

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE HOSPITAL PROVIDER  
COMPLIANCE AUDIT:  
FLAGSTAFF MEDICAL CENTER**

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# *Office of Inspector General*

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## Report in Brief

Date: September 2020  
Report No. A-07-18-05112

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



### Why OIG Did This Audit

This audit is part of a series of hospital compliance audits. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2017, Medicare paid hospitals \$206 billion, which represents 55 percent of all fee-for-service payments for the year.

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

### How OIG Did This Audit

We selected for review a stratified random sample of 90 inpatient and 10 outpatient claims with payments totaling \$2.6 million for our 2-year audit period (January 1, 2016, through December 31, 2017).

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

## Medicare Hospital Provider Compliance Audit: Flagstaff Medical Center

### What OIG Found

The Hospital complied with Medicare billing requirements for 97 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining three claims, resulting in overpayments of \$79,216 for the audit period.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$79,216 for the audit period.

### What OIG Recommends and Auditee Comments

We recommended that the Hospital: refund to the Medicare contractor \$79,216 in estimated overpayments for the audit period for claims that it incorrectly billed; based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule, and identify any of those returned overpayments as having been made in accordance with this recommendation; and strengthen controls to ensure full compliance with Medicare requirements.

The Hospital concurred with our second and third recommendations but did not entirely concur with our first recommendation. The Hospital agreed that it inappropriately billed three of the six claims that our draft report had identified as errors and stated that it had implemented additional education and controls to prevent similar mistakes in the future. The Hospital disagreed that the other three claims that our draft report had identified as errors represented overpayments. The Hospital gave us documentation that it believed would support the appropriateness of these three claims and said that they were appropriately billed and paid.

Based on the results of additional medical review performed by our independent medical review contractor as well as our evaluation of the Hospital's written comments and its additional and supplemental documentation, we revised our determinations for this final report. Specifically, we adjusted the total number of claims identified as errors in our audit period from six to three and revised our findings and the associated dollar amount in our first recommendation accordingly. We maintain that these three remaining findings—which the Hospital agreed were billed in error—and our revised recommendations are valid.

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## **INTRODUCTION**

### **WHY WE DID THIS AUDIT**

This audit is part of a series of hospital compliance audits. 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 2017, Medicare paid hospitals \$206 billion, which represents 55 percent of all fee-for-service payments; accordingly, it is important to ensure that hospital payments comply with requirements.

### **OBJECTIVE**

Our objective was to determine whether Flagstaff Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims from January 1, 2016, through December 31, 2017.

### **BACKGROUND**

#### **The Medicare Program**

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

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

Under the inpatient prospective payment system (IPPS), CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

#### **Hospital 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 hospital claims, among others, that were at risk for noncompliance:

- inpatient claims paid greater than charges,
- inpatient claims billed with high-error-rate DRG codes,
- inpatient claims billed with elective surgical procedures,
- inpatient claims for mechanical ventilation,
- inpatient claims billed with high-severity-level DRG codes, and
- outpatient claims with payments greater than \$25,000.

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 audit.<sup>2</sup>

### **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” (Social Security Act (the Act) § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1815(a)).

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

Claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)). The *Medicare Claims Processing Manual* (the Manual) requires providers to

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<sup>1</sup> The health care industry uses HCPCS codes to standardize coding for medical procedures, services, products, and supplies.

<sup>2</sup> For purposes of selecting claims for medical review, CMS instructs its Medicare contractors to follow the “two-midnight presumption” in order not to focus their medical review efforts on stays spanning two or more midnights after formal inpatient admission in the absence of evidence of systemic gaming, abuse, or delays in the provision of care (*Medicare Program Integrity Manual*, chapter 6, § 6.5.2). We are not constrained by the two-midnight presumption in selecting claims for medical review.

complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).<sup>3</sup>

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.<sup>4</sup>

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.<sup>5</sup>

## **Flagstaff Medical Center**

The Hospital is a 267-bed hospital located in Flagstaff, Arizona. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately \$360 million for 13,006 inpatient and 69,654 outpatient claims between January 1, 2016, and December 31, 2017 (audit period).

