Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF NORTHWESTERN MEMORIAL HOSPITAL FOR 2011 AND 2012

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

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Office of Inspector General

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EXECUTIVE SUMMARY

Northwestern Memorial Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated net overpayments of at least $6.4 million over 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals $148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Northwestern Memorial Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is an 894-bed acute care teaching hospital located in Chicago, Illinois. Medicare paid the Hospital approximately $438 million for 24,063 inpatient and 235,427 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered $48,550,382 in Medicare payments to the Hospital for 7,506 claims that were potentially at risk for billing errors. We selected a stratified random sample of 171 claims with payments totaling $1,449,820 for review. These 171 claims had dates of service in CY 2011 or CY 2012 and consisted of 98 inpatient and 73 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 86 of the 171 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 85 claims, resulting in net overpayments of $272,181 for CYs 2011 and 2012 (audit period). Specifically, 56 inpatient claims had billing errors, resulting in net overpayments of $228,526, and 29 outpatient claims had billing errors, resulting in net

overpayments of $43,655. 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 net overpayments totaling at least $6,389,095 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor $6,389,095 (of which $272,181 was net overpayments identified in our sample) in estimated net overpayments for incorrectly billed services, and

- strengthen controls to ensure full compliance with Medicare requirements.

NORTHWESTERN MEMORIAL HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital partially disagreed with our first recommendation and discussed steps it had taken or planned to take regarding our second recommendation.

After considering the Hospital's comments, we continue to recommend that the Hospital refund to the Medicare contractor $6,389,095 in estimated overpayments and strengthen controls to ensure full compliance with Medicare requirements.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified certain types of hospital claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals $148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

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

BACKGROUND

The Medicare Program

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

CMS contracts with Medicare Administrative Contractors (MAC) to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). 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.

CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.[1] All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient transfers,
- inpatient claims billed with high-severity-level DRG codes,
- outpatient claims billed with modifier -59, and
- outpatient claims billed with observation services that resulted in outlier payments.

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

Medicare Requirements for Hospital Claims and Payments

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

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

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

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

Northwestern Memorial Hospital

The Hospital, which is part of Northwestern Memorial HealthCare, is an 894-bed acute care teaching hospital located in Chicago, Illinois. Medicare paid the Hospital approximately $438 million for 24,063 inpatient and 235,427 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $48,550,382 in Medicare payments to the Hospital for 7,506 claims that were potentially at risk for billing errors. We selected a stratified random sample of 171 claims with payments totaling $1,449,820 for review. These 171 claims had dates of service in CY 2011 or CY 2012 and consisted of 98 inpatient and 73 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 120 claims to focused medical review to determine whether the services met medical necessity and coding requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

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

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

FINDINGS

The Hospital complied with Medicare billing requirements for 86 of the 171 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 85 claims, resulting in net overpayments of $272,181 for CYs 2011 and 2012 (audit period). Specifically, 56 inpatient claims had billing errors, resulting in net overpayments of $228,526, and 29 outpatient claims[2] had billing errors, resulting in net overpayments of $43,655. 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 net overpayments totaling at least $6,389,095 for the audit period.

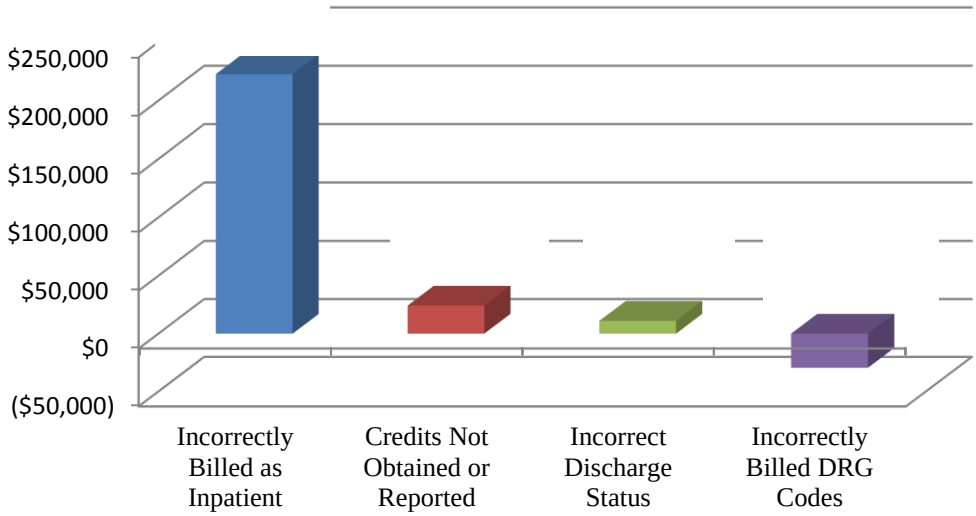
See Appendix B for our sample design and methodology, Appendix C for our sample results and estimates, and Appendix D for the results of our review by risk area.

