stay needed to have ordered a specific home health intervention, HCFA rejected such an argument back in 1998. Specifically, the preamble to the final rule contains the following Comment and Response (63 Fed. Reg. at 40980):

> *Comment*: One commenter stated that we should specify that the written plan of care for home health services should be defined clearly as "a specific order by the patient's physician in the hospital medical record that directs the hospital to arrange for home health services upon discharge."
>
> *Response*: We do not believe that it is necessary to specify the precise definition of what a written plan of care for health services must entail. We note that we would deem a case to be a transfer if care related to the discharge was provided within 3 days after the date of discharge even if the hospital had no written plan of care.

**EXTRAPOLATION**

**Hospital Comments**

The Hospital contended that the use of an extrapolation was inappropriate and not justifiable. The Hospital stated that Medicare contractors cannot use extrapolation techniques to calculate potential overpayments unless there is (1) a sustained or high level of payment error or (2) a

failure of documented educational interventions. The Hospital stated that we have not identified findings meeting these two requirements.

The Hospital also contended that our extrapolation techniques were particularly inappropriate in audits like this one which focus on questions of medical necessity and potential disagreements in professional clinical judgment. The Hospital also stated that, in the absence of any indication of systemic problems or process breakdowns, assessing the claims relies on fact-dependent, individualized determinations for each claim reviewed.

Because the Hospital intends to appeal the results of the audit, the Hospital requested that we delay any extrapolation recommendation until the appeals process is complete.

**Office of Inspector General Response**

Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[6] 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.[7]

The statistical lower limit that we use for our recommended recovery represents a conservative estimate of the overpayment that we would have identified if we had reviewed each and every claim in the sampling frame. The conservative nature of our estimate is not changed by the nature of the errors identified in this audit.[8] This approach results in an estimate that is lower than the actual overpayment amount 95 percent of the time, and thus it generally favors the provider.[9] Furthermore, our use of statistical sampling by no means removes the Hospital's right to appeal the individual determinations on which the estimation is based through the normal appeals process.[10]

[6] *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*, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), adopted by 2014 U.S. Dist. LEXIS 4474 (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).

[7] *See* Social Security Act § 1893(f)(3); CMS Medicare Program Integrity Manual, Pub. No. 100-08, ch. 8, § 8.4.1.4 (effective June 28, 2011).

[8] *See Pruchniewski v. Leavitt*, 2006 U.S. Dist. LEXIS 101218 at *51-52 (M.D. Fla 2006).

[9] See Puerto Rico Dep't of Health, DAB No. 2385, at 10 (2011); Oklahoma Dep't of Human Servs., DAB No. 1436, at 8 (1993).

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

## 60-DAY RULE

### Hospital Comments

The Hospital stated that it has worked diligently following implementation of the 60-day rule to refund any identified overpayments within the relevant time limits established by that rule. The Hospital also stated that it would continue to assess its obligations under the 60-day rule and conduct any necessary expanded review within the time limits established under the program requirements.

### Office of Inspector General Response

We acknowledge the Hospital's efforts and continue to recommend that the Hospital exercise reasonable diligence to identify and return any additional overpayments similar to those we identified that it received outside of our audit period, in accordance with the 60-day rule, and to identify any returned overpayments as having been made in accordance with this recommendation.

## STRENGTHEN CONTROLS

### Hospital Comments

The Hospital stated that it disagreed with any suggestion that the audit results demonstrate deficiencies in its key internal controls for coding, billing, and documentation processes. The Hospital requested that we revise the final audit report to reflect that any potential billing errors are more likely to be due to differences in professional clinical judgment and/or routine human error than they are due to insufficient internal controls. The Hospital also requested that we remove any specific findings regarding the adequacy of its controls from our final report. The Hospital described aspects of its controls and stated that our report does not identify any process or procedure on which the Hospital might be lacking or which should be put in place to prevent the occasional human error.

Because the Hospital intends to exercise its statutory appeal rights to obtain a final determination of the total number of claims billed in error, the Hospital requested that we withhold making any recommendations regarding its controls until an error rate has been established through the Medicare appeals process. The Hospital contended that any findings or recommendations regarding its controls would be extremely premature until an error rate has been established through the Medicare appeals process.