## **HOW WE CONDUCTED THIS AUDIT**

Our audit covered \$9,932,628 in Medicare payments to the Hospital for 414 claims that were potentially at risk for billing errors. We selected for audit a stratified random sample of 100 claims (90 inpatient and 10 outpatient) with payments totaling \$2,606,960. Medicare paid these 100 claims during our audit period.

We focused our audit on the risk areas identified because of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted all claims to an independent medical review contractor to determine whether the claim was supported by the

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<sup>3</sup> "Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Centers for Medicare & Medicaid Services 'Hospital Common Procedure Coding System' (HCPCS)" 42 CFR § 419.2(a). Moreover, claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)).

<sup>4</sup> The Act § 1128J(d); 42 CFR §§ 401.301–401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

<sup>5</sup> 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, Provider Reimbursement Manual—Part 1, Pub. No. 15-1, § 2931.2; and 81 Fed. Reg. at 7670.

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

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

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

## **FINDINGS**

The Hospital complied with Medicare billing requirements for 97 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining three claims (all of which were inpatient claims), resulting in overpayments of \$79,216 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 \$79,216 for the audit period. See Appendix B for our statistical sampling methodology, Appendix C for our sample results and estimates, and Appendix D for results of audit by risk area.

### **BILLING ERRORS ASSOCIATED WITH CLAIMS INCORRECTLY BILLED AS INPATIENT**

The Hospital incorrectly billed Medicare for 3 of the 90 inpatient claims that we audited. These errors resulted in overpayments of \$79,216.

#### **Federal Requirements and Guidelines**

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1815(a)).

A payment for services furnished to an individual may be made only to providers of services that are eligible and only if, “with respect to inpatient hospital services . . . , which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual’s medical treatment. . . .” (the Act § 1814(a)(3)). Federal regulations require an order for inpatient admission by a physician or other qualified provider at or before the time of the inpatient admission (42 CFR §§ 412.3(a)–(c)).

In addition, the regulations provide that an inpatient admission, and subsequent payment under Medicare Part A, is generally appropriate if the ordering physician expects the patient to require care for a period of time that crosses two midnights (42 CFR § 412.3(d)(1)). Furthermore, the regulations provide that the expectation of the physician “should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration” (42 CFR § 412.3(d)(1)(i)).

### **Incorrectly Billed as Inpatient**

For 3 of the 90 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status that should have billed as outpatient or outpatient with observation. The medical records did not support the necessity for inpatient hospital services. The Hospital agreed that the three claims were improperly billed as inpatient due to human error.

As a result of the errors in these three claims, the Hospital received overpayments of \$79,216.

### **OVERALL ESTIMATE OF OVERPAYMENTS**

The combined overpayments on our sampled claims totaled \$79,216. On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$79,216 for the audit period.<sup>6</sup>

### **RECOMMENDATIONS**

We recommend that Flagstaff Medical Center:

- refund to the Medicare contractor \$79,216 in estimated overpayments for the audit period for claims that it incorrectly billed;<sup>7</sup>

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<sup>6</sup> The total overpayments identified in our sample also serves as our conservative estimate of the total amount of overpayment in the sampling frame.

<sup>7</sup> OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a Medicare administrative contractor or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

- based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule,<sup>8</sup> and identify any of those returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

### **AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the Hospital concurred with our second and third recommendations but did not entirely concur with our first recommendation. The Hospital agreed that it inappropriately billed three of the six claims that our draft report had identified as errors and stated that it had implemented additional education and controls to prevent similar mistakes in the future. For these three claims, the Hospital said it concurred with refunding an amount that accurately represented true overpayments and added that it would refund and rebill any such claims under Medicare Part B.

The Hospital disagreed that the other three claims that our draft report had identified as errors represented overpayments. The Hospital gave us documentation that it believed would support the appropriateness of these three claims and said that they were appropriately billed and paid.

The Hospital's comments, from which we have removed various enclosures due to their volume and because some of them contain personally identifiable information, appear as Appendix E. We are providing the Hospital's comments in their entirety to CMS. The enclosures included additional claim-by-claim documentation related to the claims that our draft report had questioned, documentation which, the Hospital said, demonstrated the errors in our medical review.

To address the Hospital's concerns and to assist in our preparation of this final report, we requested that our independent medical review contractor review the Hospital's written comments on our draft report and the supplemental documentation that it provided.

