

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
MOBILE INFIRMARY MEDICAL CENTER**

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Deputy Inspector General
for Audit Services**

**October 2018
A-04-17-08057**

Office of Inspector General

<https://oig.hhs.gov>

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

Report in Brief

Date: October 2018

Report No. A-04-17-08057

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



Why OIG Did This Review

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

Our objective was to determine whether Mobile Infirmiry Medical Center (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 100 inpatient claims with payments totaling \$1.7 million for our 2-year audit period (January 1, 2015, through December 31, 2016).

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

Medicare Compliance Review of Mobile Infirmiry Medical Center

What OIG Found

The Hospital complied with Medicare billing requirements for 87 of the 100 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 13 claims, resulting in net overpayments of \$163,104 in calendar years 2015 and 2016. Specifically, eight claims either did not meet Medicare criteria for acute inpatient rehabilitation or did not comply with Medicare documentation requirements, resulting in overpayments of \$162,448. In addition, five claims had incorrectly billed outlier payments, resulting in net overpayments of \$656.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$340,125 for the audit period.

What OIG Recommends and Hospital Comments

We recommend that the Hospital refund to the Medicare contractor \$340,125 in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

The Hospital did not agree with all of our findings and recommendations. Specifically, the Hospital disagreed that it incorrectly billed inpatient rehabilitation claims. In addition, the Hospital disagreed with our recommendation to identify and return any additional similar overpayments received outside of the audit period. We obtained independent medical review for all IRF claims in our sample. We provided the independent medical reviewers with all documentation necessary to sufficiently determine medical necessity and documentation requirements for the IRF claims, and our report reflects the results of that review. Based on the Hospital's rebuttal and our internal review, we reduced the overpayment amount and associated recommendation in this report from the initial recommended recovery amount in our draft report.

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INTRODUCTION

WHY WE DID THIS REVIEW

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

OBJECTIVE

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

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS uses Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

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

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for rehabilitation facilities. CMS implemented the payment system for cost-reporting periods beginning on or

after January 1, 2002. Under the payment system, CMS established a Federal prospective payment rate for each of the distinct case-mix groups (CMGs). The assignment to a CMG is based on the beneficiary's clinical characteristics and expected resource needs.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient claims paid in excess of charges and
- inpatient Rehabilitation Facility (IRF) claims.

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

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the 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.

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

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).

Mobile Infirmiry Medical Center

The Hospital is a 677-bed nonprofit medical center in Mobile, Alabama, that includes Bedsole/Rotary Rehabilitation Hospital with 42 IRF beds. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately \$159 million for 18,861 inpatient claims from January 1, 2015, through December 31, 2016 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$7,276,723 in Medicare payments to the Hospital for 439 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 inpatient claims with payments totaling \$1,707,673. 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 all IRF claims to medical review to determine whether the services met medical necessity and documentation 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 87 of the 100 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 13 claims, resulting in net overpayments of \$163,104 for the audit period. Specifically, eight claims either did not meet Medicare criteria for acute inpatient rehabilitation or did not comply with Medicare documentation requirements, resulting in overpayments of \$162,448. In addition, five claims had incorrectly billed outlier payments, resulting in net overpayments of \$656. 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 \$340,125 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 13 of the 100 inpatient claims that we reviewed. These errors resulted in net overpayments of \$163,104.

Incorrectly Billed Inpatient 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* (MBPM) 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).

Finally, the MBPM 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 an IRF claim to be considered reasonable and necessary, Federal regulations require that there must be a reasonable expectation that at the time of admission, the patient 1) requires the active and ongoing therapeutic intervention of multiple therapy disciplines, 2) generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program, 3) is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; and 4) requires physician supervision by a rehabilitation physician (42 CFR § 412.622 (a)(3)(i-iv).

