

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF  
FLORIDA HOSPITAL ORLANDO FOR THE  
PERIOD JANUARY 1, 2011, THROUGH  
JUNE 30, 2012**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*Florida Hospital Orlando did not fully comply with Medicare requirements for billing inpatient services, resulting in overpayments of at least 11.5 million over 1½ years.*

### WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 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 Florida Hospital Orlando (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 a 1,080-bed acute care facility located in Orlando, Florida. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$647 million for 79,750 inpatient and 343,077 outpatient claims for services provided to beneficiaries from January 1, 2011, through June 30, 2012 (audit period).

Our audit covered \$80,159,280 in Medicare payments to the Hospital for 10,934 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 215 inpatient claims with payments totaling \$1,603,083. These 215 claims had dates of service during the audit period. We did not select any outpatient claims for review.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 121 of the 215 inpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 94 claims, resulting in overpayments of \$493,893 for the audit period. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$11,512,530 for the audit period.

## **WHAT WE RECOMMEND**

We recommend that the Hospital:

- refund to the Medicare contractor \$11,512,530 in estimated overpayments for the audit period for claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare requirements.

## **FLORIDA HOSPITAL ORLANDO COMMENTS**

In written comments on our draft report, the Hospital did not agree with our recommendations. Regarding our first recommendation, the Hospital disagreed that it improperly billed 79 of the 94 inpatient claims that we stated did not fully comply with Medicare billing requirements. For these claims, the Hospital contended that, either the coding was proper and consistent with Medicare guidance or the services met medical necessity for inpatient stays. Regarding our second recommendation, the Hospital stated that none of the findings resulted from an incomplete understanding of the current rules and regulations or from a failure to have a proactive compliance program. It also stated that it has corrective actions in place that are focused on its continuing commitment to existing compliance efforts. In addition, the Hospital suggested that we characterize our findings as preliminary and subject to adjustment for the Part B payments. Finally, it objected to the lack of clarity in the findings and to the use of sampling and extrapolation to calculate the overpayment.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

In response to the Hospital's disagreement that it improperly billed 79 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 that review. Regarding our extrapolation methodology and statistical validity, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare. We acknowledge that the Hospital may rebill Medicare for the incorrectly billed inpatient claims; however, rebilling is beyond the scope of our audit. CMS has issued the final regulations on payment policies (78 Fed. Reg. 160 (Aug. 19, 2013)), and the Hospital should contact its Medicare contractor for rebilling instructions.

Therefore, we continue to recommend that the Hospital refund to the Medicare contractor \$11,512,530 in estimated overpayments and continue to 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 other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 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 Florida Hospital Orlando (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 contractors to, among other things, process and pay claims submitted by hospitals.

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

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

#### **Hospital 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). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services

within each APC group.<sup>1</sup> 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 claims paid in excess of charges,
- inpatient claims with cancelled surgical procedures,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims billed for kyphoplasty services,<sup>2</sup>
- inpatient transfers, and
- inpatient psychiatric facility emergency department adjustments.

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-

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<sup>1</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

<sup>2</sup> Also called “balloon kyphoplasty,” this procedure is used to treat compression fractures of the spine. See National Institutes of Health’s “Medline Plus” Web site. Available online at <http://www.nlm.nih.gov/medlineplus/ency/article/007511.htm>. Accessed on August 19, 2014.

04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

## **Florida Hospital Orlando**

The Hospital is a 1,080-bed acute care facility located in Orlando, Florida. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately \$647 million for 79,750 inpatient and 343,077 outpatient claims for services provided to beneficiaries from January 1, 2011, through June 30, 2012 (audit period).

### **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$80,159,280<sup>3</sup> in Medicare payments to the Hospital for 10,934 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 215 inpatient claims with payments totaling \$1,603,083. These 215 claims had dates of service during our audit period. We did not select any outpatient claims for review.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 107 claims to medical and coding reviews to determine whether the services were medically necessary and properly coded.

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

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

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

### **FINDINGS**

The Hospital complied with Medicare billing requirements for 121 of the 215 inpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 94 claims, resulting in overpayments of \$493,893 for the audit period. These errors occurred primarily because the Hospital did not have adequate controls to

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<sup>3</sup> This was the dollar value of our sample frame at the time of the initial data extraction from the NCH. However, during the course of our review, the Medicare contractor adjusted some of the claims in our sample frame, including sampled claims, due to mass wage-index adjustments. Therefore, we reviewed the 215 sample items and determined which ones were adjusted. The sample results include the adjusted claims' paid amounts.

prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$11,512,530 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.

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

The Hospital incorrectly billed Medicare for 94 of 215 sampled inpatient claims, which resulted in overpayments of \$493,893.

### **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)).

For 74 of the 215 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. The Hospital stated that the claims it agreed were in error occurred due to a lack of timely review. As a result of these errors, the Hospital received overpayments of \$453,960.<sup>4</sup>

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

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

For 13 of the 215 selected claims, the Hospital submitted claims to Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. For example, the Hospital submitted a claim with a secondary diagnosis of rib fracture. However, the medical record did

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<sup>4</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 and adjudicated by the Medicare administrative contractor prior to the issuance of our report.

not support the coding of this diagnosis.<sup>5</sup> By including this secondary diagnosis, the Hospital's Medicare reimbursement increased because the weight of the DRG increased,<sup>6</sup> which resulted in an overpayment. These errors occurred because the hospital did not ensure that the codes submitted were substantiated by the medical record documentation during the pre-billing audits. As a result of these errors, the Hospital received overpayments of \$32,452.