### Office of Inspector General Response

We acknowledge the Hospital's existing compliance program but continue to maintain that, based on our audit results, it still needs to strengthen controls to ensure full compliance with Medicare requirements.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered $18,069,173 in Medicare payments to the Hospital for 1,913 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 263 inpatient claims with payments totaling $3,220,100. Medicare paid these 263 claims from September 1, 2014, through August 31, 2016 (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 submitted 146 claims to an independent medical review contractor to determine whether the Hospital properly coded the services.

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 February 2017 through February 2018.

### 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 263 inpatient claims totaling $3,220,100 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;

- reviewed medical record documentation provided by home health agencies to assess the relatedness of the services to the applicable inpatient claim;

- 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 146 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 review to calculate the estimated Medicare overpayment to the Hospital (Appendix C); and

- discussed the results of our review with Hospital officials.

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

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### TARGET POPULATION

The target population contained inpatient 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 $198,054,265 for 22,346 inpatient claims during the audit period.

We obtained a database of claims from the NCH data totaling $131,515,674 for 10,192 inpatient claims in 15 risk areas. From these 15 areas, we selected 3 consisting of 3,355 claims totaling $34,820,632 for further review. We then removed the following:

- claims billed with high-severity-level DRG codes with payment amounts less than $4,000,
- claims under review by the Recovery Audit Contractor (RAC), and
- claims duplicated within individual risk categories.

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: Inpatient Claims With Unreported Discharges to Home Health Services, Inpatient Claims Paid in Excess of Charges, and Inpatient Claims Billed With High-Severity-Level DRG Codes. This assignment hierarchy resulted in a sample frame of 1,913 unique Medicare paid claims in 3 risk categories totaling $18,069,173. We further separated Inpatient Claims Billed With High-Severity-Level DRG Codes into three categories based on the amount paid.[11] (See Table 1.)

[11] Paid claims less than $8,743 are in Stratum 3. Paid claims $8,743 or greater and less than $18,117 are in Stratum 4. Paid Claims $18,117 or greater are in Stratum 5.

**Table 1: Risk Categories**

| Medicare Risk Area | Number of Claims | Amount of Payments |
|---|---|---|
| 1. Inpatient Claims With Unreported Discharges to Home Health Services | 38 | $367,007 |
| 2. Inpatient Claims Paid in Excess of Charges | 62 | 812,722 |
| 3. Inpatient Claims Billed With High-Severity-Level DRG Codes—Low Dollar | 1,185 | 7,178,396 |
| 4. Inpatient Claims Billed With High-Severity-Level DRG Codes—Medium Dollar | 508 | 6,295,614 |
| 5. Inpatient Claims Billed With High-Severity-Level DRG Codes—High Dollar | 120 | 3,415,434 |
| **Total** | **1,913** | **$18,069,173** |

**SAMPLE UNIT**

The sample unit was a Medicare paid claim.

**SAMPLE DESIGN**

We used a stratified random sample. We stratified the sampling frame into five strata on the basis of Medicare risk area and amount paid (see Table 1). All claims were unduplicated, appearing in only one area and only once in the entire sampling frame.

**SAMPLE SIZE**

We selected 263 claims for review as follows in Table 2:

**Table 2: Claims by Stratum**

| Stratum | Medicare Risk Area | Claims in Sample Frame | Claims in Sample |
|---|---|---|---|
| 1 | Inpatient Claims With Unreported Discharges to Home Health Services | 38 | 38 |
| 2 | Inpatient Claims Paid in Excess of Charges | 62 | 30 |
| 3 | Inpatient Claims Billed With High-Severity-Level DRG Codes—Low Dollar | 1,185 | 85 |
| 4 | Inpatient Claims Billed With High-Severity-Level DRG Codes—Medium Dollar | 508 | 70 |
| 5 | Inpatient Claims Billed With High-Severity-Level DRG Codes—High Dollar | 120 | 40 |
| | **Total** | **1,913** | **263** |

**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 two through five. After generating the random numbers, we selected the corresponding claims in each stratum. We selected all claims in stratum one.

**ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to calculate our estimates. We used the lower-limit of the two-sided 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 | Total Value of Sample | Number of Incorrectly Billed Claims in Sample | Value of Overpayments in Sample |
|---|---|---|---|---|---|---|
| 1 | 38 | $367,007 | 38 | $367,007 | 30 | $62,255 |
| 2 | 62 | 812,722 | 30 | 393,181 | 7 | 31,599 |
| 3 | 1,185 | 7,178,396 | 85 | 508,409 | 8 | 15,705 |
| 4 | 508 | 6,295,614 | 70 | 828,868 | 12 | 38,073 |
| 5 | 120 | 3,415,434 | 40 | 1,122,635 | 12 | 102,322 |
| **Total** | **1,913** | **$18,069,173** | **263** | **$3,220,100** | **69** | **$249,954** |

### ESTIMATES

### Table 4: Estimates of Overpayments for the Audit Period

*Limits Calculated for a 90-Percent Confidence Interval*

| | |
|---|---|
| Point Estimate | $929,770 |
| Lower limit | $697,608 |
| Upper limit | $1,161,931 |

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. The seven claims with billing errors that did not affect the payment are not included in this table.

## APPENDIX D: RESULTS OF REVIEW BY RISK AREA

### Table 5: Sample Results by Risk Area

| Inpatient Risk Area | Selected Claims | Value of Selected Claims | Claims With Underpayments/ Overpayments | Value of Net Overpayments |
|---|---|---|---|---|
| Inpatient Claims with Unreported Discharges to Home Health Services | 38 | $367,007 | 30 | $62,255 |
| Inpatient Claims Paid in Excess of Charges | 30 | 393,181 | 7 | 31,599 |
| Low Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes | 85 | 508,409 | 8 | 15,705 |
| Medium Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes | 70 | 828,868 | 12 | 38,073 |
| High Dollar Inpatient Claims Billed With High-Severity-Level DRG Codes | 40 | 1,122,635 | 12 | 102,322 |
| **Inpatient Totals** | **263** | **$3,220,100** | **69** | **$249,954** |

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. The seven claims with billing errors that did not affect the payment are not included in this table.

WakeMed
3000 New Bern Avenue
Raleigh, NC 27610

May 14, 2018

Ms. Lori S. Pilcher
Regional Inspector General for Audit Services
United States Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Re: Medicare Compliance Review of WakeMed Raleigh Campus
OIG Draft Report Number A-04-17-04057

Dear Ms. Pilcher:

Thank you for the opportunity to respond to the Department of Health and Human Services Office of Inspector General ("OIG") Office of Audit Services' ("OAS") draft report entitled "Medicare Compliance Review of WakeMed Raleigh Campus" (Report Number A-04-17-04057). We truly appreciate the professionalism that Mark Wimple, Jeff Kite, Elizabeth Zyga, and the other members of your audit team have demonstrated throughout the review process.

WakeMed Health & Hospitals is Wake County's safety-net provider. It is our mission to care for everyone who walks through our doors, including the majority of the county's Medicaid, Medicare and uninsured residents. WakeMed's Raleigh Campus ("WakeMed"), a 720-bed facility located in the heart of Wake County's most underserved neighborhoods, has addressed community health issues and filled gaps in services for nearly sixty (60) years. WakeMed is Wake County's only provider of specialized services such as pediatric intensive care, Level I trauma services, and inpatient rehabilitation care. Perhaps more importantly, WakeMed is committed to improving the health and well-being of our community by providing outstanding and compassionate care to all patients.[1]

[1] See WakeMed, Mission & Vision, available at https://www.wakemed.org/mission-and-vision (last visited May 1, 2018).

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WakeMed significantly expanded its comprehensive corporate compliance program in 2012 pursuant to a corporate integrity agreement ("CIA") with the OIG. WakeMed's expanded program incorporates the OIG's seven critical elements of an effective compliance program and relies on a team of dedicated compliance, audit, privacy, and information security professionals to achieve our strategic goal of fostering trust while demonstrating transparency, accountability, integrity and honesty in all that we do.[2] These dedicated professionals partner with WakeMed's Office of Legal Affairs ("OLA"), Health Information Management Department ("HIM"), Case Management Department ("CM"), Central Billing Office ("CBO"), Revenue Cycle Department ("RC"), and others across the system to ensure the accuracy and integrity of claims submitted to Federal health care programs ("FHCPs") and other payors for reimbursement, quality metrics, statistical reporting, and other purposes. Perhaps more importantly, WakeMed's compliance program enjoys the full support of our Board of Directors, Chief Executive Officer, and senior leadership. With this support, WakeMed's compliance team has developed comprehensive policies, procedures, training, auditing, and other initiatives to continuously improve our internal controls. In the event we identify any areas of concern, our compliance staff focuses needed resources to investigate and remediate issues in a timely manner.