Based on the results of this additional medical review and our evaluation of the Hospital's written comments and its additional and supplemental documentation, we revised our determinations for this final report. Specifically, we adjusted the total number of claims identified as errors in our audit period from six to three and revised our findings and the associated dollar amount in our first recommendation accordingly. We maintain that these three remaining findings—which the Hospital agreed were billed in error—and our revised recommendations are valid.

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<sup>8</sup> This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based on the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

## **CLAIMS IDENTIFIED AS OVERPAYMENTS**

### **Auditee Comments**

For the six claims that we questioned in our draft report, the Hospital agreed that three of these claims were inappropriately billed and should have been billed as outpatient claims. For these three claims, the Hospital described additional education and controls that it had implemented or planned to implement to prevent similar mistakes in the future. However, the Hospital disagreed that the other three claims represented overpayments and gave us documentation that, it believes, supports the appropriateness of those three claims. Specifically:

For two of the three claims with which the Hospital disagreed with our draft report, the Hospital stated that its external physician advisor partner reviewed these accounts at the times of service and agreed with inpatient status at that time. The Hospital added that its external physician advisor partner maintained for these two claims, inpatient hospital admission was medically necessary, appropriate, and consistent with the best local and national standards of medical practice, and that the medical records “unquestionably” show that these admissions fulfilled the Medicare requirements for inpatient hospital admissions. The Hospital also described processes, tools, and controls that it said it would continue to use to ensure compliance with Medicare requirements. For the third claim, the Hospital stated that the procedure performed in this case was billed with a HCPCS code identified by CMS as one that would be paid only as an inpatient procedure in CY 2016. Therefore, the Hospital stated, this claim could only have been billed correctly as inpatient, and accordingly the Hospital submitted and received payment for an appropriate inpatient claim.

### **Office of Inspector General Response**

Based on the results of our independent medical review contractor’s additional medical review and our evaluation of the Hospital’s written comments and its additional and supplemental documentation, we revised our determinations for this final report. Specifically, we adjusted the total number of claims identified as errors in our audit period from six to three and revised our findings and the associated dollar amount in our first recommendation accordingly.

We maintain that our findings, as revised, are valid and are well supported by the legal criteria that we have cited and by our independent medical review contractor’s determinations. Therefore, we maintain that our first recommendation, as revised, remains valid as well.

## **REASONABLE DILIGENCE**

### **Auditee Comments**

With respect to our second recommendation, the Hospital concurred that it should exercise reasonable diligence to identify other potential overpayments like those identified in this audit. However, the Hospital disagreed that all of the overpayments identified in our draft report

were, in fact, overpayments, and said that it would await further OIG review (which we interpret as a reference to this final report) before determining the scope of a reasonably diligent search to identify and return similar overpayments.

The Hospital stated that, at a minimum, such efforts would include implementing the corrective actions it described in its comments on our first recommendation, collecting and analyzing claims identified through those corrective actions, and conducting targeted reviews of claims (or a sample of claims) containing common qualities, and further review outside the initial sample only if indicated by the results of the initial review.

### **Office of Inspector General Response**

We acknowledge the corrective actions that the Hospital described in its comments on our second recommendation. We maintain that all of our findings, as revised, are valid, for the reasons given above, and we therefore maintain that our second recommendation, regarding the identification and return of similar overpayments outside of the 4-year claim-reopening period, remains valid as well.

## **STRENGTHENED CONTROLS**

### **Auditee Comments**

With respect to our third recommendation, the Hospital said that it constantly works to improve and strengthen its controls, systems, and processes to ensure full compliance with Medicare requirements and other rules and regulations, and concurred with the recommendation that it continue to do so. The Hospital said that it has “already implemented significant changes and improvements, some of which would have prevented errors identified in this audit.” The Hospital added that it would continue to review its controls and systems and continue to strengthen them, both before and after final resolution of this audit.

### **Office of Inspector General Response**

We acknowledge the corrective actions that the Hospital said, in its comments on our third recommendation, that it had taken or planned to take to further enhance and strengthen its controls.