[2] Of the 29 outpatient claims, 5 had more than 1 type of error for a total of 34 errors.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 56 of 98 sampled inpatient claims, which resulted in net overpayments of $228,526 as shown in Figure 1 below.

Figure 1: Inpatient Billing Errors



Incorrectly Billed as Inpatient

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

The *Medicare Benefit Policy Manual* states:

> An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.
>
> The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark. . . . (T)he decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to

> inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.
>
> Factors to be considered when making the decision to admit include such things as: The severity of the signs and symptoms exhibited by the patient; the medical predictability of something adverse happening to the patient; the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and the availability of diagnostic procedures at the time when and at the location where the patient presents. (Pub. No. 100-02, chapter 1, § 10).

For 35 of the 98 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services. The Hospital agreed that 7 of the 35 were billed in error and attributed the errors to inherent uncertainties in applying vague CMS guidelines for inpatient status as reflected in inconsistent outcomes by Hospital utilization review staff as well as CMS's own reviewers.

As a result of these errors, the Hospital received overpayments of $222,692.[3]

Manufacturer Credits for Replaced Medical Devices Not Obtained or Reported

Federal regulations require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). Federal regulations state, "All payments to providers of services must be based on the reasonable cost of services …" (42 CFR § 413.9).

The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code "FD" (chapter 3, § 100.8).

The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements in additional detail (Pub. No. 15-1). The PRM states: "Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program" (part I, § 2102.1).

[3] The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor before issuance of our draft report.

The PRM further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties (part I, § 2103.A). The PRM provides the following example: "Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment." (part I, § 2103.C.4).

For 6 of the 98 sampled claims, the Hospital either received reportable medical device credits from manufacturers for a replaced devices but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required (3 claims) or did not obtain credits for replaced devices for which credits were available under the terms of the manufacturer's warranty (3 claims). Hospital officials stated that these errors occurred due to a lack of standardized processes to properly identify, obtain, and report credits from device manufacturers.

As a result of these errors, the Hospital received overpayments of $24,250.

Incorrect Discharge Status

A discharge of a hospital inpatient is considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstances 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)).

For 2 of the 98 sampled claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers. For these claims, the Hospital should have coded the discharge status as 06, "transfer to home health agency." However, the hospital incorrectly coded the discharge status to "left against medical advice" or "discharged to an intermediate care facility." Hospital officials stated that these errors occurred primarily because of human error.

As a result of these errors, the Hospital received overpayments of $11,065.

Incorrectly Billed Diagnosis-Related-Group Codes

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(a)). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

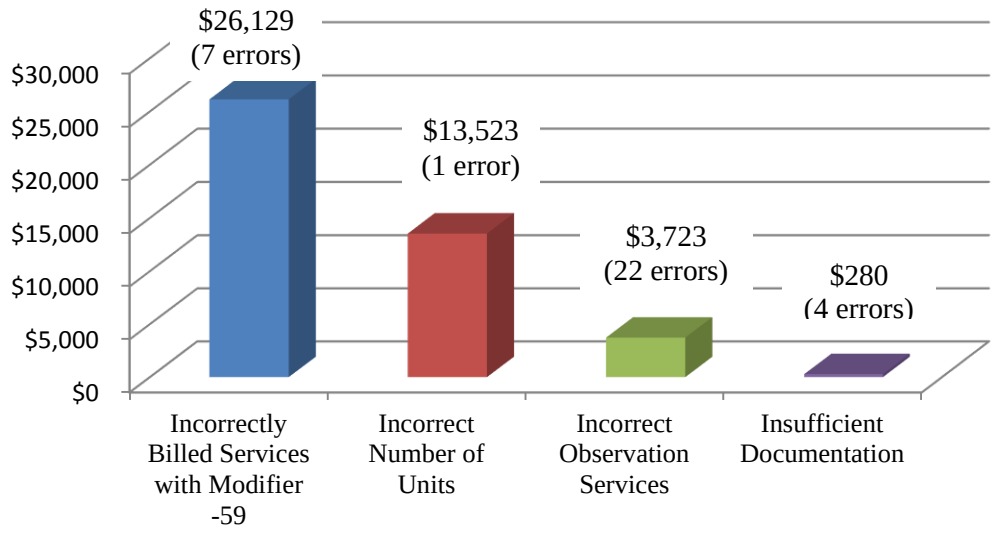
For 13 of the 98 sampled claims, the Hospital billed Medicare with incorrect DRG codes. Hospital officials stated that these errors were primarily attributable to the incorrect selection of principal and/or secondary diagnosis codes by the coding staff.