### **Incorrect Discharge Status**

Federal regulations state that a discharge of a hospital inpatient is considered to be a transfer for purposes of payment if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital paid under the IPPS (42 CFR § 412.4(b)). 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)). This policy is also effective for patients who leave against medical advice. For patients who are admitted to another IPPS hospital on the same day they leave an IPPS hospital, the "transferring" hospital will be subject to the payment outlined by the transfer policy (*CMS Manual System, Medicare Claims Processing*, Pub. 100-04, Transmittal 87).

For 2 of the 215 inpatient claims, Medicare overpaid the Hospital for claims billed to Medicare for discharged patients that were readmitted the same day to other hospitals paid under the IPPS because the Hospital received the full DRG payment instead of the graduated per diem payment. The Hospital stated that it had no knowledge of the patients being readmitted the same day to another IPPS hospital because they left the Hospital against medical advice. However, because the policy is also effective for patients who leave against medical advice, Medicare should have paid the Hospital the graduated per diem payment instead of the full DRG payment, even though the Hospital was unaware at the time that other hospitals had readmitted the patients. These errors occurred because the Hospital was unaware, at the time that it originally submitted the claims, that the patients were readmitted on the same day to other hospitals paid under the IPPS. As a result, the Hospital received overpayments of \$7,132.

### **Incorrect Source-of-Admission Code**

CMS increases the Federal per diem rate for the first day of a Medicare beneficiary's Inpatient Psychiatric Facility (IPF) stay to account for the costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary used emergency department services. Federal regulations state that the IPF should

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<sup>5</sup> According to the independent medical review contractor, the secondary diagnosis code of rib fracture was not substantiated because the discharge summary, history and physical examination report, consultation reports, and progress notes did not indicate a current rib fracture.

<sup>6</sup> Each DRG has a payment weight assigned to it on the basis of the average resources used to treat Medicare patients in that DRG.

not receive the additional payment if the beneficiary was discharged from the acute care section of the same hospital (42 CFR § 412.424 and the Manual, chapter 3, § 190.6.4). The Manual also states that IPFs report source-of-admission code “D” to identify patients who have been transferred to the IPF from the same hospital (chapter 3, § 190.6.4.1). An IPF’s proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

For 5 of the 215 inpatient claims, the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to its IPF upon discharge from its acute care section. The Hospital stated that these errors occurred because its system edits did not process the claims correctly. Specifically, its system edits did not receive a timely update, and the source-of-admission code “D” was not used. As a result of these errors, the Hospital received overpayments of \$349.

## **OVERALL ESTIMATE OF OVERPAYMENTS**

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$11,512,530 for the audit period.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$11,512,530 in estimated overpayments for the audit period for claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare requirements.

## **FLORIDA HOSPITAL ORLANDO COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

### **FLORIDA HOSPITAL ORLANDO COMMENTS**

In written comments on our draft report, the Hospital did not agree with our recommendations. Regarding our first recommendation, the Hospital disagreed that it improperly billed 79 of the 94 inpatient claims that we stated did not fully comply with Medicare billing requirements. For these claims, the Hospital contended that either the coding was proper and consistent with Medicare guidance or the services met medical necessity for inpatient stays. Regarding our second recommendation, the Hospital stated that none of the findings resulted from an incomplete understanding of the current rules and regulations or from a failure to have a proactive compliance program. In addition, the Hospital suggested that we characterize our findings as preliminary and subject to adjustment for the Part B payments. Finally, it stated that there is no fundamental flaw in the Hospital’s systems or processes, and it has corrective actions in place that are focused on its continuing commitment to existing compliance efforts.

In addition, the Hospital objected to the lack of clarity in the findings and to the use of sampling and extrapolation to calculate the overpayment. It stated that:

- due process requires availability of timely challenge to statistical sampling foundation,
- there is no authority for sampling without a finding of a sustained or high error rate, and
- there is insufficient documentation of the sampling methodology to satisfy Medicare guidance.

We included the Hospital's comments as Appendix E; however, we did not include the attachments because they were too voluminous. In addition, we redacted from the comments the name of the medical review contractor.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

### **Contested Determinations of Claims**

In response to the Hospital's disagreement that it improperly billed 79 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 that review.

### **Statistical Sampling and Extrapolation**

Regarding our extrapolation methodology and statistical validity, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare. Additionally, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology. *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). 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.

Furthermore, no statutory or other authority limits OIG's ability to recommend to CMS a recovery based upon sampling and extrapolation.

Generally, the use of statistical sampling and extrapolation to determine overpayment amounts in Medicare does not violate due process because the auditee is given the opportunity to appeal the audit results through the Medicare appeals process. *See Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at \*34 (S.D. Tex. 2012). Concerns about any delays in CMS's hearing of appeals should be taken up with CMS should it decide to adopt all or part of our

recommendations. It remains OIG's statutory obligation to determine, using the tools available to us, the accuracy of payments to Medicare providers.

We acknowledge that the Hospital may rebill Medicare for the incorrectly billed inpatient claims; however, rebilling is beyond the scope of our audit. CMS has issued the final regulations on payment policies (78 Fed. Reg. 160 (Aug. 19, 2013)), and the Hospital should contact its Medicare contractor for rebilling instructions. As stated in the report, we were unable to determine the effect that billing Medicare Part B would have had on the overpayment amount because the Hospital had not billed, and the Medicare contractor had not adjudicated, these services prior to the issuance of our report.

