

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF  
UNIVERSITY OF MIAMI HOSPITAL**

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September 2013  
A-04-12-07033

# *Office of Inspector General*

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of claims using computer matching, data mining, and analysis of claims. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected types of claims for inpatient and outpatient services.

University of Miami Hospital (the Hospital) is a 560-bed acute care facility located in Miami, Florida. Medicare paid the Hospital approximately \$223 million for 20,953 inpatient and 24,535 outpatient claims for services provided to beneficiaries during calendar years 2009 and 2010 based on CMS's National Claims History data.

Our audit covered \$22,784,260 in Medicare payments to the Hospital for 2,194 claims that were potentially at risk for billing errors. We selected a stratified random sample of 200 inpatient claims with payments totaling \$2,905,695 for review. These 200 claims had dates of service from April 1, 2009, through December 31, 2010 (audit period).

### **OBJECTIVE**

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient services on selected types of claims.

## **SUMMARY OF FINDINGS**

The Hospital complied with Medicare billing requirements for the majority of the claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 68 inpatient claims resulting in overpayments totaling \$524,009.

Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors.

Based on our stratified random sample results, we estimated that the Hospital received overpayments totaling at least \$3,717,557 for the audit period.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare program \$3,717,557 in estimated overpayments for the audit period that it incorrectly billed for inpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

## **UNIVERSITY OF MIAMI HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital disagreed with our first recommendation. The Hospital contested that it improperly billed five inpatient claims. Furthermore, the Hospital objected to our decision to extrapolate the results from the audit sample. It also stated that it concurred with footnote number 3 (page 5) regarding the possibility of rebilling Medicare Part B for some services and that rebilling could have an effect on the estimated overpayments if adjusted by the Medicare Administrative Contractor (MAC). The issue of whether older claims can be rebilled has been subject to recent scrutiny at various levels; therefore, the Hospital thought OIG should not extrapolate any estimated amounts of overpayments or make any recommendations regarding refunds until the rebilling issue is settled. In regard to our second recommendation, the Hospital discussed steps it had taken or planned to take to strengthen its internal controls to ensure compliance with Medicare billing requirements.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

### **Contested Determinations of Claims**

In response to the Hospital's contestation that it improperly billed five inpatient claims, we obtained an independent medical review of all of these claims for medical and coding errors and our report reflects the results of the review.

## **Rebilling of Medicare Part B Services**

In response to the Hospital's concerns regarding its ability to rebill for certain services that were denied as part of this review, we acknowledge its comments; however, the rebilling issue is beyond the scope of our audit. After the completion of our audit, CMS concurrently issued the proposed rule CMS-1455-P and CMS Ruling 1455-R (78 Fed. Reg. 16614 (Mar. 18, 2013)) for implementing Medicare Appeals Council and Administrative Law Judge decisions and for handling claims and appeals until CMS could issue final regulations. CMS has now issued the final regulations (78 Fed. Reg. 160 (Aug. 19, 2013)). The Hospital should contact its MAC for rebilling instructions.

## **Statistical Sampling**

During the course of the audit, we discussed with Hospital officials our plans to use statistical sampling. As the hospital compliance review initiative has matured, we have refined our audit methodologies. Some reviews use statistical sampling and estimation techniques to draw conclusions about a larger portion of a hospital's claims while other reviews use judgmental sampling. Each hospital review is unique, and the sampling method used in each of these reviews will vary. For this reason, we review different risk areas at different hospitals and use both statistical and non-statistical methods for selecting our samples.

We acknowledge that most previously published compliance reviews did not use statistical sampling and estimation. However, we maintain that the statistical sampling and estimation techniques planned and used for this review are statistically valid methodologies that we have successfully used to identify overpayments. Therefore, we recommend that the Hospital refund to the Medicare program \$3,717,557 in estimated overpayments for the audit period.