As a result of these errors, the Hospital was underpaid $29,481.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 29[4] of 73 sampled outpatient claims, which resulted in net overpayments of $43,655 as shown in Figure 2 below.

Figure 2: Outpatient Billing Errors



Incorrectly Billed Outpatient Services with Modifier -59

The Manual states: "The '-59' modifier is used to indicate a distinct procedural service…. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)" (chapter 23, § 20.9.1.1). In addition, the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 7 of the 73 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes, appended with modifier -59, which were already included in the payments for other services billed on the same claim or did not require modifier -59. Hospital officials stated these errors occurred primarily because of human error, including the hospital staff's misunderstanding of Medicare billing requirements for claims with modifier -59.

As a result of these errors, the Hospital received overpayments of $26,129.

[4] Of the 29 outpatient claims, 5 had more than 1 type of error for a total of 34 errors.

Incorrectly Billed Number of Units

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)). The Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2). The Manual also states: "The definition of service units …is the number of times the service or procedure being reported was performed." (chapter 4, § 20.4).

For 1 of the 73 sampled claims, the Hospital submitted a claim to Medicare with an incorrect number of units for radiation treatment delivery (HCPCS 77371). Based on the NCCI Medically Unlikely Edits, only 1 unit (not 3) can be submitted for HCPCS 77371. Hospital officials stated that this error occurred because of human error.

As a result of this error, the Hospital received an overpayment of $13,523.

Incorrectly Billed Observation Services and Unsupported Charges Resulting in Incorrect Outlier Payments

The Act states that 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" (§ 1862(a)(1)(A)). The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

The Manual states: "Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services" (chapter 4, § 290.1). In addition, the Manual states: "Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order… Observation time ends when all medically necessary services related to observation care are completed. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4 to 6 hours), which should be billed as recovery room services" (chapter 4, § 290.2.2).

For 22 of the 73 sampled claims, the Hospital incorrectly billed Medicare for observation hours resulting in incorrect outlier payments. Specifically, the Hospital included observation time for services that were part of another Part B service including postoperative monitoring or standard recovery care (10 errors), for time the patients remained in the hospital after treatment was finished (3 errors), or the medical record did not contain an order for the observation services (1 error). For the remaining 8 errors, the patient's condition did not warrant observation services. For 18 of these 22 errors, the Hospital also incorrectly billed Medicare for medications that were not supported in the medical records. Hospital officials stated that these errors primarily occurred because of inadequate procedures to correctly identify observation hours.

As a result of these errors, the Hospital received overpayments of $3,723.

Insufficiently Documented Services

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

For 4 of the 73 sampled claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record. Hospital officials stated that these errors occurred primarily because of human error.

As a result of these errors, the Hospital received an overpayment of $280.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received net overpayments totaling at least $6,389,095 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $6,389,095 (of which $272,181 was net overpayments identified in our sample) in estimated net overpayments for incorrectly billed services, and

- strengthen controls to ensure full compliance with Medicare requirements.

NORTHWESTERN MEMORIAL HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

NORTHWESTERN MEMORIAL HOSPITAL COMMENTS

In written comments on our draft report, the Hospital partially disagreed with our first recommendation and discussed steps it had taken or planned to take regarding our second recommendation.

The Hospital's response is included as Appendix E.

Contested Determination of Claims

The Hospital agreed with 57 of the 85 claims identified in our draft report as being improperly billed. The Hospital disagreed with our determination that it did not correctly bill the remaining 28 inpatient claims and stated that it intends to appeal the denial of those claims. For these claims, the Hospital believed that our medical review contractor made its determinations of admission necessity with the benefit of hindsight, focusing on the final outcome and disposition of the patient. Furthermore, the Hospital stated that CMS's standards guiding determinations of admission necessity in effect during the scope of our review were vague and complex.

Statistical Sampling

The Hospital expressed concerns about the methodology and the statistical validity of the amount extrapolated. Specifically, the Hospital stated that we oversampled lower dollar claims in the Inpatient Short Stay risk area and did not select a probe sample for the Inpatient MCC/CC risk area as required by CMS guidelines. As a result, the Hospital believed that our sample was not random and our findings were extrapolated across a larger universe, thus resulting in incorrect and overstated overpayment amounts.

In addition, the Hospital stated that our methodology substantially overestimated the overpayment amount because it did not reflect the potential Medicare Part B reimbursement that could result from rebilling the claims as outpatient or outpatient with observation services.