In response to the Hospital's objection to the lack of transparency in the sampling methodology used in this case, we provided the Hospital with a copy of our approved sample plan, which contained a detailed description of the sample design and methodology. In addition, we provided the Hospital with the information from the OIG/OAS statistical software, including the random number files and the sampling frame from which we drew the sample units.

### **Clarity of the Findings**

In response to the Hospital's comparing the results of this audit with the results of an audit of another hospital, each hospital review is unique, and the sampling method used in each of these reviews will vary. As a result, the refinement of our audit methodologies will also vary.

Therefore, we continue to recommend that the Hospital refund to the Medicare contractor \$11,512,530 in estimated overpayments and continue to strengthen controls to ensure full compliance with Medicare requirements.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered \$80,159,280<sup>7</sup> in Medicare payments to the Hospital for 10,934 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 215 inpatient claims with payments totaling \$1,603,083. These 215 claims had dates of service from January 1, 2011, through June 30, 2012 (audit period). We did not select any outpatient claims for review.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 107 claims to medical and coding reviews to determine whether the services were medically necessary and properly coded.

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 fieldwork at the Hospital during July of 2013.

### **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 the audit period;
- removed all claims with dates of services after June 30, 2012;
- 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 215 inpatient claims totaling \$1,603,083 for detailed review (Appendix B);

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<sup>7</sup> See footnote 3.

- 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 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 utilization management and coding patient records;
- used an independent contractor and the Medicare Administrative Contractor to determine whether 107 sampled claims met medical necessity requirements and were properly coded;
- 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 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

We obtained a database of claims from CMS's NCH data totaling approximately \$379 million for 28,975 inpatient and 154,546 outpatient claims in 24 risk areas.

From these 24 risk areas, we selected 7 inpatient risk areas consisting of 19,309 claims totaling \$130,278,229 for further refinement. We did not select any outpatient risk areas for review.

We performed data analyses of the claims within each of the seven risk areas and removed the following:

- \$0 paid claims;
- claims duplicated within individual risk areas by assigning each inpatient claim that appeared in multiple risk areas to just one category based on the following hierarchy:
  - Inpatient Transfers,
  - Inpatient Psychiatric Facility Emergency Department Adjustments,
  - Inpatient Claims Billed for Kyphoplasty Services,
  - Inpatient Claims With Cancelled Surgical Procedures,
  - Inpatient Claims Paid in Excess of Charges,
  - Inpatient Short Stays, and
  - Inpatient Claims Billed With High-Severity-Level DRG Codes; and
- claims under review by the Recovery Audit Contractor as of May 12, 2013.<sup>8</sup>

Removing these claims resulted in a sampling frame of 10,934 unique Medicare claims in 7 risk areas totaling \$80,159,280.<sup>9</sup>

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<sup>8</sup> To ensure that our overpayment extrapolation is valid, any sample items that have been reviewed or are currently under review by a RAC will be treated as non-errors. This adjustment results in a valid overpayment estimate regardless of when the RAC claims are identified. As an extra precaution, repayment of claims in the sampling frame reviewed by the RAC will be subtracted from the total overpayments.

<sup>9</sup> See footnote 3.

### Risk Areas Sampled

Risk Area	Number of Claims	Amount of Payment
Inpatient Claims Billed With High-Severity-Level DRG Codes	7,408	\$59,795,129
Inpatient Short Stays	3,478	19,874,392
Inpatient Claims Paid in Excess of Charges	30	378,114
Inpatient Claims with Cancelled Surgical Procedures	9	38,692
Inpatient Psychiatric Facility Emergency Department Adjustments	5	32,967
Inpatient Claims Billed for Kyphoplasty Services	2	22,378
Inpatient Transfers	2	17,608
<b>Total</b>	<b>10,934</b>	<b>\$80,159,280<sup>10</sup></b>

#### SAMPLE UNIT

The sample unit was a Medicare paid claim.

#### SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into seven strata based on the risk area. All claims are unduplicated, appearing in only one area and only once in the entire sampling frame.

#### SAMPLE SIZE

We selected 215 claims for review as follows:

#### Sampled Claims by Stratum

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Claims Billed With High-Severity-Level DRG Codes	7,408	84
2	Inpatient Short Stays	3,478	83
3	Inpatient Claims Paid in Excess of Charges	30	30
4	Inpatient Claims with Cancelled Surgical Procedures	9	9

<sup>10</sup> See footnote 3.

5	Inpatient Psychiatric Facility Emergency Department Adjustments	5	5
6	Inpatient Claims Billed for Kyphoplasty Services	2	2
7	Inpatient Transfers	2	2
	<b>Total</b>	<b>10,934</b>	<b>215</b>

### **SOURCE OF RANDOM NUMBERS**

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

### **METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the claims within strata one and two. After generating the random numbers for these strata, we selected the corresponding claims in each stratum. We selected all claims in strata three through seven.

### **ESTIMATION METHODOLOGY**

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

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**SAMPLE RESULTS**

<b>Stratum</b>	<b>Frame Size (Claims)</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Incorrectly Billed Claims in Sample</b>	<b>Value of Overpayments in Sample</b>
1	7,408	\$59,795,129	84	\$665,094	12	\$28,915
2	3,478	19,874,392	83	447,731	51	277,523
3	30	378,114	30	378,569	13	118,883
4	9	38,692	9	38,713	9	38,713
5	5	32,967	5	32,967	5	349
6	2	22,378	2	22,378	2	22,378
7	2	17,608	2	17,631	2	7,132
<b>Total</b>	<b>10,934</b>	<b>\$80,159,280<sup>11</sup></b>	<b>215</b>	<b>\$1,603,083</b>	<b>94</b>	<b>\$493,893</b>

**ESTIMATES**

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

Point Estimate	\$14,366,741
Lower Limit	11,512,530
Upper Limit	17,220,951

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<sup>11</sup> See footnote 3.