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# INTRODUCTION

## BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

### **Hospital Inpatient Prospective Payment System**

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33 and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>1</sup> The OPPS is effective for services furnished on or after August 1, 2000. 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). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.<sup>2</sup> All services and items within an APC group are comparable clinically and require comparable resources.

### **Hospital Claims at Risk for Incorrect Billing**

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG

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<sup>1</sup> In 2009, SCHIP was formally redesignated as the Children's Health Insurance Program.

<sup>2</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

identified these types of hospital claims using computer matching, data mining, and analysis of claims. The types of claims identified included:

- inpatient claims for short stays,
- inpatient claims paid in excess of charges,
- inpatient claims with same-day discharges and readmissions,
- inpatient transfers,
- inpatient manufacturer credits for replaced medical devices, and
- inpatient claims with high-severity-level DRG codes.

For purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.” This review is part of a series of OIG reviews of Medicare payments to hospitals for selected types of claims for inpatient and outpatient services.

### **Medicare Requirements for Hospital Claims and Payments**

Section 1862(a)(1)(A) of 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.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

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

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

### **University of Miami Hospital**

University of Miami Hospital (the Hospital) is a 560-bed acute care facility located in Miami, Florida. Medicare paid the Hospital approximately \$223 million for 20,953 inpatient and 24,535 outpatient claims for services provided to beneficiaries during calendar years (CYs) 2009 and 2010 based on CMS’s National Claims History (NCH) data.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient services on selected types of claims.

### **Scope**

Our audit covered \$22,784,260 in Medicare payments to the Hospital for 2,194 claims that were potentially at risk for billing errors. We selected a stratified random sample of 200 inpatient claims with payments of \$2,905,695 for review. These 200 claims had dates of service from April 1, 2009, through December 31, 2010 (audit period).

We focused our review on the risk areas that we had identified during prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 33 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 areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the NCH file, but we did not assess the completeness of the file.

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

We conducted our fieldwork at the Hospital during August of 2012.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's NCH file for CYs 2009 and 2010;
- removed all claims with dates of service prior to April 1, 2009;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2009 and 2010;
- 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 200 inpatient claims totaling \$2,905,695 for detailed review (Appendix A);
- 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;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- used an independent medical review contractor to determine whether a limited selection of sampled claims met medical necessity and coding requirements;
- calculated the correct payments for those claims requiring adjustments;
- used OIG/Office of Audit Services software to estimate the total overpayment to the Hospital (Appendix B); 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.

## **FINDINGS AND RECOMMENDATIONS**

The Hospital complied with Medicare billing requirements for the majority of the claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 68 inpatient claims resulting in overpayments totaling \$524,009.

Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors.

Based on our stratified random sample results, we estimated that the Hospital received overpayments totaling at least \$3,717,557 for the audit period. See Appendix A for details on our sample design and methodology, Appendix B for our sample results and estimates, and Appendix C for the results of our review by risk area.

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 68 of the 200 inpatient claims that we reviewed. These errors resulted in overpayments totaling \$524,009.

### **Incorrectly Billed as Inpatient**

Section 1862(a)(1)(A) of the Act states 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.”

For 56 of the 200 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed either as outpatient or as outpatient with observation services. These errors occurred because of weaknesses in the Hospital’s review process and turnover in case management leadership. As a result, the Hospital received overpayments totaling \$447,982.<sup>3</sup>

### **Incorrectly Billed as Separate Inpatient Stay**

The Manual, chapter 3, section 40.2.5, states:

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 3 of the 200 inpatient claims, the Hospital incorrectly billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that these errors occurred because of human error in case management, miscommunication with the billing office, and claim-specific filing issues. As a result, the Hospital received overpayments totaling \$33,645.

### **Incorrect Diagnosis-Related Groups**

Section 1862(a)(1)(A) of 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

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<sup>3</sup> 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 or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

or to improve the functioning of a malformed body member.” Chapter 1, section 80.3.2.2, of the Manual requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

For 5 of the 200 inpatient claims, the Hospital billed Medicare for incorrect DRG codes. For one claim, the Hospital stated that this error occurred because the coder did not seek clarification of the physician documentation. The Hospital stated that the remaining four errors occurred because of weaknesses in the review process and turnover in case management leadership. As a result, the Hospital received overpayments totaling \$17,475.