Federal regulations require that the patient’s medical record must contain certain documentation to ensure that the IRF coverage requirements are met. The record must include 1) a comprehensive preadmission screening that is completed within the 48 hours immediately preceding the admission, 2) a post-admission physician evaluation that is completed within 24 hours of admission and documents the patient’s status on admission to the IRF, and includes a comparison with the information in the preadmission screening; and 3) an individualized overall plan of care that is completed within 4 days of admission to the IRF (42 CFR § 412.622 (a)(4)(i-iii)).

According to Federal regulations, for the IRF claim to be considered reasonable and necessary, the patient must require an interdisciplinary team approach to care. This must be evidenced by

documentation in the medical record of weekly interdisciplinary team meetings. The meetings must be led by a rehabilitation physician, and further consist of a registered nurse, a social worker or case manager, and a licensed or certified therapist from each therapy discipline involved in treating the patient (42 CFR § 412.622 (a)(5)(A)).

For 8 of the 100 selected inpatient claims, the Hospital incorrectly billed IRF services. Specifically, for four of the eight claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation. For four of the eight claims, the Hospital incorrectly billed IRF claims that did not comply with Medicare documentation requirements. The eight errors consisted of the following:

- for four claims, there was not a reasonable expectation at the time of admission that the patient required the intensive rehabilitation therapy services that are provided in an IRF;
- for two claims, the documentation did not support that a rehabilitation physician developed and documented an individualized overall plan of care; and
- for two claims, the documentation did not show that all required team members were present at the interdisciplinary team conferences.

The Hospital did not provide a cause for these errors because officials contended that these claims met Medicare requirements. As a result of these errors, the Hospital received overpayments of \$162,448.

Incorrectly Billed Outlier Payments

Section 1815(a) of the Act precludes payment to any provider without information necessary to determine the amount due the provider. Chapter 3, section 10, of the Manual states that a hospital may bill only for services provided. Additionally, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 5 of the 100 selected inpatient claims, the Hospital incorrectly billed Medicare for goods or services that caused incorrect outlier payments. The Hospital indicated that these errors occurred because of human error. As a result, the Hospital received net overpayments of \$656.

OVERALL ESTIMATE OF OVERPAYMENTS

The combined net overpayments on our sampled claims totaled \$163,104. On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$340,125 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$340,125 in estimated overpayments for the audit period for claims that it incorrectly billed;²
- exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day repayment rule; and
- strengthen controls to ensure full compliance with Medicare requirements.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital did not agree with all of our findings and recommendations. The Hospital disagreed that it incorrectly billed inpatient rehabilitation claims that we identified as not fully complying with Medicare billing requirements. In addition, the Hospital disagreed with our recommendation to exercise reasonable diligence to identify and return any additional similar overpayments received outside of the audit period, in accordance with the 60-day repayment rule due to their disagreement with the incorrectly billed IRF claims. Specifically, the Hospital stated that the medical review contractor failed to properly identify and analyze the available documentation, and the Hospital cited specific documentation that rebutted the medical review findings. Furthermore, the Hospital stated that its legal and medical experts noted patterns of misapplication of IRF regulations, and, in some cases, the medical reviewers created their own rules to reject IRF payment. The auditee asserts that this is a misapplication of regulations and leads to the following four mistaken error categories:

² OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to HHS action officials. Action officials at CMS, acting through a Medicare Administrative Contractor (MAC) or other contractor, will determine whether 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 Parts A and B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a decision by the Office of 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.

- Category 1: Hospital officials stated that the medical review contractors created their own additional regulatory requirements that did not exist in either 42 CFR § 412.622 or the MBPM, and, in some instances, denials were based on the lack of a specific format or form for the post-admission physician evaluation.
- Category 2: Hospital officials stated that IRF care was declared unnecessary based solely on certain functional scores without taking into account the individualized patient specific facts. In these cases, the contractors created their own requirement regarding a severity level of dysfunction to qualify for the IRF benefit.
- Category 3: Hospital officials stated that medical records supported the existence of a compliant individualized plan of care, but medical review contractors inappropriately denied claims based on their preferences for a particular document format, even though Medicare guidance does not require a particular format for the plan of care.
- Category 4: Hospital officials stated that OIG's application of current Federal regulations regarding documentation of required team members during interdisciplinary team conferences is inconsistent with CMS's intent in CMS's *Fiscal Year 2019 Inpatient Prospective Payment System Proposed Rule 1694-P*. In addition, they stated that the medical review contractors created their own team meeting signature requirement and presumed that clinicians were absent from meetings if they could find no signature.