**APPENDIX D: 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>				
Short Stays	83	\$447,731	51	\$277,523
Claims Paid in Excess of Charges	30	378,569	13	118,883
Claims with Cancelled Surgical Procedures	9	38,713	9	38,713
Claims Billed With High-Severity-Level DRG Codes	84	665,094	12	28,915
Claims Billed for Kyphoplasty Services	2	22,378	2	22,378
Transfers	2	17,631	2	7,132
Psychiatric Facility Emergency Department Adjustments	5	32,967	5	349
<b>Inpatient Totals</b>	<b>215</b>	<b>\$1,603,083</b>	<b>94</b>	<b>\$493,893</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 the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

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October 22, 2014

## VIA FEDEX & E-MAIL

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

**Re: RESPONSE TO OIG DRAFT REPORT: A-04-13-07043  
Florida Hospital Orlando**

Dear Ms. Pilcher:

On behalf of Florida Hospital Orlando (Florida Hospital or Hospital), King & Spalding, LLP respectfully submits this letter, along with the attached Appendices in response to the draft report issued by the U.S. Department of Health & Human Services, Office of Inspector General (OIG), entitled *Medicare Compliance Review of Florida Hospital Orlando for the Period January 1, 2011, through June 30, 2012* (Draft Report). In accordance with the instructions in the September 23, 2014 letter transmitting the Draft Report, this timely response sets forth the Hospital's written comments regarding the Draft Report, including the Hospital's statements of concurrence or non-concurrence with the OIG's recommendations.

### EXECUTIVE SUMMARY OF RESPONSE

The Hospital disagrees with the OIG's review, findings and conclusions and we detail these disagreements below. In summary, the Hospital's objections fall into five general areas.

**Medical Necessity** – Florida Hospital does not concur with many of the medical review determinations of the OIG and its contractor. The Hospital has robust and extensive procedures in place to ensure the care it provides is “medically necessary.” Each claim at issue in this case is accompanied by documentation establishing that necessity through specific medical information on each patient, including presenting conditions, diagnoses, co-morbidities, medications, prior medical issues and prognosis.

***Statistical Extrapolation*** – There is no assertion in the Draft Report that the clinical services at issue were not rendered or were not clinically indicated, or that the Hospital has a sustained or high level of payment error. Accordingly, the OIG findings do not support the use of statistical sampling to extrapolate an overpayment.

***Calculation of Extrapolated Overpayment*** – Florida Hospital asserts that the OIG’s extrapolation of an overpayment is not authorized by statute or regulation. The OIG’s recommendation that reimbursement should be denied in its entirety because services were rendered to an individual designated as an inpatient, instead, as the OIG’s reviewer deemed, as an outpatient, is neither a fair, nor an accurate application of Medicare payment rules. To make multi-million dollar recoupment recommendations without addressing the availability of Part B billing is unmerited and contrary to law.

***Compliance Systems*** – Florida Hospital contests the finding that the Hospital did not perform a timely review of its Medicare claims or that it otherwise failed to exercise due care in ensuring compliance with Medicare guidance. Moreover, Florida Hospital objects to the finding that the Hospital did not have adequate internal controls to prevent incorrect billing of Medicare claims in the OIG’s selected risk areas.

***Lack of Clarity in OIG’s Findings*** – There is a fundamental lack of clarity in the findings as the audit design, the selection of statistical strata, and the Draft Report all differ in the categories of the cases selected for review. Moreover, there was only general information provided on how the statistical sampling design was developed and executed, leading the Hospital to question whether the sampling methods support an extrapolated overpayment.

## **I. BACKGROUND**

The OIG’s audit of Florida Hospital is part of a series of hospital compliance reviews in which the OIG has utilized computer matching, data mining, and other data analysis techniques to identify hospital inpatient and outpatient claims that OIG asserts are at risk for noncompliance with Medicare billing requirements. Based on work with other hospitals, the OIG identified seven types of hospital inpatient claims that it asserts are at risk for noncompliance. These “risk areas” are:

- Inpatient claims billed with high-severity-level DRG codes
- Inpatient short stays
- Inpatient claims paid in excess of charges
- Inpatient claims with cancelled elective surgical procedures
- Inpatient psychiatric emergency department adjustments
- Inpatient short stays involving kyphoplasty services
- Inpatient transfer

The OIG focused its audit of the Hospital’s inpatient claims on these seven risk areas for dates of service from January 1, 2011, through June 30, 2012 (the “Audit Period”). No outpatient claims were included in the OIG’s study.

For the Audit Period, the Draft Report states that the Hospital received a total of \$80,159,280 in Medicare payments for 10,934 claims that were potentially at risk for billing errors (the “Universe”). Based on a stratified random sample selection from the Universe, the OIG selected for review a sample of 215 inpatient claims totaling reimbursement of \$1,603,083. The OIG assigned each claim in the sample to one of seven strata based on the seven risk areas identified for review. Thus,

Stratum	Medicare Risk Area	Sample Size
1	Inpatient Claims Billed with High Severity Level DRG Codes	84
2	Inpatient Short Stays	83
3	Inpatient Claims Paid in Excess of Charges	30
4	Inpatient Claims with Cancelled Elective Surgical Procedures	9
5	Inpatient Psychiatric Facility Emergency Department Adjustments	5
6	Inpatient Short Stays Involving Kyphoplasty	2
7	Inpatient Transfers	2
	<b>Total Sampled Claims</b>	<b>215</b>

Of the 215-claim sample, the OIG subjected 107 claims, which OIG initially found to be in error, to additional medical and coding reviews by its contractor, [REDACTED]. [REDACTED] disagreed with some of the OIG’s initial findings and recommended that several claims that had been slated for denial remain covered.