### **Incorrect Discharge Status**

Federal regulations (42 § CFR 412.4(b)) state that a discharge of a hospital inpatient is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge. A hospital that transfers an inpatient under the above circumstance is paid a graduated per diem rate for each day of the patient’s stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 § CFR 412.4(f)).

For 3 of the 200 inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers. The Hospital stated that these errors occurred because of coder error, inconsistent notes within the medical charts, or both. As a result, the Hospital received overpayments totaling \$16,407.

### **Manufacturer Credit for a Replaced Medical Device Not Obtained**

Federal regulations (42 CFR § 412.89) require reductions in the inpatient prospective payment 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 cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

#### *Prudent Buyer Principle*

Pursuant to 42 CFR § 413.9, “All payments to providers of services must be based on the reasonable cost of services ....” The CMS *Provider Reimbursement Manual* (PRM), part 1, § 2102.1, 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.

Section 2103.A of the PRM further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties for medical devices. Section 2103.C.4 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 supplied.

For 1 of the 200 inpatient claims, the Hospital did not obtain a credit for a replaced medical device that was available under the terms of the manufacturer's warranty. The Hospital stated that this error occurred because it lacked clear policies and standard operating procedures. As a result, the Hospital received an overpayment of \$8,500.

## **OVERALL ESTIMATE OF OVERPAYMENTS**

Based on our sample results, we estimated that the Hospital received overpayments totaling at least \$3,717,557 for the audit period. See Appendix A for details on our sample design and methodology and Appendix B for our sample results and estimates.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare program \$3,717,557 in estimated overpayments for the audit period that it incorrectly billed for inpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

## **UNIVERSITY OF MIAMI HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital disagreed with our first recommendation. Concerning our second recommendation, the Hospital discussed steps it had taken or planned to take to strengthen its internal controls to ensure compliance with Medicare billing requirements.

### **Contested Determinations of Claims**

The Hospital contested that it improperly billed five inpatient claims. For these claims, the Hospital did not agree with our error determinations.

### **Rebilling of Medicare Part B Services**

The Hospital stated that it concurred with footnote number 3 (page 5) regarding the possibility of rebilling Medicare Part B for some services and that rebilling could have an effect on the estimated overpayments if adjusted by the Medicare Administrative Contractor (MAC). The

issue of whether older claims can be rebilled has been subject to recent scrutiny at various levels; therefore, the Hospital thought OIG should not extrapolate any estimated amounts of overpayments or make any recommendations regarding refunds until the rebilling issue is settled.

### **Statistical Sampling**

The Hospital disagreed with the decision to extrapolate the results. It stated that it had reviewed past hospital compliance reports and that those reports recommended repayment solely of audited cases, with no extrapolation.

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

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

### **Contested Determinations of Claims**

In response to the Hospital's contestation that it improperly billed five inpatient claims, we obtained an independent medical review of these claims for medical and coding errors, and our report reflects the results of the review.

### **Rebilling of Medicare Part B Services**

In response to the Hospital's concerns regarding its ability to rebill for certain services that were denied as part of this review, we acknowledge its comments; however, the rebilling issue is beyond the scope of our audit. After the completion of our audit, CMS concurrently issued the proposed rule CMS-1455-P and CMS Ruling 1455-R (78 Fed. Reg. 16614 (Mar. 18, 2013)) for implementing Medicare Appeals Council and Administrative Law Judge decisions and for handling claims and appeals until CMS could issue final regulations. CMS has now issued the final regulations (78 Fed. Reg. 160 (Aug. 19, 2013)). The Hospital should contact its MAC for rebilling instructions.