Hospital officials concluded that, because none of the alleged overpayments were certain, the extrapolated figure seems premature and possibly inappropriate because it does not reflect the statutorily required sustained or high level of payment error, or documented educational intervention has failed to correct the payment error in accordance with section 1893(f)(3) of the SSA and 42 USC § 1395ddd(f)(3).

The Hospital agreed with our third recommendation and provided information regarding the Hospital's controls over IRF billing and documentation requirements. The Hospital did not comment on the outlier errors detailed in the audit report. See Appendix E for the Hospital's comments on our draft report in their entirety.

OFFICE OF INSPECTOR GENERAL RESPONSE

After review and consideration of the Hospital's comments, we have reevaluated our initial findings and recommendations from our draft report. We obtained an independent medical review to determine the medical necessity for all IRF claims in our sample, which included the 16 claims that the Hospital says either met medical necessity or documentation requirements. In addition, a different independent medical review contractor conducted a second level of medical review on these 16 claims. We provided the medical review contractors with the complete medical record, initial medical review determinations, and a comprehensive written rebuttal of the first medical review results detailing why the initial determination was

considered inaccurate. Our draft report reflected the results of the determinations that both of the independent medical reviewers made.

In regards to category 1, based on the Hospital's rebuttal and our internal review regarding 42 CFR § 412.622 and the MBPM, we no longer consider 8 of the original sample claims to be errors. This revision reduced the overpayment amount and associated recommendation in this report from the initial recommended recovery amount in our draft report.

In regards to category 2, the medical review contractors denied the claims based on their reviews of the preadmission screening, post-admission physician evaluation, and inpatient rehabilitation facility medical record and determined that the documentation did not validate an expectation that the patient would need any or all of the required elements of an inpatient rehabilitation facility. The medical review contractors, therefore, determined these claims were not reasonable and necessary. In addition, the Hospital's Independent Review Organization recommended conceding three of the four errors in its initial rebuttal based on its own independent review.

In regards to category 3, the medical review contractor reviewed the medical records and the Hospital's rebuttal and determined that there was no plan of care contained in the medical records. In addition, the Hospital's Independent Review Organization indicated no plan of care could be identified in the medical record document that was transmitted and reviewed.

In regards to category 4, we made a determination regarding compliance with laws and regulations that were in effect during the audit period. In order for these IRF claims to be considered reasonable and necessary, these regulations required documentation in the medical record of weekly interdisciplinary team meetings. The Hospital could not provide documentation that all required participants were included in the weekly interdisciplinary team meetings; therefore these claims were determined to be an error.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$7,276,723 in Medicare payments to the Hospital for 439 claims that were potentially at risk for billing errors. We selected a stratified random sample of 100 inpatient claims with payments totaling \$1,707,673 for review. Medicare paid these 100 claims from January 1, 2015, through December 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 subjected all IRF claims to medical review to determine whether the services met medical necessity and documentation 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 NCH data, 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 2017 through May 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 database 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 \$1,707,673 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 two independent medical review contractors to determine whether all IRF claims met medical necessity and documentation requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample review to calculate the estimated Medicare overpayment to the Hospital (Appendix C); and
- discussed the results of our review with Hospital officials.

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

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

SAMPLING FRAME

According to CMS's NCH database, Medicare paid the Hospital \$159 million for 18,861 inpatient claims during the audit period.

We obtained a database of claims from the NCH data totaling \$76 million for 7,807 inpatient claims in 13 risk areas. From these 13 areas, we selected 2 consisting of 743 claims totaling \$10,513,774 for further review.