## **OTHER MATTERS**

For an additional 6 of the 90 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays of less than two midnights, which it should have billed as outpatient or outpatient with observation. As a result of these errors, the Hospital received overpayments totaling \$103,901. None of the claims in this audit were targeted because they were short stays but rather because they fell into one of the high-risk categories discussed in the background section of this report. OIG has voluntarily suspended audits of inpatient short stay claims after

October 1, 2013. As such, we are not including the number and estimated dollar amount of these errors in our overall estimate of overpayments and repayment recommendation.

Regarding this issue in its written comments on our draft report, the Hospital acknowledged that OIG is not pursuing overpayments for these six additional claims and added that the Hospital had reviewed those claims and disagreed with our determinations for five of them. However, the Hospital identified one claim that it agreed was incorrectly billed and accordingly overpaid, and said that it had already provided additional education to the employee involved in that error.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered \$9,932,628 in Medicare payments to the Hospital for 414 claims that were potentially at risk for billing errors. We selected for audit a stratified random sample of 100 claims (90 inpatient and 10 outpatient) with payments totaling \$2,606,960. Medicare paid these 100 claims from January 1, 2016, through December 31, 2017 (audit period).

We focused our audit on the risk areas identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted all claims to an independent medical review contractor to determine whether the claim was supported by the medical record.<sup>9</sup>

We limited our review of the Hospital's internal controls to those applicable to the inpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the NCH data, but we did not assess the completeness of the file. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our audit work from April 2018 through July 2020.

### 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;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;

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<sup>9</sup> For purposes of selecting claims for medical review, CMS instructs its Medicare administrative contractors, Supplemental Medical Review Contractor, Recover Audit Contractors, and the Comprehensive Error Rate Testing (CERT) contractor to follow the "two-midnight presumption" (*Medicare Program Integrity Manual*, chapter 6, § 6.5.2). This presumption says that hospital stays spanning two or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment, and it asks Medicare contractors not to focus their medical review efforts on stays spanning two or more midnights after formal inpatient admission in the absence of evidence of systemic gaming, abuse, or delays in the provision of care. In accordance with our authority to conduct audits and our independence established by the Inspector General Act of 1978, OIG is not bound by the two-midnight presumption that might otherwise limit medical review by Medicare contractors in the absence of evidence of systemic gaming, abuse, or delays in provision of care.

- selected a stratified sample of 90 inpatient claims and 10 outpatient claims totaling \$2,606,960 for detailed review (Appendix B);
- obtained and reviewed billing and medical record documentation provided by the Hospital to support the selected claims;
- used an independent medical review contractor to determine whether the 100 claims contained in the sample complied with selected billing requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample review to calculate the estimated Medicare overpayment to the Hospital (Appendix C);
- discussed the results of our audit with Hospital officials on March 27, 2019; and
- used the independent medical review contractor to review the Hospital's written comments on our draft report and the additional and supplemental documentation that it provided, and on that basis revised our findings and recommendations as discussed earlier in this report.

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

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### TARGET POPULATION

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

### SAMPLING FRAME

The sampling frame consisted of a database of 414 claims, valued at \$9,932,628, from CMS's NCH file.<sup>10</sup>

### SAMPLE UNIT

The sample unit was a Medicare paid claim.

### SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into five strata based on Medicare risk area. Elective procedure claims were in stratum 1, CERT DRG (footnote 9) and inpatient claims billed with high-severity-level DRG codes were in stratum 2, inpatient claims paid greater than charges were in stratum 3, outpatient claims paid greater than \$25,000 were in stratum 4, and mechanical ventilation claims were in stratum 5. All claims were unduplicated, appearing in only one area and only once in the entire sampling frame. See Table 1.

**Table 1: Sample Strata**

Stratum	Dollar Range of Frame Units	Number of Frame Units		Sample Size	Dollar Value of Frame Units
1	\$4,899.37 to \$74,541.49	315		62	\$8,319,537
2	\$5,884.92 to \$31,433.53	81		20	879,336
3	\$28,759.01 to \$54,396.88	5		5	239,806
4	\$30,969.46 to \$32,353.55	10		10	314,390
5	\$57,411.57 to \$63,453.32	3		3	179,559
<b>Totals</b>		<b>414</b>		<b>100</b>	<b>\$9,932,628</b>

<sup>10</sup> Our sampling frame excluded claims associated with (1) claims with certain discharge status codes, (2) all \$0 paid claims, (3) all duplicated claims within individual high-risk areas, and (4) claims associated with error codes 534 or 540 (claims that are excluded from further review, such as Recovery Audit Contractor-reviewed claims).