### **Statistical Sampling**

During the course of the audit, we discussed with Hospital officials our plans to use statistical sampling. As the hospital compliance review initiative has matured, we have refined our audit methodologies. Some reviews use statistical sampling and estimation techniques to draw conclusions about a larger portion of a hospital's claims while other reviews use judgmental sampling. Each hospital review is unique, and the sampling method used in each of these reviews will vary. For this reason, we review different risk areas at different hospitals and use both statistical and non-statistical methods for selecting our samples.

We acknowledge that most previously published compliance reviews did not use statistical sampling and estimation. However, we maintain that the statistical sampling and estimation techniques planned and used for this review are statistically valid methodologies that we have successfully used to identify overpayments. Therefore, we recommend that the Hospital refund to the Medicare program \$3,717,557 in estimated overpayments for the audit period.

# **APPENDIXES**

## **APPENDIX A: SAMPLE DESIGN AND METHODOLOGY**

### **POPULATION**

The population is inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during CYs 2009 and 2010.

### **SAMPLING FRAME**

According to CMS's NCH data, Medicare paid the Hospital \$222,934,440 for 20,953 inpatient and 24,535 outpatient claims for services provided to beneficiaries during CYs 2009 and 2010.

We obtained a database of claims from the NCH data totaling \$112,907,650 for 5,780 inpatient and 23,060 outpatient claims in 30 risk areas.

From the 30 risk areas, we selected 6 that consisted of 4,289 claims totaling \$71,828,441. The risk areas are: Inpatient Claims for Short Stays, Inpatient Claims with High-Severity-Level DRG Codes, Inpatient Claims Paid in Excess of Charges, Inpatient Claims with Same-Day Discharges and Readmissions, Inpatient Transfers, and Inpatient Manufacturer Credits for Replaced Medical Devices.

We combined claims from each of the risk areas into a single database. We then removed 2,095 claims totaling \$49,044,181 as follows:

- all claims less than \$100,
- all duplicate claims,
- all claims under review by the Recovery Audit Contractor, and
- all claims with dates of service prior to April 1, 2009.

We further refined the sampling frame for inpatient claims paid in excess of charges, inpatient claims with same-day discharges and readmissions, inpatient transfers, and inpatient manufacturer credits for replaced medical devices.

This resulted in a sampling frame of 2,194 unique Medicare claims totaling \$22,784,260.

### **SAMPLE UNIT**

The sample unit was a Medicare paid claim.

## SAMPLE DESIGN

We used a stratified sample. We divided the sampling frame into six strata based on the risk areas.

## SAMPLE SIZE

We randomly selected 200 sample claims for review.

## SOURCE OF RANDOM NUMBERS

We generated 147 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 and 2. After generating the random numbers for these strata, we selected the corresponding claims from our sampling frame. We selected all claims in strata 3, 4, 5, and 6.

## ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of improper Medicare payments in our sampling frame for the Hospital for the audit period.

**Sampled Claims by Stratum<sup>1</sup>**

<b>Stratum</b>	<b>Risk Area</b>	<b>Number of Claims in Sample Frame</b>	<b>Number of Claims in the Sample</b>
1	Inpatient Claims for Short Stays	971	74
2	Inpatient Claims with High-Severity-Level DRG Codes	1,170	73
3	Inpatient Claims Paid in Excess of Charges	27	27
4	Inpatient Claims with Same-Day Discharges and Readmissions	10	10
5	Inpatient Transfers	3	3
6	Inpatient Manufacturer Credits for Replaced Medical Devices	13	13
	<b>TOTAL</b>	<b>2,194</b>	<b>200</b>

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<sup>1</sup> Each claim can appear in only one stratum.