We performed data filtering and analysis of the claims within each of the two 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 \$0, and
- claims under review by the Recovery Audit Contractor as of June 28, 2017.

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: Inpatient Claims Paid in Excess of Charges and Inpatient Rehabilitation Facility Claims.

This assignment hierarchy resulted in a sample frame of 439 Medicare paid claims in two high-risk areas totaling \$7,276,723 from which we drew our sample (Table 1).

Table 1: Risk Areas

Medicare Risk Area	Frame Size	Value of Frame
Inpatient Claims Paid in Excess of Charges	100	\$1,215,878
Inpatient Rehabilitation Facility Claims	339	6,060,845
Total	439	\$7,276,723

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We stratified the sampling frame into two strata on the basis of Medicare risk area and then split the IRF Claims risk area on the basis of the amount paid. We put paid claims less than \$18,770 into stratum 2 and paid claims \$18,770 or greater into stratum 3. All claims were unduplicated, appearing in only one area and only once in the entire sampling frame.

We selected 100 claims for review as shown in Table 2.

Table 2: Claims by Stratum

Stratum	Medicare Risk Area	Claims in Sampling Frame	Value of Frame	Claims in Sample
1	Inpatient Claims Paid in Excess of Charges	100	\$1,215,878	30
2	Inpatient Rehabilitation Facility Claims (low dollar)	218	3,193,164	35
3	Inpatient Rehabilitation Facility Claims (high dollar)	121	2,867,681	35
	Total	439	\$7,276,723	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 strata 1 through 3. 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 Overpayments in Sample
1	100	\$1,215,878	30	\$364,997	1	\$14,210
2	218	3,193,164	35	504,560	5	47,055
3	121	2,867,681	35	838,116	7	101,839
Total	439	\$7,276,723	100	\$1,707,673	13	\$163,104

ESTIMATES

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

Point Estimate	\$692,521
Lower Limit	340,125
Upper Limit	1,044,917

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Table 5: Sample Results by Risk Area

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over Payments	Value of Overpayments
Inpatient Claims Paid in Excess of Charges	30	\$364,997	1	\$14,210
Inpatient Rehabilitation Services (low dollar)	35	504,560	5	47,055
Inpatient Rehabilitation Services (high dollar)	35	838,116	7	101,839
Inpatient Totals	100	\$1,707,673	13	\$163,104

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX E: HOSPITAL COMMENTS



August 6, 2018

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

Re: Mobile Infirmiry Medical Center's Response to
Draft Report Number A-04-17-08057
Office of Inspector General ("OIG")
U.S. Department of Health and Human Services ("DHHS")

Dear Ms. Pilcher:

Please accept this letter as Mobile Infirmiry Association, d/b/a Mobile Infirmiry Medical Center's (the "Hospital") response to the OIG's Draft Report Number A-04-17-08057 entitled "Medicare Compliance Review of Mobile Infirmiry Medical Center." (The "Draft Report").

In the Draft Report, the OIG recommends that Hospital:

1. refund to the Medicare contractor \$895,325 in estimated overpayments for the audit period for claims that, according to the OIG, it incorrectly billed;
2. exercise reasonable diligence to identify and return any additional similar overpayments received outside of the OIG audit period, in accordance with the 60-day rule; and
3. strengthen controls to ensure full compliance with Medicare requirements.

Introduction

Mobile Infirmiry Association was founded in 1910. It is an affiliate of Infirmiry Health System, Inc. which is Alabama's largest non-governmental non-profit healthcare organization. With four hospitals located in southern Alabama on the Gulf Coast and more than 30 medical clinics conveniently located in Mobile and Baldwin County, each year affiliates of the health system serve more than one million patients from 11 counties.