## **SAMPLE SIZE**

We randomly selected 62 unique inpatient claims from stratum 1 and 20 from stratum 2. We selected all 5 claims in stratum 3, all 10 outpatient claims in stratum 4, and all 3 claims in stratum 5. Our total sample size was therefore 100 claims.

## **SOURCE OF RANDOM NUMBERS**

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

## **METHOD OF SELECTING SAMPLE ITEMS**

We consecutively numbered the sample units in the frame from 1 to 315 for stratum 1 and from 1 to 81 for stratum 2. A statistical specialist generated 62 random numbers for stratum 1 and 20 random numbers for stratum 2. With these random numbers, we selected the corresponding frame items for review. We also selected all 5 claims in stratum 3, all 10 claims in stratum 4, and all 3 claims in stratum 5.

## **ESTIMATION METHODOLOGY**

We used the OIG, OAS, statistical software to calculate our estimates, including a two-sided 90-percent confidence interval. The calculated lower limit of this interval was less than the total overpayment that we identified in the sample. As a result, we recommend recovery of the total overpayments identified in the sample, which serves as a conservative estimate of the total overpayment amount in the sampling frame.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**SAMPLE RESULTS**

**Table 2: 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	315	\$8,319,537	62	\$1,659,645	0	\$0
2	81	879,336	20	213,560	2	24,819
3	5	239,806	5	239,806	1	54,397
4	10	314,390	10	314,390	0	0
5	3	179,559	3	179,559	0	0
<b>Total</b>	<b>414</b>	<b>\$9,932,628</b>	<b>100</b>	<b>\$2,606,960</b>	<b>3</b>	<b>\$79,216</b>

**ESTIMATES**

**Table 3: Estimates of Overpayments for the Audit Period**  
*Limits Calculated for a 90-Percent Confidence Interval*

Point Estimate	\$154,913
Lower limit <sup>11</sup>	\$79,216
Upper limit	\$264,741

<sup>11</sup> The total amount of overpayments identified in our sample serves as our conservative estimate of the overpayment total in the sampling frame. In effect, this means that we did not have confidence that the frame contained additional overpayments beyond what was observed in the sample.

**APPENDIX D: RESULTS OF AUDIT BY RISK AREA**

**Table 4: Sample Results 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 Overpayments</b>
Inpatient Claims Billed With CERT DRG Codes	14	\$148,930	2	\$24,819
Inpatient Claims Paid Greater Than Charges	5	239,806	1	54,397
Inpatient Elective Procedures Claims	62	1,659,645	0	0
Inpatient Mechanical Ventilation Claims	3	179,559	0	0
Inpatient Claims Billed With High-Severity-Level DRGs	6	64,630	0	0
<b>Inpatient Totals</b>	<b>90</b>	<b>\$2,292,570</b>	<b>3</b>	<b>\$79,216</b>
Outpatient Claims Paid in Excess of \$25,000	10	\$314,390	0	\$0
<b>Outpatient Totals</b>	<b>10</b>	<b>\$314,390</b>	<b>0</b>	<b>\$0</b>
<b>Inpatient and Outpatient Totals</b>	<b>100</b>	<b>\$2,606,960</b>	<b>3</b>	<b>\$79,216</b>

Note: The table above illustrates the results of our audit by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at 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.



## N O R T H E R N A R I Z O N A H E A L T H C A R E

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October 31, 2019

**Sent via FedEx overnight delivery and secure email to  
 Scott.Englund@oig.hhs.gov and Doug.Kelly@oig.hhs.gov**

Office of Audit Services, Region VII  
 ATTN: Patrick J. Cogley  
 601 East 12<sup>th</sup> Street, Room 0429  
 Kansas City, MO 64106

RE: Written Comments Regarding Draft Report No. A-07-18-05112

Dear Mr. Cogley:

I write on behalf of Flagstaff Medical Center (“FMC”), a Northern Arizona Healthcare Corporation hospital. I write in response to the U.S. Department of Health and Human Services, Office of Inspector (“OIG”) 12-page draft report entitled *Medicare Compliance Review of Flagstaff Medical Center* (the “Draft Report”) on October 1, 2019. The Draft Report is dated August 9, 2019, but apparently multiple attempts at electronic transmission to FMC were unsuccessful, and the Draft Report was only received by FMC on October 1; accordingly, and as agreed with OIG Senior Auditor Doug Kelly, we are submitting these comments today.