## II. OIG DRAFT REPORT

In its Draft Report, the OIG adopted the [REDACTED] changes and concluded that the Hospital complied with Medicare billing requirements for 121 of the 215 inpatient claims reviewed, but had not satisfied such requirements for the remaining 94 claims. According to the Draft Report, errors associated with the 94 claims resulted in a claims-based overpayment to the Hospital of \$493,893 for the Audit Period.

Rather than organizing its findings by risk area or even by strata, the Draft Report summarized the alleged errors found in the claims in four categories, as follows:

- *Services Incorrectly Billed as Inpatient* – The OIG alleged that the Hospital incorrectly billed Medicare Part A for seventy-four (74) of the 215 inpatient claims for beneficiary stays that should have been billed as outpatient or outpatient with observation services. This billing purportedly resulted in overpayments to the Hospital of \$453,960,

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

however, the OIG acknowledged that it did not reduce the overpayment amount by Part B payments that should be available for the services rendered.

- *Incorrectly Billed Diagnosis-Related-Group Codes* – The OIG found that the Hospital submitted thirteen (13) of the 215 claim sample with incorrect codes that resulted in higher DRG payments to the Hospital. The OIG found that the alleged errors resulted in an overpayment to the Hospital of \$32,452.

- *Incorrect Discharge Status* – For two (2) claims, the OIG found that the Hospital incorrectly billed Medicare for discharges instead of transfers to another IPPS hospital. As a result, the Hospital received the full DRG payment instead of the adjusted per diem payment. The Hospital had no knowledge that the patients were readmitted the same day to another IPPS hospital because the patients had left the Hospital against medical advice. Nevertheless, the OIG alleged that the Hospital received an overpayment of \$7,132 for these two claims.

- *Incorrect Source of Admission Code* – For five (5) claims, the OIG found that the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to its inpatient psychiatric facility (IPF) upon discharge from its acute care section. The claims did not include source-of-admission code “D” to identify patients who have been transferred to an IPF from the same hospital, which code alerts the contractor not to apply the emergency department adjustment. As a result of this coding error, the OIG alleged that the Hospital received an overpayment of \$349.

According to the Draft Report, the 94 claims “errors” resulted in actual overpayments totaling \$493,893. The OIG then projected its findings with respect to claims assigned to the first two of the seven strata to reach an extrapolated overpayment amount of \$11,512,530.

Based on its findings, the OIG recommends that the Hospital:

- Refund to the Medicare contractor \$11,512,530 in estimated overpayments for the audit period for claims that it allegedly incorrectly billed; and
- Strengthen controls to ensure full compliance with Medicare requirements.

### **III. FLORIDA HOSPITAL ORLANDO’S RESPONSE**

The Hospital has included in the enclosed Appendices, its defense of the claims for which it does not concur with the OIG’s findings. In addition, the Hospital has the following objections.

#### **A. Florida Hospital Does Not Concur with the OIG’s Determinations Regarding Coding on High Severity DRGs**

The Hospital contests twelve (12) of the thirteen (13) claims that the OIG found were billed with incorrect DRGs. *See Appendix A-1.* The Hospital contends that the coding was proper and consistent with Medicare guidance.

Ironically, the case specifically referenced by the OIG in its Draft Report is a particularly clear example showing the proposed denial to be clearly erroneous. The OIG incorrectly asserts that the medical record did not support the Hospital's coding of a secondary diagnosis of rib fracture on a claim. Yet, documentation in the record shows radiology studies performed upon admission identified an acute or subacute fracture of the 9<sup>th</sup> rib laterally. Progress notes further indicate that the rib fracture was secondary to a fall and that there was right upper quadrant tenderness near the fracture, which was treated with pain medication. The Hospital's coding of the secondary diagnosis of rib fracture is thereby substantiated by the medical record documentation. The OIG must question the accuracy of its coding review where, as here, the reviewer overlooked clearly observable patient symptoms.

The Hospital denies that coding errors are the result of any deficiency in its coding capabilities. The Hospital has a robust internal coding claims audit process, with quality controls that monitor the accuracy of its coding. It offers proactive routine education and training, including training on issues identified where it appears that specific policies and procedures have not been followed. This education and training is provided to ensure that all persons involved in coding have a complete understanding of the defined processes and associated regulatory and coding requirements.

**B. Florida Hospital Does Not Concur with the OIG's Determinations of Medical Necessity on Inpatient Stays**

The Hospital disputes the majority of the OIG's findings that services were billed incorrectly as inpatient stays. Specifically, the Hospital contests 67 of the 74 claims at issue in this category. *See Appendix A-2.*

In addition to the specific clinical challenges included in **Appendix A-2**, the Hospital is concerned about the fundamentally subjective nature of the OIG's coverage decisions. The Hospital understands that the evaluation of the short stay cases is a fact-intensive inquiry and the OIG will be reluctant to disturb the findings of its medical reviewers even though the medical review contractor, [REDACTED], also disagreed with some of the OIG's initial medical review conclusions. This highlights the subjective nature of the review.