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Infirmary Health's affiliated flagship hospital is Mobile Infirmary Medical Center, with 677 licensed beds including an Inpatient Rehabilitation Facility (IRF) J.L. Bedsole/Rotary Rehabilitation Hospital. The Hospital is among the leading hospitals in the state for surgical volume and houses a comprehensive cardiovascular program with a hybrid OR/catheter lab. The region's only long term acute care hospital, Infirmary LTAC Hospital, operated by an affiliate, Infirmary Health Hospitals, Inc., is also located within the Mobile Infirmary Medical Center facility. The Hospital also participates in the health system's renowned cancer program, Infirmary Cancer Care with surgical, radiation, and medical oncology.

At J. L. Bedsole/Rotary Rehabilitation Hospital, patients hospitalized due to an illness or injury are helped to gain independence and resume their normal daily activities. Rehabilitation is provided for patients affected by stroke, spinal cord injury, brain injury and other neurological illnesses. Rotary is located on the third floor of Mobile Infirmary Medical Center facility and has served the community since 1931.

Rotary is accredited by The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF). The CARF accreditation is a notable distinction as the mission of CARF is "to promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of persons served."

The Hospital is committed to robust compliance efforts and respects the OIG's role in assessing compliance to ensure that Medicare dollars are spent on reasonable and necessary services. The compliance program at the Hospital is dedicated to the same basic principles and based on the OIG's Compliance Program Guidance for Hospitals. The Hospital aims to provide quality medically necessary care, generate and maintain comprehensive documentation, code and bill accurately and correctly, monitor and audit billings, and promptly refund any identified overpayments.

Mobile Infirmary Disagrees with the Findings on Incorrectly Billed Rehabilitation Claims

The Hospital disagrees with the finding that its documentation did not comply with Medicare medical necessity (coverage) and documentation requirements as outlined in 42 CFR 412.622 and section 110 of Chapter 1 of the Medicare Benefit Policy Manual (MBPM). The OIG sets forth applicable law and regulations related to inpatient rehabilitation services designed to ensure that Medicare pays for services that are reasonable and necessary for the "diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (USCA 1862(a)(1)(A)). However, the contractor conducting the medical record review for the OIG failed



to properly identify and analyze the available documentation with respect to whether there was substantial compliance with the regulations as necessary to support payment.

The Hospital engaged an accredited Independent Review Organization, MedManagement LLC (“MedManagement”) to review each record audited. MedManagement engaged board certified physicians with experience in both IRF patient care and Medicare IRF regulation / guidance interpretation to carefully review those claims identified by OIG’s selected review contractors (Palmetto and Cahaba, both Medicare Administrative Contractors) as overpayments. The Hospital disagreed with the majority of the overpayment findings that were alleged by OIG’s contractors related to the IRF claims reviewed by the OIG. Further, the hospital cited specific medical record documentation and regulations/guidance that convincingly rebutted the OIG’s reviewers’ findings in many cases of alleged errors. The case by case analysis will be included in an appeal for each case denied. To date, the Hospital has not received any sufficiently detailed response showing these cases suffered from documentation or medical necessity errors that would prohibit part A payment. The cases were originally reviewed by the Medicare Administrative Contractor, (MAC) Cahaba GBA. Due to a change in the MAC during the audit, all cases were also reviewed by the new MAC, Palmetto GBA. Palmetto determined that many of the denials by Cahaba were inappropriate. In fact, Palmetto overturned well over half of Cahaba GBA’s, initial denials.

In addition to case specific findings, our legal and medical experts noted patterns of misapplication of IRF regulations by OIG’s selected contractors. In some cases, the contractors’ written findings show that they created their own, auditor created rules to reject IRF payment in an already extremely detailed regulatory arena. This misapplication of regulations leads to the four mistaken “error” categories noted in OIG’s findings. We will address these by category.