The Draft Report makes three recommendations:

- First, the Draft Report recommends refunding \$149,260 in estimated overpayments. As explained further below and in the attachments, we do not concur. We do not concur because we do not agree that all of the claims which the OIG has identified as ‘overpayments’ are, in fact, overpayments. For example, the OIG identifies one claim as an overpayment, asserting an inpatient procedure should have been outpatient, but in fact the procedure is inpatient-only pursuant to CMS. We do concur with refunding an amount that accurately represents true overpayments; and will refund and rebill any such claims under Medicare Part B.

Mission  
 Improving health, healing people.

Vision  
 Always better care.  
 Every person, every time...together.

- Second, the Draft Report recommends FMC exercise reasonable diligence to identify and return any additional similar overpayments. We concur and will do so with respect to claims determined to be actual overpayments.
- Third, the Draft Report recommends FMC strengthen controls to ensure full compliance with Medicare requirements. We concur, and in fact have already done so, as described further herein.

### Claims Identified as Overpayments

The Draft Report itself does not identify which claims in the sample are being considered overpayments. We confirmed with OIG Senior Auditor Doug Kelly that the six alleged overpayments are those identified in previous correspondence as Claims B03, B06, B08, B10, B11, and D01. We disagree that claims B03, B06, and B08 represent overpayments and have enclosed documentation supporting the appropriateness of those claims. We do concur that Claims B10, B11, and D01 were inappropriately billed, for the reasons explained below, and have already implemented additional education and controls to prevent similar mistakes in the future.

- **B03:** FMC maintains this claim was appropriately billed and paid. FMC's external physician advisor partner, Executive Health Resources, reviewed this account at the time of service and agreed with inpatient status at that time, and maintains today that "inpatient hospital admission was medically necessary, appropriate, and consistent with the best local and national standards of medical practice," and that the medical record "unquestionably shows that this admission fulfilled the Medicare requirements for an inpatient hospital admission." (Exhibit B03.) We will continue to use the following processes and tools, among others, to ensure compliance with Medicare requirements: specially trained utilization nurses who conduct first level review applying InterQual criteria to each individual patient's clinical situation; both internal and external physician advisor partners who review more clinically complex cases in a second level review; a specially trained team of utilization nurses who review patient charts for correct pre- and post-operative admission status orders; InterQual Interrater Reliability testing of our utilization team; a minimum of four hours of education annually with InterQual for each utilization team member; and regular feedback to and from our utilization nurse team to identify any gaps and respond with appropriate education, training, tools, or revised processes. We will continue to rely on the controls described both in B03 and in our Internal Controls Questionnaire, and on all those processes as we evolve and improve them to ensure such claims are appropriately billed.
- **B06:** FMC maintains this claim was appropriately billed and paid. The procedure performed in this case is identified by CMS as a HCPCS Code that would be paid only as an inpatient procedure in CY 2016. (Exhibit B06.) That is, according to CMS, this claim could only have been billed correctly as inpatient, and FMC followed that rule and submitted and received payment for an appropriate inpatient claim. We will continue to rely on the controls described in B03, in

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our Internal Controls Questionnaire, and on all those processes as we evolve and improve them to ensure such claims are appropriately billed.