## APPENDIX B: 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 Overpayments in Sample
1	971	\$8,175,436	74	\$549,048	48	\$325,060
2	1,170	13,215,515	73	963,338	1	2,252
3	27	357,325	27	357,325	12	138,145
4	10	98,424	10	98,424	3	33,645
5	3	29,826	3	29,826	3	16,407
6	13	907,734	13	907,734	1	8,500
<b>Total</b>	<b>2,194</b>	<b>\$22,784,260</b>	<b>200</b>	<b>\$2,905,695</b>	<b>68</b>	<b>\$524,009</b>

### ESTIMATES

#### Estimated Value of Overpayments for the Audit Period *Limits Calculated for a 90-Percent Confidence Interval*

Point Estimate	\$4,462,013
Lower Limit	3,717,557 <sup>1</sup>
Upper Limit	5,208,720

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<sup>1</sup> In accordance with OAS policy, we did not use the results from strata 2 in calculating the estimated overpayments. Instead, we added the actual overpayments from strata 2 (\$2,252) to the lower limit (\$3,715,305) which resulted in an adjusted lower limit of \$3,717,557.

**APPENDIX C: RESULTS OF REVIEW BY RISK AREA**

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Over-payments</b>	<b>Value of Over-payments</b>
<b>Inpatient</b>				
Claims for Short Stays	74	\$549,048	48	\$325,060
Claims Paid in Excess of Charges	27	357,325	12	138,145
Claims With Same-Day Discharges and Readmissions	10	98,424	3	33,645
Transfers	3	29,826	3	16,407
Manufacturer Credits for Replaced Medical Devices	13	907,734	1	8,500
Claims With High-Severity-Level DRG Codes	73	963,338	1	2,252
<b>Inpatient Totals</b>	<b>200</b>	<b>\$2,905,695</b>	<b>68</b>	<b>\$524,009</b>

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 University of Miami 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.



# University of Miami Hospital

July 12, 2013

## Via FedEx and Electronic Submission via E-Mail

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

Report Number A-04-12-07033

Dear Ms. Pilcher:

The University of Miami Hospital ("UMH" or "Hospital") appreciates the opportunity to review and provide comments on the U.S. Department of Health and Human Services, Office of the Inspector General ("OIG") draft report entitled *University of Miami Hospital Substantially Complied With Medicare Billing Requirements for 2009 and 2010* ("report"). UMH is committed to complying with all regulations and standards governing Federal health care programs, improving internal controls and proactively auditing and monitoring to minimize the risk of errors.

UMH's responses to the OIG's specific findings and recommendations are set forth below. Unless otherwise stated, UMH accepts the OIG's findings and will process the necessary adjustments through its Medicare Administrative Contractor.

### **OIG Summary of Findings and Recommendations and UMH Comments**

#### *OIG Summary*

The Hospital complied with Medicare billing requirements for 132 of the 200 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 68 claims resulting in overpayments of \$524,009.

These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors.

Based on our stratified sample results, we estimated that the Hospital received overpayments of \$3,717,557 for the audit period.

*Recommendations*

We recommend that the Hospital:

- refund to the Medicare program \$3,717,557 in estimated overpayments received for incorrectly billed inpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

*UMH Comment*

UMH will continue to strengthen its controls in order to assure full compliance with Medicare billing requirements. UMH remains committed to accurate submission of claims to the Medicare program and conducts auditing, monitoring, and educational activities on a regular basis. These efforts focus on all areas, with particular emphasis on those areas that are identified as at risk by the OIG and other regulatory agencies. UMH will continue to make accurate claim submission a primary component of the organization's compliance program. It acknowledges and appreciates the cooperative efforts of the OIG auditors on this matter and the practical guidance derived from those interactions.

Except as otherwise noted in the section below related to incorrectly billed inpatient claims, UMH does not dispute the findings set forth in Appendix B of the report regarding the value of the overpayments identified in the six samples. With respect to those identified overpayments the University of Miami Hospital will take the appropriate actions to refund any overpayments received, taking into consideration that the total amount refunded may vary based upon factors raised in this response that may impact the actual amount due to the Medicare program.

Respectfully, however, UMH does have specific comments and concerns regarding the nature, scope, and methods used in the extrapolation that resulted in the estimated overpayments and recommended refunds. It submits that the decision to extrapolate should be reconsidered and the recommended refund modified.