Report Process

The Hospital expressed concerns with the reporting process citing a lack of due process. Specifically, the Hospital stated that it received a recovery demand letter based on the draft report findings when it was their understanding that CMS would receive the report only after the final report, including the Hospital's comments, was issued.

OFFICE OF INSPECTOR GENERAL RESPONSE

Contested Determination of Claims

We subjected these claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Each case that was denied was reviewed by 2 Clinicians—one of them being a physician. We continue to stand by those determinations. The Hospital maintains its appeal rights. In those instances where the Hospital disagrees with the results, the Hospital should contest these disallowances with the CMS action official, and finally, the last recourse is the appeals process.

Statistical Sampling

The use of statistical sampling to determine overpayment amounts in Medicare is well established and has repeatedly been upheld on administrative appeal within the Department and in Federal courts.[5]

Regarding the Hospital's objections to our statistical sampling and extrapolation methodology, the legal standard for use of sampling and extrapolation is that it must be based on a statistically

[5] *See 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).

valid methodology, not the most precise methodology.[6] We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

The Hospital's argument that a probe sample was not selected according to guidelines prescribed for CMS and its contractors is not applicable because the OIG is not a Medicare contractor.

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

Report Process

The Hospital raised a concern about the audit report process. Our process for finalizing an audit report does not change because the MAC has issued a demand letter. As with every audit report, OIG allows auditees to review draft reports and respond in writing, which is included with the final report. The OIG makes adjustments to the final report based on the auditee's response as we deem appropriate. Once the report is finalized, the OIG transmits the final report to CMS in accordance with our typical procedures.

Therefore, we continue to recommend that the Hospital refund to the Medicare contractor $6,389,095 in estimated overpayments and strengthen controls to ensure full compliance with Medicare requirements.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $48,550,382 in Medicare payments to the Hospital for 7,506 claims that were potentially at risk for billing errors. We selected a stratified random sample of 171 claims with payments totaling $1,449,820 for review. These 171 claims had dates of service in CY 2011 or CY 2012 and consisted of 98 inpatient and 73 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 120 claims to focused medical review to determine whether the services met medical necessity and coding requirements.

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

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

We conducted our fieldwork from September 2013 through November 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers 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 171 claims (98 inpatient and 73 outpatient) totaling $1,449,820 for detailed review (Appendix B and C);
- 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 submitting Medicare claims;

- used an independent medical review contractor to determine whether 120 sampled claims met medical necessity and coding requirements;

- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;

- calculated the correct payments for those claims requiring adjustments;

- used the results of the sample review to calculate the estimated Medicare overpayments to the Hospital (Appendix C); and

- discussed the results of our review with Hospital officials.

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

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

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

SAMPLING FRAME

Medicare paid the Hospital $438,065,380 for 24,063 inpatient and 235,427 outpatient claims for services provided to beneficiaries during the audit period based on CMS's National Claims History data.

We downloaded claims from the National Claims History database totaling $259,476,095 for 11,823 inpatient and 41,375 outpatient claims in 25 risk areas. From these 25 areas, we selected 7 consisting of 28,241 claims totaling $154,459,868 for further review.

We performed data analysis of the claims within each of the seven risk areas. For risk areas one and two, we removed claims with payment amounts less than $3,000. For risk area three, we removed claims with claim lines containing modifier -59 with payment amounts less than $50 and payment amounts greater than $6,762. There were 2 modifier -59 claims with a claim line payment greater than $6,762. We placed these 2 claims in a stratum separate from the other modifier -59 claims because of their high claim payment amounts.

We then removed the following:

- all $0 paid claims,
- all claims under review by the Recovery Audit Contractor, and
- all duplicated claims within individual risk areas.

We assigned each claim that appeared in multiple risk areas to just one area based on the following hierarchy: Inpatient Medical Devices, Inpatient Transfers, Outpatient Observation Services that Resulted in Outlier Payments, Outpatient Medical Devices, Outpatient Claims Billed with Modifier -59, Inpatient MCC/CC, and then Inpatient Short Stays. This resulting database contained 7,506 unique Medicare claims in 7 risk areas totaling $48,550,382 from which we drew our sample.

Risk Area	Number of Claims	Amount of Payments
Inpatient Short Stays	2009	$13,723,791
Inpatient Claims Billed With High-Severity-Level DRG Codes	2458	$28,397,139
Outpatient Claims Billed with Modifier -59 – low dollar stratum	2986	$5,787,137
Outpatient Claims Billed with Modifier -59 – high dollar stratum	2	$51,027
Inpatient Manufacturer Credits for Replaced Medical Devices	16	$392,900
Outpatient Manufacturer Credits for Replaced Medical Devices	8	$91,559
Inpatient Transfers	2	$28,518
Outpatient Claims Billed With Observation Services That Resulted in Outlier Payments	25	$78,311
Total	**7,506**	**$48,550,382**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into eight strata based on the risk area.