Category 1 - Post Admission Physician Evaluation did not contain sufficient medical information: We have identified repeated statements by OIG’s contractors that show they created their own, additional regulatory requirements. A frequent assignment of error was based on the post admission physician evaluation’s failure to expressly, “... document how the medical conditions interact between the medical and functional status; and did not tie the patient’s medical conditions to the functional status.” No such requirement exists in 42 CFR 412.622 or the Medicare Benefit Policy Manual (MBPM). Further, in the cases where this reason was cited, the interactions between disease and function were quite obvious to our physicians and nurse with extensive rehabilitation experience. These interactions and connections could clearly be inferred from the document at issue which was provided to the OIG. In addition, it appears that

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in some instances denials were based on the lack of a specific format or form for the post admission physician evaluation and no form or specific format is required by federal law or guidance.

Category 2 - Not a reasonable expectation at the time of admission that the patient required intensive rehabilitation services provided in an IRF. We have identified a flawed approach in the OIG contractors' use of auditor-created rules of thumb. MBPM, Chapter 1, Section 110 provides that, "Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs." IRF care was declared unnecessary based solely on certain functional scores, without taking into account the individualized patient specific facts. In these cases, the contractors created their own requirement that there be a certain severity of dysfunction (i.e., very low function scores) in order to qualify for the IRF benefit. As such, the contractors rejected cases with moderate functional impairments without performing the requisite analysis required in Medicare regulations.

Category 3 - The documentation did not support that a rehabilitation physician developed and documented an individualized overall plan of care. We have identified inappropriate denials based on the contractors' preference as to a particular document format. However, Medicare guidance does not require a particular format for the plan of care. In the cases at issue, the documentation supported the existence of a compliant individualized plan of care. In some cases, Palmetto recognized that the plan of care could be derived from the record in its entirety; in other cases, it appears that Palmetto reviewers were looking for a specific document format, an error also common in the Cahaba GBA review.

Category 4 - The documentation did not show that all required team members were present at the interdisciplinary team conferences. We are concerned about the inappropriate application of this particular rule because it leads to an unjust outcome inconsistent with federal law. Federal regulations expressly state that the decision for a compliant IRF admission, as well as all associated documentation, must focus on the necessity of IRF care "at the time of admission." (42 CFR 412.622(a) (4)). Consider those cases where a perfect rehabilitation candidate is admitted to the IRF in full compliance, but then six days later one of the five required team meeting participants stays home sick and misses the team meeting. Seven days of fully compliant, medically necessary IRF care would suddenly cease to exist at the moment the team meeting was concluded absent the sick employee. We do not think such an application of this regulation is consistent with CMS's intent, nor do we think recoupment of money in this regard is consistent with due process. This draconian application of a technicality is akin to that which



has been clearly rejected by CMS's recent release on April 24, 2018 of Fiscal Year 2019 Inpatient Prospective Payment System Proposed Rule 1694-P, which proposes to remove the requirement of a written inpatient order as a specific Condition of Payment for Medicare Part A payment. Importantly, CMS acknowledges that sub-regulatory guidance related to timing of signatures for authentication had an unintended consequence of contractors denying payment for medically necessary Part A hospital stays based on the mere technicality of a delayed or missing signature. CMS explains: "...medical reviews should primarily focus on whether the inpatient admission was medically reasonable and necessary rather than occasional inadvertent signature documentation issues unrelated to the medical necessity of the inpatient stay. It was not our intent when we finalized the admission order documentation requirements that they should themselves lead to the denial of payment for otherwise medically reasonable and necessary inpatient stays, even if such denials occur infrequently." CMS 1694-P, page 1057

In addition, the contractors reviewing these cases created their own team meeting *signature* requirement, which has no basis in IRF Federal Regulations or MBPM guidance. A clinician was simply presumed absent from a meeting if no signature was found on a particular piece of paper without any assessment of the medical record to discern the presence of the disciplinary team members.

Response to OIG Recommendation 2 that the facility exercise reasonable diligence to identify and return any additional similar overpayments received outside of the audit period, in accordance with the 60-day repayment rule- concurred:

The Hospital disagrees with the OIG's findings on the rehabilitation claims and therefore, also disagrees with the first recommendation in the OIG report that the Hospital refund estimated overpayments of \$895,325.