WakeMed appreciates the opportunity to respond to OAS' specific audit findings in writing. As we discussed during our exit interview, after further review of the draft audit report, we respectfully disagree with both the number of claims that OAS determined were billed in error, as well as the calculated and estimated overpayment amounts included in your report. We also disagree with OAS' recommendation regarding the need to conduct an expanded claims review and finding that any billing errors occurred primarily due to insufficient internal controls. A more thorough discussion is set forth below.

**Overview of Audit and Draft Report Findings**

It is our understanding that OAS conducted this routine audit as part of a series of hospital compliance reviews in North Carolina and other states across the country. It is our further understanding that the types of claims that OAS reviewed during this routine audit were identified based on OAS' previous work at other hospitals and not as a result of any specific complaints or concerns regarding WakeMed's billing and reimbursement processes.

As noted in the draft report, OAS reviewed 263 claims drawn from five (5) different strata of inpatient hospital services with admission dates between January 15, 2014 and August 7, 2016:

[2] See id.

- Thirty eight (38) inpatient claims for patients who received home health services after discharge;
- Thirty (30) inpatient claims paid in excess of charges;
- Eighty five (85) "low payment" inpatient claims billed with high severity DRG codes;
- Seventy (70) "medium payment" inpatient claims billed with high severity DRG codes; and
- Forty (40) "high payment" inpatient claims billed with high severity DRG codes.

Notably, we understand that OAS determined WakeMed complied with Medicare billing requirements for 187 of the 263 inpatient claims reviewed. However, OAS determined that WakeMed did not fully comply with Medicare billing requirements for the remaining seventy six (76) claims, resulting in net overpayments of $249,954 for the audit period.[3] We also understand that OAS estimated WakeMed received overpayments of at least $697,608 during the audit period.

Based on these preliminary findings, OAS has proposed the following recommendations:

- refund to the Medicare program $697,608 in estimated overpayments for the audit period;
- exercise reasonable diligence to identify and return any additional similar overpayments in accordance with the 60-day rule; and
- strengthen controls to ensure full compliance with Medicare requirements.

As noted above, WakeMed respectfully disagrees with both the number of claims that OAS determined were billed in error, as well as the calculated and estimated overpayment amounts. WakeMed's specific response to these audit findings and recommendations is set forth below, along with a discussion of any corrective action steps.

**Recommendation #1 – Refund Overpayments to the Medicare Contractor**

**Inpatient Discharges and Home Health Services**

As an initial matter, WakeMed disagrees with OAS' finding that it incorrectly billed Medicare

[3] It is our understanding that the OAS audit was not designed to identify potential underpayments from Medicare to WakeMed. For example, we understand that the audit team did not review any claims that may have been underpaid due to the fact that they were coded as transfers to home health agencies but did not result in a patient receiving home health services within three (3) days of discharge.

for thirty-seven (37) inpatient discharges that should have been billed as transfers to home health services. WakeMed also disagrees that it received overpayments of $57,013 for these claims.

Internal and external reviews of the clinical information and physician documentation included in each patient's medical record both determined that the medical records for twenty-seven (27) of the claims reviewed by OAS did not include a physician's order for home health services in the discharge planning instructions. In fact, twenty-one (21) of those claims did not include any discussion of home health services in the discharge planning instructions whatsoever. As OAS notes in its report, a discharge of a hospital inpatient is only considered to be a "transfer" when the patient's stay is assigned to one of the qualifying DRGs **AND** the discharge is to home under a **written plan of care** for home health services that begin within three (3) days after the date of discharge.[4] In other words, there cannot be a true "transfer" of care from a hospital to a home health agency ("HHA") if the patient's attending physician does not order a specific home health intervention. It should also be noted that the Centers for Medicare and Medicaid Services ("CMS"), writing in response to comments regarding the post-acute care transfer rule when it was first implemented, specifically rejected a suggestion that **any** home health care beginning within three (3) days of an inpatient discharge constitutes a transfer.[5]

This nuanced understanding of the intent behind the post-acute care transfer rule is critically important for developing an accurate assessment of the claims reviewed by OAS. As a practical matter, the fact that twenty-seven (27) of these claims did not include an order for home health services means that these claims were not subject to Medicare's post-acute care transfer policy when the patients were discharged. As OAS notes in its draft report, WakeMed is responsible for coding a patient's bill based on its discharge plan for the patient.[6] Since these twenty-seven (27) claims did not include an order for home health services in the discharge instructions, WakeMed did, in fact, bill these claims correctly based on the discharge instructions and information available at the time of service. Whether these patients ultimately received home health care within three (3) days of discharge does not change this fact. Nor would any argument that the medical records for thirty-two (32) of these claims "indicated the **intention or**

[4] 42 CFR § 412.4(c)(3).