Medical reviewers have the benefit of hindsight, but they must be reluctant to *substitute* their judgment for that of the treating practitioner. The inherent shortcoming of medical review is that each inpatient short stay is a past event that can be reviewed only by reference to the documentary medical record. In contrast, Hospital physicians must make the judgments in the moment, based on available information and professional judgment about the need for inpatient care.

In reviewing medical necessity, courts have imposed a standard of review that requires reviewers to acknowledge the different perspectives of physician and reviewer.

In demonstrating to us that substantial evidence underlies his determination that inpatient hospitalization was not reasonable and necessary, the Secretary of course is at an immediate disadvantage, because none of his representatives ever

personally examined [the patient]. To reach his determination, the Secretary had to patch together discrete findings and observations in records made by the very same health care professionals who were on the scene examining and caring for [the patient] and who were unquestionably in the best position to certify the necessity of the patient stay. Given the Secretary's second-hand knowledge, we must necessarily demand that his review of the record be probing, precise and accurate.

*State of New York on behalf of Bodnar v. Sec'y of Health & Human Servs.*, 903 F.2d 122 (2d Cir. 1990).

Physician opinion and medical judgment regarding admission status should be evaluated in terms of the information available to the physician at the time of the admission. Retrospective knowledge that there were no setbacks or deterioration of the patient's condition should not undercut a physician's reasoned initial assessment that the patient's overall condition and treatment plan would require inpatient care. Indeed, the Medicare Benefit Policy Manual provides that a medically necessary inpatient admission is based upon:

the *expectation* that [the individual] will remain 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.

CMS Pub. 100-02, Ch. 1 § 10 - Covered Inpatient Hospital Services Covered Under Part A, (Rev. 1, 10-01-03.)

Where, as here, reasonable authorities disagree on the assessment of some cases, the OIG should not rely on the sampled cases as representative of the entire universe of claims.

### **C. Florida Hospital Objects to Sampling and Extrapolation of an Overpayment**

The Hospital objects to the use of statistical sampling to calculate an overpayment which is then extrapolated to the full sampling frame. Although sampling may be appealing as a cost effective alternative to actual review of a universe of provider claims, we cannot lose sight of the fact that statistical sampling still results in an "estimated" overpayment. Sampling methods represent a compromise between precision, and audit resources including budget, time, and personnel. Because the burden of that compromise falls primarily on the provider, the Secretary must use sampling and extrapolation judiciously and properly.

1. Due process requires availability of timely challenge to statistical sampling foundation.

To begin, it is clear that there is no express authority for OIG to use sampling to determine extrapolated overpayment determinations. But even if the use of extrapolation would be permitted, neither Congress, nor the Courts, nor the Secretary, have granted free rein to government authorities to use sampling absent affording due process to providers challenging the sampling. The Ninth Circuit Court of Appeals found extrapolation based on statistical sampling to be reasonable provided that the defendant provider has the opportunity to challenge the

statistical sampling methodology. *See Chaves County Home Health Service, Inc. v. Sullivan*, 931 F.2d 914 (D.C. Cir. 1991).

To be sure, the Hospital *will* dispute the OIG's audit findings through the normal claim appeals process. But it must be noted that this process for appeal is not simple and straight forward. As the OIG is aware, a moratorium on the assignment of new claims appeals to administrative law judges was adopted last year by the Office of Medicare Hearings and Appeals.<sup>1</sup> The OMHA delay means that the Hospital will not have the opportunity to challenge the sampling before an ALJ for well over four years. This OMHA delay arguably amounts to a denial of due process. In the meantime, Florida Hospital will be deprived of the time value of the funds recouped.

The significance of timely ALJ review to due process is obvious to the provider community. Although it is the third station on the administrative appeals track, it is the first station at which due process is truly offered: providers are first able to make their case in person, before a party who is not a Medicare contractor, to present reasons why the sampling should not be upheld, to call witnesses, to cross-examine adverse witnesses, and to have a record of the evidence presented.

We anticipate CMS will argue that this OMHA delay does not amount to due process denied, just process delayed. But federal courts have held that extraordinary delays in the administrative processing can ripen into a compensable taking under the Constitution. *See Boise Cascade Corp. v. United States*, 296 F.3d 1339, 1352 (Fed.Cir. 2002); *see also Tahoe-Sierra Preservation Council, v. Tahoe Reg'l Planning Agency*, 535 U.S. 302, 332, 122 (2002). Given that the express recognition in CMS's own regulatory scheme that a hearing and decision must be effected expeditiously, the OMHA moratorium may well be considered to impose an extraordinary delay and, thus, a denial of due process.

2. There is no authority for sampling without a finding of a sustained or high rate of error.

Not all audits or claims reviews are appropriate subjects for extrapolation based on the results of statistical sampling. Congress, in the 2003 Medicare Prescription Drug Improvement and Modernization ("MMA"), passed a provision that limited CMS's discretion to engage in statistical sampling to estimate overpayments. Pursuant to the limitation on use of extrapolation enacted as part of Section 935 of the MMA:

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<sup>1</sup> The Office of Medicare Hearing and Appeals (OMHA) has suspended docketing of new cases to individual Administrative Law Judges (ALJ) for at least 28 months. *See OMHA Notice, available at* [http://www.hhs.gov/omha/important\\_notice\\_regarding\\_adjudication\\_timeframes.html](http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html). Although hearings will continue, no new cases will be scheduled for hearing until further notice

A Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, unless the Secretary determines that – (A) there is a sustained or high level of payment error; or (B) documented educational intervention has failed to correct the payment error.