SAMPLE SIZE

We selected 171 claims for review as follows:

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Short Stays	2009	40
2	Inpatient Claims Billed With High-Severity-Level DRG Codes	2458	40
3	Outpatient Claims Billed with Modifier -59 – low dollar stratum	2986	38
4	Outpatient Claims Billed with Modifier -59 – high dollar stratum	2	2
5	Inpatient Manufacturer Credits for Replaced Medical Devices	16	16
6	Outpatient Manufacturer Credits for Replaced Medical Devices	8	8
7	Inpatient Transfers	2	2
8	Outpatient Claims Billed With Observation Services That Resulted in Outlier Payments	25	25
	Total	**7,506**	**171**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software, RAT-STATS to estimate the total amount of overpayments paid to the hospital during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Net Over-payments in Sample
1	2009	$13,723,791	40	$248,449	31	$158,703
2	2458	28,397,139	40	509,111	17	34,508
3	2986	5,787,137	38	49,945	5	2,321
4*	2	51,027	2	51,027	2	37,542
5*	16	392,900	16	392,900	6	24,250
6*	8	91,559	8	91,559	0	0
7*	2	28,518	2	28,518	2	11,065
8*	25	78,311	25	78,311	22	3,792
Total	**7,506**	**$48,550,382**	**171**	**$1,449,820**	**85**	**$272,181**

*We reviewed all claims in this stratum.

ESTIMATES

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

Point Estimate	$10,168,026
Lower Limit	6,389,095[7]
Upper Limit	13,949,278

[7] In accordance with OAS policy, we did not use the results from stratum 3 in calculating the estimated overpayments. Instead, we added the actual overpayments from stratum 3 ($2,321) to the lower limit ($6,386,774) which resulted in an adjusted lower limit of $6,389,095.

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Under/ Over-payments	Value of Net Over-payments
Inpatient				
Short Stays	40**	$248,449	31	$158,703
Manufacturer Credits for Replaced Medical Devices	16	392,900	6	24,250
Transfers	2	28,518	2	11,065
Claims Billed With High-Severity-Level Diagnosis-Related Group Codes	40**	509,111	17	34,508
Inpatient Totals	**98**	**$1,178,978**	**56**	**$228,526**
Outpatient				
Claims Billed with Modifier -59 – low dollar stratum	38**	49,945	5	2,321
Claims Billed with Modifier -59 – high dollar stratum	2**	51,027	2	37,542
Claims Billed With Observation Services That Resulted in Outlier Payments	25	78,311	22	3,792
Manufacturer Credits for Replaced Medical Devices	8	91,559	0	0
Outpatient Totals	**73**	**$270,842**	**29**	**$43,655**
Inpatient and Outpatient Totals	**171**	**$1,449,820**	**85**	**$272,181**

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

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at Northwestern Memorial 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: NORTHWESTERN MEMORIAL HOSPITAL COMMENTS

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January 21, 2015

Via Courier and Electronic Submission

Ms. Sheri L. Fulcher
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region V
233 N. Michigan Ave.
Suite 1360
Chicago, IL 60601

RE: Report Number A-05-13-00051
Response of Northwestern Memorial Hospital

Dear Ms. Fulcher:

This letter sets forth the response of Northwestern Memorial Hospital (NMH) to the Office of Inspector General (OIG) draft report entitled *Medicare Compliance Review of Northwestern Memorial Hospital for 2011 and 2012*. NMH appreciates the opportunity to review and comment on the findings of the OIG Office of Audit Services. NMH is first and foremost committed to its *Patients First* mission and, consistent with this mission, operating with the utmost integrity and in compliance with the rules and regulations governing Federal health care programs.

NMH's responses to OIG's specific findings are set forth below.

OIG Summary of Findings

The Hospital complied with Medicare billing requirements for 86 of the 171 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 85 claims, resulting in net overpayments of $272,181 for CYs 2011 and 2012 (audit period). Specifically, 56 inpatient claims had billing errors, resulting in net overpayments of $228,526, and 29 outpatient claims had billing errors, resulting in net overpayments of $43,655. 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 estimate that the Hospital received net overpayments totaling at least $6,389,095 for the audit period.