[5] 63 Fed. Reg. 40954, 40976 (July 31, 1998) (noting that this approach "might be too broad and the hospital would not be able to predict which cases should be coded as transfers because the hospital often may not know about home health services that are provided upon discharge but were not ordered or planned for as part of the hospital discharge plan").

[6] 63 Fed. Reg. 40954, 40980 (July 31, 1998).

**possibility** that the patient would start or resume home health services after discharge . . . ."[7] This is simply not the standard and should not be used in auditing these claims.

Rather, the standard for application of CMS' post-acute care transfer policy is clearly spelled out in regulations and sub-regulatory guidance. Only those discharges from a qualifying DRG to home **under a written plan of care** for home health services that begin within three (3) days after the date of discharge will qualify as a transfer.[8] Medical records that might be read to suggest the "intention or possibility" that the patient may receive home health services do not qualify. Accordingly, we respectfully disagree with OAS' finding that twenty-seven (27) of the claims reviewed were billed in error. As such, we respectfully reiterate our request that OAS revise its preliminary results to reflect the fact that, at most, ten (10) of the 263 claims sampled may have been paid incorrectly due to an incorrect discharge status code. We also request that the OIG OAS reduce its preliminary overpayment calculation by at least $39,950.91.

**Inpatient Claims and DRG Codes**

Similarly, WakeMed respectfully disagrees with OAS' finding that it submitted forty one (41) claims to Medicare with incorrect diagnosis related group ("DRG") codes. WakeMed also disagrees that it received overpayments of $192,941 for these claims. In contrast, internal and external reviews of the clinical information and physician documentation included in the medical records for nineteen (19) of these claims indicated that the items and services provided were reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body part.[9] Our review of the financial records associated with these claims also indicates that WakeMed completed the relevant bills accurately so that our Medicare contractor could process them correctly and promptly.[10] Accordingly, we respectfully request that OAS revise its preliminary results to reflect the fact that, at most, twenty-two (22) of the 263 claims sampled may have been paid incorrectly due to a DRG error. We also request that OAS reduce its preliminary overpayment calculation by at least $82,790.23.

**Extrapolated Overpayment Determination**

In light of these areas of disagreement, WakeMed does not concur with OAS' determination that

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[7] OIG OAS, DRAFT – Medicare Compliance Review of WakeMed Raleigh Campus at 5 (Report Number A-04-17-04057) (Apr. 2018) [hereinafter Draft Report].

[8] 42 CFR § 412.4(c).

[9] Social Security Act § 1862(a)(1)(A).

[10] CMS, Medicare Claims Processing Manual ch. 1 § 80.3.2.2.

it received an extrapolated overpayment of $697,608. Even more importantly, WakeMed strongly objects to OAS' recommendation that extrapolation is justifiable or appropriate based on the current audit results.[11]

As we discussed during the audit exit conference, Medicare contractors cannot use extrapolation techniques to calculate potential overpayments unless there is (1) a sustained or high level of payment error; **OR** (2) a failure of documented educational interventions. The audit team did not indicate that either of these mandatory pre-conditions for extrapolation existed during the exit conference or during any of our previous informal conversations. Nor does OAS' draft audit report include any findings regarding these two statutory requirements. Accordingly, WakeMed maintains that it is inappropriate for OAS to make any extrapolation recommendations in the absence of a final, unappealed determination that the claims included in the current audit demonstrate a sustained or high level of payment error.

Moreover, extrapolation techniques are particularly inappropriate in audits like this one which focus on questions of medical necessity and potential disagreements in the exercise of professional clinical judgment. In the absence of any indication of systemic problems or process breakdowns, the question of whether the claims reviewed by OAS were billed correctly necessarily depends on fact-dependent, individualized determinations for each and every claim reviewed. As such, any potential coding or billing disagreements will be due to either human error or differences in medical decision making.

Accordingly, WakeMed again respectfully requests that OAS remove any recommendations regarding extrapolation until after WakeMed's Medicare contractor has made a determination about whether to demand repayment for the claims at issue and WakeMed has had an opportunity to pursue its programmatic appeal rights. OAS, CMS, and/or contractors should only make the decision to extrapolate from any remaining claims if there is a significant or sustained error rate after WakeMed's appeals are exhausted. At the very least, OAS should delay making any extrapolation recommendations until the appeals process is complete.