In this instance, there was neither allegation, nor proof, that the Hospital had a sustained or high level error rate. OIG cited as the basis for its decision to review Florida Hospital, OIG’s own “previous work at other hospitals.” The Draft Report, at page 3, provides:

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

There were no other bases stated for the use of extrapolation.

Florida Hospital acknowledges that there were some claims identified by the OIG as inaccurate, but the Hospital does not concede that those errors support a finding of *sustained or high level of payment error*, which is a necessary predicate to the use of sampling to calculate an extrapolated overpayment.

We anticipate the response that the MMA’s statutory and regulatory limitation on sampling, by its terms, applies only to Medicare contractors, and not OIG. However, such a response would be disingenuous. The OIG’s recommendation for recoupment does not relieve the contractor of its obligation to limit use of statistical sampling to situations of identified abusive billing. It is the contractor that would be charged with implementing the OIG’s recommended extrapolated overpayment.

CMS’s own interpretive guidelines, published in the Medicare Program Integrity Manual, CMS Pub. 100-08 (MPIM), echo the law, saying that a Medicare contractor may use statistical sampling after it has found a sustained or high level of payment error or that education has failed to correct the payment error. *See MPIM § 8.4.1.4.*<sup>2</sup>

We find it unprincipled for the OIG to recommend that contractors implement recoupment of an extrapolated overpayment when the factual predicate of sustained or high rates of error are not present. We also object to OIG’s draft recommendation to CMS to collect an overpayment that OIG acknowledges is inflated. OIG notes in footnote 4 of the Draft Report that Part A overpayments may be offset by the Part B payments the hospital is entitled to receive for the reasonable and necessary services furnished. Nonetheless, OIG fails to account for any Part B billing and used the inflated overpayment as the basis for extrapolation—increasing the impact of that error.

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<sup>2</sup> See also MPIM, CMS Pub. 100-08, Transmittal No. 114, June 10, 2005.

In the Draft Report, OIG suggests that it has no ability to address the availability of Part B billing for outpatient services. *See* Draft Report, at fn. 4. We disagree. There is no legal obligation for the OIG to make a specific recommendation for an extrapolated overpayment. We request that none be made. Instead, we suggest that the OIG can characterize its findings as preliminary and subject to adjustment for the Part B payments.

If amounts payable under Part B were included in the sampling results, the actual overpayment would be reduced. According to recent efforts undertaken by CMS, settlement of such claims might be made available for 68 percent of the claimed amounts.<sup>3</sup> As the actual overpayment was reduced, so would the extrapolated overpayment decrease. Indeed, the restoration of reimbursement for Part B billing in the short stay cases could reduce the overpayment in more than half of the 94 cases slated for denial.

3. There is insufficient documentation of the Sampling Methodology to satisfy Medicare guidance.

Florida Hospital also objects to the lack of transparency in the sampling methodology utilized in this case. Although a complete exploration of the mathematical principles that support statistical sampling is beyond the scope of this response, one point is clear. An essential component of a valid statistical analysis is that the methods of sampling and extrapolation must be fully documented so that there is a complete audit trail that would enable others to verify that the methodology is sound. To date, Florida Hospital has not been provided the level of detailed needed to make this determination.

The question of documenting the statistical sampling is not simply a technical debate over the rules governing which materials must be provided to the audited entity. To determine whether or not a statistical sample is valid, it is essential that any statistical sampling be thoroughly documented to ensure that the sample chosen was randomly selected and representative of its population. Without such information, one cannot test or validate a statistical sampling or extrapolation.

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<sup>3</sup> CMS is now offering an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount). Although CMS has encouraged hospitals with inpatient status claims currently in the appeals process or within the timeframe to request an appeal to make use of this administrative agreement mechanism, it will not be available to Florida Hospital on this OIG audit unless the program is extended. [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/HospitalParticipantSettlementInstructions\\_updated09092014.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/HospitalParticipantSettlementInstructions_updated09092014.pdf).

There are two primary sources of authority regarding the conduct of a statistical sampling in a Medicare audit. The first source is generally accepted policies and procedures in statistical analysis. The second source is the guidance provided by the Medicare Program.<sup>4</sup>

Under both authorities, the validity of any extrapolation from the sample depends on strict adherence to procedures to ensure that the mathematical inferences are sound and rational. These procedures apply throughout the entire course of every statistical analysis, from the identification of the audit target, to the decision to perform a sampling, to the development of the study hypothesis and protocol, to the selection of the sample, to the evaluation of the sample results, to the assessment of any overpayment.

Chapter 8 of the MPIM requires statisticians to keep data and records in a form so that others may verify audit projections by replicating the auditor's statistical work. The MPIM requires:

An explicit statement of how the universe is defined and elements included shall be made and maintained in writing.

CMS Pub. 100-08 § 8.4.4.1

The CMS Program Memorandum on statistical sampling also requires auditors to “provide complete documentation of the sampling methodology that you followed.”<sup>5</sup> The OIG did not produce a line level *universe* data file showing all information necessary to replicate the statistical process or ensure the validity of the process used.