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OIG Recommendations

We recommend that the Hospital:

- *Refund to the Medicare contractor $6,389,095 (of which $272,181 was net overpayments identified in our sample) in estimated net overpayments for incorrectly billed services, and*
- *Strengthen controls to ensure full compliance with Medicare requirements.*

NMH Response

NMH respectfully disagrees with OIG's findings for 28 of the 85 claims which OIG determined to not be fully compliant with Medicare billing requirements. In addition to disagreement on the merits of these 28 claims, NMH has concerns with procedural aspects of this audit, including the application and accuracy of extrapolation, and the fact that NMH has already received a demand letter for $6,389,095 from National Government Services (NGS) based on the draft, incomplete, report from OIG.

OIG erred in two ways with respect to the technical application of the statistical methodology underlying the extrapolation. First, OIG oversampled lower dollar claims in the "Inpatient Short Stay" stratum. These lower dollar claims, by their very nature, have a higher propensity for overpayment findings than higher dollar claims. This error in methodology not only resulted in a sample that was not representative of the full population of claims in this stratum, but also overstated alleged overpayments. Second, OIG did not appropriately select a probe sample for the "Inpatient MCC/CC" stratum, as required by provider audit guidelines from CMS. These errors illustrate the problematic way in which OIG draws samples that are not entirely random and extrapolates these findings across a larger universe of claims, thus resulting in incorrect and overstated overpayment findings.

More significant than these technical errors, however, is the fact that OIG's "Incorrectly Billed as Inpatient" overpayment calculation completely ignores the substantial amount of Part B payment NMH would be entitled to receive if OIG's conclusion that these claims should be treated as outpatient were true. Neither the outside medical reviewer nor the OIG question that these patients received medically necessary services. The only controversy is whether payment should have been made under Part A or Part B.

Ignoring the amount of Part B reimbursement corrupts the validity of the extrapolation. In footnote 3 of the draft report, OIG acknowledges that the overpayment findings do not account for any recoupment due NMH under Part B ("*We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare Administrative Contractor before issuance of our draft report.*") The fact that OIG admits that the overpayment findings are inaccurate and overstated makes the application of extrapolation in this

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category particularly troubling. Thus, the only firm conclusion that can be drawn is that OIG's extrapolation is substantially overstated.

Upon receipt of the preliminary audit findings, NMH contacted NGS to discuss the process for rebilling those claims that OIG contends should have been reimbursed under Part B. At that time, NGS informed NMH that it would not permit any adjustment in specific claims until after the issuance of OIG's final report. NMH urged OIG to take into account estimated Part B payments as an offset to the alleged overpayments, but OIG refused to do so as they considered such estimates to be "*un-auditable.*" The issue regarding Part B reimbursements has been raised in other hospital Medicare compliance reviews and it is concerning that OIG has yet to develop a process by which such payments can be accounted for and reflected in the published findings. As the process stands today, it is clear that the published findings are incomplete. Upon final adjudication of any Part B payment due as well as appeals of individual claims, OIG will need to reflect this adjustment and re-calculate the extrapolation.

Furthermore, NMH has significant concerns with the gross deficiencies in the procedural aspects of the audit. Specifically, NMH received a demand letter from NGS, dated December 29, 2014, for $6,389,095 based on the draft OIG findings. Although OIG has consistently acknowledged that these audit findings were not complete and accurate as a result of its inability to calculate Part B reimbursement owed NMH, OIG decided to send its draft report to CMS to execute on these preliminary findings before giving NMH the opportunity to comment on the report. Thus, NGS issued a demand letter on a report that is not even final on a dollar amount that OIG has acknowledged is substantially overstated.

On numerous occasions throughout this audit, NMH was informed that OIG would send the report to CMS only after the final report was issued, which would include NMH's response. OIG advised NMH that CMS would then send the report to NGS and from there NMH could initiate the process for appeals and, as appropriate, rebilling. This was reiterated when NMH contacted NGS upon receipt of the initial findings to inquire about the process for rebilling those claims that OIG contends should have been reimbursed under Part B and was informed that no such rebilling could occur until the receipt of the ***final*** report from OIG. NMH is very disappointed in the lack of transparency – and arguably lack of due process – with respect to the audit protocols and procedures. NMH strongly urges OIG to assess these processes in order to more effectively coordinate the role of OIG with CMS with respect to the Medicare Compliance Reviews to ensure a more efficient and effective use of government and provider resources.

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Below is NMH's response to OIG's specific findings in the areas reviewed.

Incorrectly Billed as Inpatient

OIG Finding

For 35 of the 98 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services.

As a result of these errors, the Hospital received overpayments of $222,692.

NMH Response

NMH respectfully disagrees with 28 of the 35 claims that OIG asserts were improperly billed as inpatient admissions. NMH believes that the determinations made by OIG and its outside medical review contractor, [redacted], are inaccurate for the reasons detailed below and will appeal these denials.