**Recommendation #2 – Exercise Reasonable Diligence to Return Similar Overpayments**

OAS also recommends that WakeMed "exercise reasonable diligence to identify and return any additional similar overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with this recommendation . . . ."[12] As an

[11] It is our understanding from conversations with your audit team during the exit conference that any potential billing errors relating to Medicare's post-acute care transfer policy were not included in OAS' extrapolation calculation. If those statements were not accurate, then we would respectfully request that OAS update its draft audit report and overpayment calculations accordingly.

initial matter, it is important to note that WakeMed has worked diligently following implementation of the sixty (60) day rule to refund any identified overpayments within the relevant time limits established by that rule. Since the claims noted above were the subject of an ongoing OAS audit, however, it would have been premature to submit any refunds prior to the audit's completion. Following receipt of the OAS' draft report, WakeMed is now able to refund any identified overpayments and will do so within sixty (60) days.

WakeMed also recognizes that OAS audits generally constitute credible information of a potential overpayment that could trigger further investigation under the relevant Medicare rules. To that point, WakeMed launched a thorough internal review of the claims requested by OAS immediately upon receiving the initial audit letter dated February 10, 2017. A multi-disciplinary team of compliance experts, HIM experts, case managers, internal and external physician reviewers, and internal and external coding professionals reviewed all 263 claims included in the OAS sample. As discussed above, the results of WakeMed's multidisciplinary internal review varied dramatically from the results published in OAS' draft report.[13]

Regardless, WakeMed remains committed to fostering an environment of transparency, accuracy, and accountability in its coding, billing, and documentation processes. As such, WakeMed will continue to monitor its internal controls. To the extent that CMS seeks a refund on additional claims based upon the OAS audit, WakeMed will exercise its statutory appeal rights to obtain a final determination of the total number of claims across each stratum that may have been billed in error. WakeMed will also continue to assess its obligations under the sixty (60) day overpayment rule and conduct any necessary expanded review within the time limits established under the program requirements. If WakeMed's Medicare contractor decides to follow OAS' recommended disallowances of these claims, then WakeMed will also "conduct reasonable diligence to confirm or contest the audit's findings" as permitted under law and regulation.[14]

**Recommendation #3 – Strengthen Controls to Ensure Full Compliance**

Finally, OAS recommends that WakeMed strengthen its internal controls in order to ensure full compliance with Medicare requirements. WakeMed is fully committed to continuous quality

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[12] Draft Report at 5.

[13] As noted previously, it is our understanding that the OAS audit was not designed to identify potential underpayments from Medicare to WakeMed (e.g., low severity DRG claims that may have been undercoded; patients who were transferred to a home health agency but did not actually receive home health services within three (3) days; etc.).

[14] 81 Fed. Reg. 7667 (Feb. 12, 2016).

improvement in all of its clinical, financial, and administrative processes. As such, WakeMed always appreciates the opportunity to identify any gaps in its internal controls, policies, or procedures. That said, WakeMed disagrees with any suggestion that the claims errors identified by OAS "occurred primarily because [it] did not have adequate controls to prevent the incorrect billing of Medicare claims . . . ."[15] On the contrary, OAS' draft report does not identify any process or procedure on which WakeMed might be lacking or which should be put in place to prevent the occasional human error.

As noted in the questionnaires submitted in response to OAS' preliminary audit findings, WakeMed firmly believes that its existing controls over coding, billing, and reimbursement meet or exceed professionally-recognized standards and best practices. In addition to its extensive and robust compliance program, WakeMed has developed a comprehensive HIM program to review and monitor claims submitted for inpatient hospital services. The most relevant aspects of that program include:

- Extensive training and education programs for HIM team members, including an on-site ICD-10 Academy by the American Health Information Management Association ("AHIMA") and quarterly Coding Clinic Reviews;
- Routine external audits and educational sessions by independent consultants;
- Automated audit software (SMART by PriceWaterhouseCoopers) to identify potential coding errors prior to submission of a claim based on industrywide and site-specific standards and guidelines;
- Pre-billing claims review protocols including a DRG mismatch process to ensure that claims contain accurate clinical information and that physician documentation in the medical record supports the DRG listed on the claim;
- Monthly joint education sessions with coders and clinical documentation integrity specialists on specific focus areas;
- Purchase of continuing education, disease-based coding modules with assignments based on recommendations from external audits;
- Regular submission of ambiguous coding issues to AHA's Coding Clinic for clarification and guidance;

[15] Draft Report at 3.