As noted above, the Hospital engaged MedManagement to conduct an independent audit of the claims identified. The Infirmiry Health Corporate Compliance plan directs compliance activities and has an established, robust auditing program of claims. Infirmiry Health will continue to engage MedManagement on an ongoing basis for an independent and critical review of IRF billing and documentation processes of Rotary. Audits have been completed by internal and external experts for many years at the Hospital and were inclusive of medical record documentation in support of Medicare claims. In 2018, the existing infrastructure was enhanced to include the Corporate Audit Steering Committee which meets quarterly to discuss all audit activity within the organization. Audit Steering Committee information is reported to the Executive Compliance Committee. The Corporate Compliance officer facilitates each of these committees and reports compliance related activities to the Infirmiry Health Board of Directors.



Response to OIG Recommendation 3 that Mobile Infirmary Strengthen Controls to Ensure Compliance with Medicare Requirements:

In response to the OIG's third recommendation, the Hospital agrees that it should continuously improve its procedures to ensure that it bills Medicare only for services that comply with the Medicare documentation requirements. Prior to accepting a patient for admission to the Rotary Rehabilitation Hospital (Rotary), each patient's medical record is rigorously screened by the Rotary Admissions Registered Nurse (RN). The Admissions RN discusses every patient with the Rotary Medical Director to confirm criteria are met. A Pre-Admission form is completed by the Admissions RN. The Admissions RN receives extensive training in CMS Inpatient Rehabilitation Facility (IRF) criteria and the Medical Director is Board Certified in Physical Medicine & Rehabilitation.

Prior to admission, the Medical Director reviews each Pre-Admission form to again confirm the patient meets rehabilitation criteria and signs the form to validate this review. If the Medical Director determines the patient does not meet IRF criteria, the admission is cancelled.

Once a patient is admitted to Rotary the Medical Director, Nursing, Case Management, Therapy and other ancillary departments collaborate to ensure all required medical record documentation elements are complete and timely.

Checks and balances are in place to identify gaps in documentation, including, but not limited to, electronic medical record alerts and a secure physician messaging tool for improved communication with the Medical Director. Rotary also uses an online patient assessment system used to assist inpatient rehabilitation facilities in their compliance with CMS's regulations under the IRF-PPS, based on the IRF-PAI, and allows real time reporting to assist with outcomes and compliance. Additional steps are underway to integrate with the electronic medical record, leading to more process improvements.

Rotary staff and the Medical Director receive the latest education related to IRF compliance, criteria and documentation requirements. The Rotary Medical Director and staff are actively involved in multiple Rehabilitation Associations at the national and state level including, but not limited to, the American Medical Rehabilitation Providers Association, and the Alabama Hospital Association's statewide IRF coalition.

As mentioned above, Rotary was surveyed and received accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF). During CARF surveys records are reviewed to ensure compliance with CMS requirements for medical necessity and timeliness. As such, CARF accreditation is an external validation of Rotary's internal controls.



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The Hospital has established in-house Utilization Review routines with periodic audits and education from both in-house and outside experts in IRF medical necessity as well as the billing and documentation requirements.

Conclusion

Given the issues identified above, we respectfully request the OIG withdraw the recommendation for refunding the amount identified for the IRF and at this time allow for a full and fair hearing on the facts of each case by HHS's administrative law judges. Since none of the actual alleged overpayments are certain at this point, the extrapolated figure seems, at best, premature and possibly inappropriate as not reflecting the statutorily required "(A) ...sustained or high level of payment error; or (B) documented educational intervention [that] has failed to correct the payment error." Section 1893 (f) (3) of the Social Security Act, 42 U.S.C. 1395ddd (f) (3). The Hospital suggests that, after a full hearing, the OIG may revise the refund amount, if any is appropriate.

Please do not hesitate to contact me if you would like to discuss this response at Amy.Bennett@InfirmaryHealth.org or 251-435-5743.

Respectfully,

Amy Katherine Bennett
Vice President, Corporate Compliance Officer
Infirmary Health System, Inc.