First, the outside reviewer made its determination with the benefit of hindsight, focusing on the final outcome and disposition of the patient. This approach does not adequately reflect the complex, time-sensitive environment in which hospitals and physicians must make such decisions before the ultimate patient outcome is known. Such decisions require the professional, clinical judgment of the admitting physician. In fact, the Medicare Benefit Policy Manual (an excerpt of which is included on page 4 of the draft report) states:

> *"The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors."*

Such factors *must only be those available to the physician at the time of the admission decision,* including the patient's initial presentation, co-morbidities, and medical history. It is clear that OIG's contracted outside medical reviewers did not conduct their review in light of the information that was available at the time of the admission decision. Further, it is important to point out that the medical necessity of the care provided in these cases is not being challenged; rather, the challenge is solely on whether the medically necessary hospital services should be billed and reimbursed by Medicare under Part A or Part B.

Second, CMS's standards guiding the determination of the appropriate admission status for patients are vague and complex, leaving physicians in a difficult position as they are seeking to make decisions that are in the patient's best interest. CMS acknowledged the difficulty in applying these guidelines through the adoption of the Two-Midnight Rule in October of 2013, which is intended to reduce the ambiguity of

Office of Inspector General Note—We redacted the name of the medical review contractor from the Hospital's comments.

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these standards. Additionally, the recent announcement by CMS of the 68% Settlement Offer for certain claims denied by the Recovery Audit Contractors ("RAC") and similar audits now under appeal recognizes the ambiguities of the prior CMS standards. CMS's offer at least tacitly acknowledges that the review contractors themselves – ***the same contractors that were contracted by OIG for this review*** – frequently reach an incorrect conclusion when they deny inpatient status.

The short-stay inpatient category has been the subject of great controversy and disagreement – both with respect to this audit and by other providers across the country.[1] Indeed, a number of cases OIG and its outside reviewer assert did not meet inpatient criteria are indistinguishable from other cases which were upheld in the review. This further demonstrates the ambiguities in the inpatient admission criteria and an inconsistent application of the guidelines by OIG's outside medical reviewer. Given the confusion around applying these standards, it is patently unreasonable for OIG to pursue such claims, in particular considering that these are the same types of claims that are already routinely reviewed through the RAC audit program. Furthermore, it is important to note that inpatient short stay claims represent the majority of NMH's complex medical review claims since the inception of RAC, for which NMH has an appeal success rate exceeding the 68% settlement offered by CMS. NMH anticipates a similar success rate in its appeal of these 28 cases.

Manufacturer Credit for Replaced Medical Devices Not Obtained or Reported

OIG Finding

For 9 of the 98 sampled claims, the Hospital either received reportable medical device credits from manufacturers for a replaced devices but did not adjust its inpatient claims with the proper condition and value codes to reduce payment as required (3 claims) or did not obtain credits for replaced devices for which credits were available under the terms of the manufacturer's warranty (3 claims).

As a result of these errors, the Hospital received overpayments of $24,250.

NMH Response

NMH generally concurs with the findings in this section. NMH has implemented a process to identify procedures involving the replacement of a medical device, pursue warranty credits from the

[1] For example, see the letter from Richard Pollack of the American Hospital Association to Ms. Kathleen Sebelius, Secretary, US Department of Health and Human Services dated June 2, 2014 and letter from Melinda Hatton of the American Hospital Association to Ms. Gloria Marjon, Deputy Inspector General for Audit Services, Office of Inspector General, US Department of Health and Human Services dated November 20, 2014, both on the subject of "hospital compliance reviews" performed by OIG and extrapolated audit findings, *available at* http://www.aha.org/advocacy-issues/letter/2014/140603-aha-cl-hhs.pdf and http://www.aha.org/advocacy-issues/letter/2014/141124-aha-cl-oig-hhs.pdf.

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manufacturer, and where appropriate, update claims to reflect the required warranty credit information. NMH continues to review processes and improve controls in this area.

Incorrect Discharge Status

OIG Finding

For 2 of the 98 sampled claims, the Hospital incorrectly billed Medicare for patient discharges that should have been billed as transfers.

As a result of these errors, the Hospital received overpayments of $11,065.

NMH Response

NMH generally concurs with the findings for these two claims. NMH has provided additional education to Social Work and Clinical Coding staff regarding the Medicare Post Acute Care Transfer policy and proper prioritization of discharge codes. A departmental policy has been implemented to strengthen controls with the accurate assignment of patient discharge disposition.

Incorrectly Billed Diagnosis-Related Group Codes

OIG Finding

For 13 of the 98 sampled claims, the Hospital billed Medicare with incorrect DRG codes.