- Regular communication with WakeMed's Coding Educator who currently serves on the AHA's Coding Clinic Editorial Advisory Board;
- Increase in Senior Coder staff members in order to allow for timely second level review
- Specific EPIC work queues to hold accounts for second level review;
- Continued collaboration with physicians and others on clinical documentation;
- Creation of educational flash cards for challenging diagnoses and procedures, including Root Operations Flash/Pocket Cards, CDI Common Diagnoses Flash/Pocket Cards (e.g., Malnutrition; Heart Failure; Respiratory Failure; Sepsis; etc.), and Coding/CDI Physician Documentation Pamphlets; and
- Cross-disciplinary projects involving physicians and other clinical staff in order to gain first-hand knowledge of relevant clinical information for coding purposes.

In addition to these general internal controls, which are designed to ensure the accuracy of claims for all types of inpatient hospital services, WakeMed has implemented additional protocols to proactively identify patients who will be receiving home health services within three (3) days of discharge. For example, the members of each patient's care team work collaboratively to choose the most appropriate discharge status at the point of care based on the clinical information that is available at the time. Each patient's discharge paperwork and supporting instructions are then reviewed by administrative staff on the relevant clinical unit before the patient is actually discharged from WakeMed. Each patient's discharge status is also reviewed by HIM team members and revised as needed before the claim for services is submitted. Documentation in the medical record is subsequently reviewed to confirm the accuracy of discharge status indicators. Finally, WakeMed conducts routine internal and external billing and coding audits to confirm that data fields such as discharge status indicator are accurate.

Accordingly, WakeMed respectfully disagrees with any suggestion that OAS' preliminary results demonstrate deficiencies in its key internal controls for coding, billing, and documentation processes. As such, WakeMed respectfully requests that OAS revise the final audit report to reflect the fact that any potential billing errors are more likely to be due to differences in professional clinical judgment and/or routine human error than they are to be due to insufficient internal controls. WakeMed also requests that OAS remove any specific findings regarding the adequacy of its internal controls from the final audit report.

At the very least, OAS should withhold making any recommendations regarding WakeMed's internal controls until the actual error rate for the claims reviewed has been established through the Medicare appeals process. The dramatic difference between OAS' calculated error rate and

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the error rate established by WakeMed's internal and external reviews of the same claims further underlines this point. As noted above, WakeMed fully intends to exercise its statutory appeal rights to obtain a final determination of the total number of claims across each stratum that may have been billed in error. Until that number has been established through the appeals process, WakeMed would respectfully suggest that any findings or recommendations regarding its internal controls would be extremely premature.

**Conclusion**

WakeMed appreciates the opportunity to respond to OAS' audit findings in writing. After further review of the draft audit report, we continue to disagree with both the number of claims that OAS determined were billed in error, as well as the calculated and estimated overpayment amounts included in the draft report. As discussed in greater detail above, WakeMed disagrees with OAS' finding that twenty-seven (27) of the claims reviewed were billed with the incorrect discharge status code. As such, WakeMed requests that OAS reduce its preliminary overpayment calculation by at least $39,950.91. WakeMed also requests that OAS revise its preliminary results to reflect the fact that, at most, twenty-two (22) of the 263 claims sampled may have been paid incorrectly due to a DRG error and that, as a result, OAS reduce its preliminary overpayment calculation by an additional $82,790.23.

In light of these significant disagreements, WakeMed contests OAS' determination that it received an extrapolated overpayment of $697,608. As noted above, WakeMed fully intends to exercise its statutory appeal rights to obtain a final determination of the total number of claims across each stratum that may have been billed in error. Until that number has been established through the Medicare appeals process, any findings or recommendations regarding an extrapolated overpayment would be extremely premature, as would any recommendations regarding the need to conduct an expanded claims review and/or to strengthen WakeMed's internal controls.

* * * * *

Thank you in advance for your time and attention. As always, we will be happy to discuss any additional questions or concerns at your convenience.

Best regards,

/Ted Lotchin/

Ted Lotchin, JD, MPH
Vice President & Chief Compliance and Privacy Officer