**FINDINGS AND COMMENTS:****Incorrectly Billed as Inpatient***OIG Finding*

For 56 of the 200 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed either as outpatient or as outpatient with observation services. These errors occurred because of weaknesses in the Hospital's review process and turnover in case management leadership. As a result, the Hospital received overpayments of \$447,982.3

*Hospital Comments:*

With respect to these risk areas, the hospital has taken the following actions:

1. Electronic InterQual review at the time of admission and continuously throughout the patient admissions as needed for continued stay.
2. All Medicare accounts with LOS 3 days or less are placed on an automatic bill hold and are not released for billing until reviewed for appropriateness by Case Management.
3. A formal work queue has been developed and implemented to facilitate better tracking, monitoring and communication among the Billing Office and Case Management.
4. The role of Physician Advisor has been re-defined to include more active engagement in short stay reviews and assistance in resolving status conflicts with admitting physicians.
5. Quarterly audits of short stay accounts are being performed by the UHealth Billing Compliance office.

*Additional Comments:*

The hospital respectfully disagrees with the findings of OIG and its focused medical reviewers regarding the following claims/case numbers: A-02;A-16; A-29; A-35; and A-51. A re-determination that these were proper inpatient claims would reduce the amount due for that claim category, and would reduce any extrapolation derived in part from those estimates. In addition, footnote 3 on page 5 of the report States that the Hospital may be able to re-bill Medicare Part B for some services as reasonable and necessary outpatient services. UMH concurs in this observation and would welcome the opportunity to do so. Nevertheless, OIG's position throughout the course of the audit has been that these charges could not be re-billed because they were from a period of time more than one year from the date of service. Also, the audit team understandably instructed UMH that no readjustment or other actions related to the claims under review should occur while the audit was pending and that such re-billing was an issue that should be addressed at the CMS level. This acknowledgement, however, that rebilling may have an effect on the estimated overpayment, if and when rebilled and adjusted by the Medicare administrative contractor, is a basis to choose not extrapolate any estimated amounts of overpayments or make any recommendation as to refunds until the re-billing issue has been appropriately raised and determined in an appropriate forum. This issue—whether older claims that are subject to review can be re-billed after such review, including in part the category of the inpatient claims at issue – have been subject to recent scrutiny and activity at the level of CMS, administrative law judges and the federal courts. This uncertainty is a further basis to allow these issues to be considered prior to making a recommendation regarding estimated amounts. .

**Incorrectly Billed as Separate Inpatient Stay**

*OIG Findings:*

For 3 of the 200 inpatient claims, the Hospital incorrectly billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that these errors occurred because of human error in case management, miscommunication with the billing office, and claim-specific filing issues. As a result, the Hospital received overpayments of \$33,645.

*Hospital Comments:*

The Billing Office reviews patient accounts daily prior to billing to identify those accounts with a discharge and an admission within the same 24 hour period (Inpatient/Inpatient overlap). A bill hold is placed on any accounts that are identified as potential Inpatient / Inpatient overlap. Each account is reviewed by Case Management to determine whether the claims needed to be combined prior to releasing the bill hold.

Case Management reviews all accounts identified at risk for overlap with a second review as needed for discrepancies. A determination not to combine overlapping accounts requires review, approval, and documentation by the Physician Advisor. Outcomes of all inpatient overlapping accounts are presented to the Utilization Review Committee.

Compliance issues will be added to the agenda for monthly service calls with the Billing Office. The UHealth Billing Compliance office will participate on those calls in the future.

### **Incorrect Diagnosis-Related Groups**

#### *OIG Findings:*

For 5 of the 200 inpatient claims, the Hospital billed Medicare for incorrect DRG codes. For one claim, the Hospital stated that this error occurred because the coder did not seek clarification of the physician documentation. The Hospital stated that the remaining four errors occurred because of weaknesses in the review process and turnover in case management leadership. As a result, the Hospital received overpayments of \$17,475.