As a result of these errors, the Hospital was underpaid $29,481.

NMH Response

NMH generally concurs with the findings in this section that it was underpaid as a result of minor DRG coding differences. NMH has provided additional education to the clinical coding staff and clinical documentation specialists issue queries to providers when necessary to obtain additional information to reflect all diagnoses more accurately. An escalation process has been implemented to facilitate the resolution of queries. In additional, new systems have been implemented for computer-assisted coding and clinical documentation improvement.

Incorrectly Billed Outpatient Services with Modifier -59

OIG Finding

For 7 of the 73 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes, appended with modifier -59, which were already included in the payments for other services billed on the same claim or did not require modifier -59.

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As a result of these errors, the Hospital received overpayments of $26,129.

NMH Response

NMH generally concurs with the findings in this section. NMH has provided and continues to provide additional education to staff on the correct assignment of modifier -59. Additional monitoring and auditing have been incorporated into the annual compliance work plan.

Incorrectly Billed Number of Units

OIG Finding

For 1 of the 73 sampled claims, the Hospital submitted a claim to Medicare with an incorrect number of units for radiation treatment delivery (HCPCS 77371). Based on the NCCI Medically Unlikely Edits, only 1 unit (not 3) can be submitted for HCPCS 77371.

As a result of these errors, the Hospital received an overpayment of $13,523.

NMH Response

NMH generally concurs with the findings in this section. Departmental standard practice is to only charge 1 per day for HCPCS 77371. This single error is attributed to an instance of human error. Patient Accounting has implemented additional controls to assure the accurate assignment of number of units.

Incorrectly Billed Observation Services and Unsupported Charges Resulting in Incorrect Outlier Payments

OIG Finding

For 22 of the 73 samples claims, the Hospital incorrectly billed Medicare for observation hours resulting in incorrect outlier payments.

As a result of these errors, the Hospital received overpayments of $3,723.

NMH Response

NMH generally concurs with the findings in this section. NMH has provided additional education to Utilization Review staff regarding observation hour reporting. Updates have been made to departmental policy to strengthen controls and system updates have been made to facilitate accurate reporting. Additional monitoring and auditing have been incorporated into the annual compliance work plan.

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Insufficiently Documented Services

OIG Finding

For 4 of the 73 samples claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record.

As a result of these errors, the Hospital received an overpayment of $280.

NMH Response

NMH generally concurs with the findings in this section. NMH has provided additional education to staff. In addition, new systems have been implemented for computer-assisted coding and clinical documentation improvement.

Conclusion

NMH is committed to its *Patients First* mission, and consistent with this mission, maintaining a culture of compliance and ensuring integrity of all processes impacting its patients. NMH appreciates the mission of OIG to detect and prevent inaccuracies in billing and reimbursement for federal healthcare programs. However, many of the findings from the *OIG Medicare Compliance Review of Northwestern Memorial Hospital for 2011 and 2012* reflect the vague and ambiguous CMS standards for inpatient Part A reimbursement and then extrapolates such findings in a manner that creates the appearance of abuse, when this is not the case. It bears repeating that at no point in its report does OIG make reference to any service provided as being medically unnecessary or otherwise challenge the quality of the care provided by NMH.

Further, the lack of coordination between OIG and CMS with respect to audit findings and the ultimate determination creates an inefficient process with hospital providers bearing the burden of this inefficiency. NMH urges OIG to review its process and protocols with respect to these Medicare Compliance Reviews in order to focus government and provider resources more effectively. In addition, NMH strongly suggests that extrapolation not be applied in such circumstances where the guidance at the time of the applicable claims was unclear and where the true overpayment findings have not been calculated. Alternatively, to the extent extrapolation is to be applied, NMH strongly urges that it be suspended until final determinations have been made with respect to Part B payments and the appealed claims have reached final adjudication.

In closing, NMH recognizes its obligation to continually improve internal processes to ensure appropriate billing for services provided. NMH continues to improve these areas through education and

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training, and ongoing auditing and monitoring through its compliance program to ensure compliant claims submission.

If you require any additional information or if I can provide any further assistance, please do not hesitate to contact me.

Sincerely,

/Jennifer Wooten Ierardi/

Jennifer Wooten Ierardi
Chief Integrity Executive
Northwestern Memorial HealthCare

CC:
Dean M. Harrison, President & CEO, Northwestern Memorial HealthCare
Peter J. McCanna, Executive Vice President & COO, Northwestern Memorial HealthCare
John A. Orsini, Senior Vice President & CFO, Northwestern Memorial HealthCare
James C. Dechene, Senior Vice President & General Counsel, Northwestern Memorial HealthCare
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