The Draft Report states that OIG started with a National Claims History database totaling \$378,675,582 for 28,975 inpatient and 154,546 outpatient claims in 24 high risk areas. We would like to know, specifically, which claims were removed from the universe to arrive at the frame. The Draft Report further states that the universe was modified to remove “certain patient discharge status codes and revenue codes” but does not specify which codes. OIG also states that it took into consideration such things as certain vulnerable diagnosis codes, and procedure codes. Which codes were considered is not indicated. Further, we know from the Draft Report

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<sup>4</sup> See Program Memoranda, Transmittal No. B-02-007, Feb. 7, 2002 (citing, *inter alia*, Cochran, William G., *Sampling Techniques*, Third Edition, New York: John Wiley & Sons, Inc., 1977; Deming, W. Edward, *Sample Design in Business Research*, (John Wiley & Sons, Inc., 1960); Hansen, M. H., Hurwitz, W. W., and Madow, W. G., *Sample Survey Methods and Theory*, New York: John Wiley and Sons, 1953 (Paperback 1993)).

<sup>5</sup> Program Memorandum, Transmittal B-03-022, Use of Statistical Sampling for Overpayment Estimation When Performing Administrative Reviews of Part B Claims (Mar. 21, 2003).

that OIG removed all claims under review by the Recovery Audit Contractor. Did OIG remove claims that had been denied and appealed in the ordinary course by Medicare Contractors?<sup>6</sup> The Hospital has asked for that information from OIG, but, inexplicably, the request was declined.

The Hospital has more than a mere academic interest in this additional information regarding the population and the sample frame. First, the Hospital is aware of other published OIG reports on similar audits of like-sized institutions where the sampling frame, and the estimated overpayment was significantly smaller. The disparity has caused us to question whether the methods for identifying claims that fit into the identified “risk categories” are consistent across institutions.<sup>7</sup> If the OIG’s statistical methods remain unavailable, the Hospital

<sup>6</sup> MPIM, CMS Pub. 100-08 § 8.4.4.2.

<sup>7</sup> We analyzed data available in the OIG’s Report titled, *Medicare Compliance Review of Orlando Hospital for the Period January 1, 2011, Through June 30, 2012 (A-04-13-07042) (September 2014)* and compared several statistics. This comparison is reflected in the tables below.

NCH Data (Total)	
Florida Hospital	\$647M / 80K IP / 343K OP
Orlando Hospital	\$332M / 35K IP / 167K OP
Florida Hospital has 1.9x dollars in revenue in its frame	

OIG Universe of 24 Risk Areas	
Florida Hospital	\$379M / 29K IP / 155K OP
Orlando Hospital	\$210M / 12K IP / 51K OP
Florida Hospital has 1.9x dollars in its frame	

OIG Universe of Selected Risk Areas	
Florida Hospital	\$130M / 19K Claims
Orlando Hospital	\$56M / 7K Claims
Florida Hospital has 2.3x dollars in its frame	

OIG Frame -	
Florida Hospital	\$80M / 10,934 Claims
Orlando Hospital	\$12M / 1,260 Claims
Florida Hospital has 6.7x dollars in its frame	

Short-Stay Findings	
Florida Hospital	\$20M / 3,478 Claims in Frame \$447K / 83 Claims in Audit \$278K / 51 Claims with Findings
Orlando Hospital -	\$ 3.8M / 449 Claims in Frame \$757K / 85 Claims in Audit \$354K / 40 Claims with Findings

must insist that the sample and the calculation of an overpayment based on that sample be rejected.

**D. Florida Hospital Concurrs with Some of OIG’s Determinations of Claims on Discharge Status/Source of Admission Code**

The Hospital acknowledges that two (2) claims were billed with incorrect discharge status and five (5) claims were billed with incorrect source of admission codes. Notwithstanding this concurrence, the Hospital maintains that it is without fault at least with respect to the two claims billed with incorrect discharge status. For those claims, the Hospital had no knowledge that the patients, who left against medical advice, were readmitted the same day to another IPPS hospital.

Although the Hospital acknowledges some errors in its claims, these errors are limited to cases where, for example, a computer error failed to insert proper modifiers, or where the Hospital was unaware of subsequent inpatient admissions to other facilities. Importantly, none of the negative audit findings result from an incomplete understanding of the current rules and regulations or failure to have a proactive compliance program.

**E. Clarity of OIG Findings**

Finally, we noted that the Draft Report is difficult to decipher and understand due to the lack of correlation of the risk areas and the strata to the report findings. We have requested additional input on how the numbers of claims listed as problematic in the Draft Report correlate to the claims reviewed and we await OIG’s input on the selection of Florida Hospital for audit and the detail on the sampling methodology that was followed.

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Florida Hospital has 5.3x dollars in its frame	
<b>High-Severity DRG Findings</b>	
Florida Hospital	\$60M 7,408 Claims in Frame;
Orlando Hospital -	\$7.6M 778 Claims in Frame; \$
Florida Hospital has 7.9x dollars in its frame	

It is unclear how the sample results for the two hospitals could be so out of sync, given the parameters of the review. For example, the Hospital has a patient volume in the selected risk areas that is 2.3 times the size of Orlando Hospital’s selected risk areas, but a frame that is 6.7 times the size of Orlando Hospital’s sampling frame. Based on these data, it appears that OIG may be defining at-risk claims inconsistently, or not properly refining the claims for the frame.

### CORRECTIVE ACTIONS

The OIG's Draft Report does not reflect any fundamental flaw in the Hospital's systems or processes. Accordingly, the corrective actions noted by the Hospital are focused on continuing commitment to existing compliance efforts.

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On behalf of Florida Hospital Orlando, we appreciate the opportunity to respond to the Draft Report and your consideration of our submission. As we have been throughout this process, we are willing and available to respond to your questions or further inquiries.

Sincerely yours,

*Donna K. Thiel*

Attachments:

Appendix A-1

Appendix A-2