#### *Hospital Comments:*

With regard to DRG accuracy, the hospital implemented a Clinical Documentation Program with the hiring of four (4) Clinical Documentation Specialists in July 2012. The specialists concurrently review the medical record documentation for clarity with a physician prior to the discharge of the patient. The cornerstone of the program is continuous education and timely feedback to the clinical providers.

In addition, coders have been educated regarding best practices with physician queries.

### **Incorrect Discharge Status**

#### *OIG Findings*

For 3 of the 200 inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers. The Hospital stated that these errors occurred because of coder error, inconsistent notes within the medical charts, or both. As a result, the Hospital received overpayments of \$16,407.

#### *Hospital Comments:*

For clarity, the prior case management weakness related solely to the inpatient issues and was not part of the DRG response regarding Stratum 3. In addition, the response to one of the inpatient claims strata identified an issue with CMS processing of the claim rather than a billing error.

UMH has completed and/or initiated the following corrective actions for inpatient transfers:

- Education and training has been provided to all full time coders
- SOPs for training of per diem coders have been updated to include targeted education for inpatient transfers
- Review of Discharge Disposition status has been added to the monthly monitoring plan for Case Management with outcomes being presented to the Utilization Review (UR) Committee.

### **Manufacturer Credit for a Replaced Medical Device Not Obtained**

#### *OIG Findings:*

For 1 of the 200 inpatient claims, the Hospital did not obtain a credit for a replaced medical device that was available under the terms of the manufacturer's warranty. The Hospital stated that this error occurred because it lacked clear policies and standard operating procedures. As a result, the Hospital received an overpayment of \$8,500 on this claim.

#### *Hospital Comments:*

As a result of the OIG audit, we have completed a review of our processes and have taken the following actions:

1. Drafted a UMH policy for the relevant clinical service lines and laboratories. Completion of the policy and presentation to the hospital governance committee is expected in the late summer with implementation to follow.
2. Designed and implemented a monitoring and auditing plan to assure accuracy going forward.

### **OIG Overall Estimate of Overpayments**

Based on our sample results, we estimated that the Hospital received overpayments of \$3,717,557 for the audit period.

#### *OIG Recommendations*

We recommend that the Hospital:

- refund to the Medicare program \$3,717,557 in estimated overpayments received for incorrectly billed inpatient claims and
- strengthen controls to ensure full compliance with Medicare requirements.

#### *Hospital's Response to Recommendations*

As stated in the report, unrelated prior OIG audits, investigations, and inspections identified certain hospital claims that are at risk for non-compliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis techniques including six listed areas that, for purposes of the report were referred to as "risk areas (report at 1-2). Those risk areas served as the basis for the audit review of the Hospital. The report acknowledges that "this review is part of a series of OIG reviews of Medicare Payments to hospitals for selected types of claims for inpatient and outpatient services.

UMH disagrees with the decision to extrapolate the results from the audit sample. We have reviewed the published reports relating to audits of other hospitals on the same issues considered here. Almost without exception, those audits recommended repayment solely of audited cases, with no extrapolation. There is no reasoned basis for treating UMH differently, especially in view of the fact that the results in those others are comparable to the proposed findings for UMH. The lack of clarity regarding the standards for short stays and the controversy over rebilling also argues strongly against extrapolation.

Despite the objections above and that follows, which UMH hereby reserves, UMH recognizes its obligations and reconfirms its commitment to appropriately interpret and bill services and appreciates the opportunity to learn from the items highlighted in the review and will continue to use the outcomes of this audit as a guideline for further process improvement.

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

Sincerely,

Darryl Caulton  
Chief Financial Officer  
University of Miami Hospital

cc: Pascal Goldschmidt, M.D., Senior Vice President for Medical Affairs and Dean, University of Miami - Miller School of Medicine, Chief Executive Officer, University of Miami Health System  
Joe Natoli, Interim Chief Operating Officer, University of Miami Miller School of Medicine  
Jennifer McCafferty-Cepero, Ph.D., Chief Medical Compliance Officer, University of Miami Miller School of Medicine