- **B08:** FMC maintains this claim was appropriately billed and paid. FMC's external physician advisor partner, Executive Health Resources, reviewed this account at the time of service and agreed with inpatient status at that time, and maintains today that "inpatient hospital admission was medically necessary, appropriate, and consistent with the best local and national standards of medical practice," and that the medical record "unquestionably shows that this admission fulfilled the Medicare requirements for an inpatient hospital admission." (Exhibit B08.) We will continue to rely on the controls described both in B03 and in our Internal Controls Questionnaire, and on all those processes as we evolve and improve them to ensure such claims are appropriately billed.
- **B10:** FMC concurs that this claim should have been billed as outpatient. In 2016, the CPT code that the surgeon's office assigned *pre*-operatively to this patient was CPT 22840, an inpatient-only procedure. However, ultimately that was not the procedure performed in the operating room or coded after discharge. We agree that the procedure actually performed and accurately coded should have been outpatient. In 2016, FMC did not have an in-house coding department to provide immediate *post*-operative coding information. Today, we do have such a department and are confident this case would have been immediately identified and billed appropriately. Accordingly, we do not plan to take further corrective action specific to this type of claim, other than to continue to train and evaluate our in-house coding department. We concur that this claim represents an overpayment and agree to refund an appropriately calculated amount.
- **B11:** FMC concurs that this claim should have been billed as outpatient. This claim involves a patient who was identified as appropriate for observation status while at FMC, but internal processes to move the patient to observation status were not completed prior to discharge. FMC has a standardized Code 44 process when patients need to be moved from inpatient to observation and has provided additional education and training to staff, including FMC utilization nurses, to ensure that these cases are timely addressed by our staff and are appropriately billed. Our Code 44 processes include a formal checklist that we train our utilization nurses to employ to ensure all steps of the Code 44 process are followed. In the case of B11, our standard process failed due to human error and timing. We attempt to identify gaps in these processes by tracking and trending Code 44 volumes through our compliance database, Midas. Our system-wide Director of Care Management, who has responsibility for FMC Care Management, regularly reviews that data and pulls specific cases and works with specific utilization nurses when trends suggest further review is warranted. Although missed Code 44 cases (i.e., claims that should have gone through the Code 44 process but did not) are very difficult to identify retrospectively, we will increase scrutiny on all Code 44-related work and on the trends for these claims to ensure we catch errors and identify any deficiencies in training or adherence to policy and process. FMC concurs that the submitted inpatient claim that Medicare

paid should have been billed as OBV. We concur that this claim represents an overpayment and agree to refund an appropriately calculated amount.

- **D01:** FMC concurs that this claim should have been billed as outpatient. This claim involves a patient who failed outpatient treatment and was admitted to FMC for osteomyelitis. The patient had surgery and a three-day stay including intravenous antibiotics and Infectious Disease consultation. Our first level utilization review appropriately identified the patient's medical necessity status as satisfying InterQual criteria for inpatient. However, in response to the OIG inquiry, the case was retrospectively reviewed by FMC's internal physician advisor, Dr. Derek Feuquay, who indicated he could only support observation status on this claim. This patient had a unique history for osteomyelitis surgery and complexities which the InterQual tool did not capture (and which were not obvious to the first level utilization review team such that the team would have recognized to refer for second level physician review at the time). FMC concurs that this claim represents an overpayment and agrees to refund an appropriately calculated amount. We believe that the best corrective action we can take for claims such as this is to provide additional education to our utilization nurses, to encourage utilization nurses to refer cases for second level review for admission status, and to ensure our utilization nurses receive effective feedback on these complex clinical cases. We regularly do those things, and will continue to, with renewed emphasis on clinically complex cases following this audit.

FMC respectfully requests that the OIG re-review Claims B03, B06, and B08 in light of the documentation and explanations provided and, upon identifying them as appropriately billed, recalculate the amount the OIG recommends FMC refund based solely on the three incorrectly billed claims (B10, B11, and D01).

#### Reasonable Diligence

FMC concurs that it should exercise reasonable diligence to identify other potential overpayments similar to those identified in this audit. As explained above, FMC disagrees that all of the identified 'overpayments' are, in fact, overpayments, and will await further OIG review before determining the scope of a reasonably diligent search to identify and return 'similar' overpayments. At a minimum, such efforts will include implementing the corrective actions discussed above, collecting cases identified through such implementation, analysis of those collected cases for common qualities that can be searched for within our electronic medical record and/or other databases, and then targeted review of claims containing those common qualities (or, in a situation where those common qualities produce an unreasonably large number of results, a sample of claims containing those common qualities, and further review outside the initial sample only if indicated by the results of the initial review).

#### Strengthened Controls

FMC constantly works to improve and strengthen its controls, systems, and processes to ensure full compliance with Medicare requirements and other rules and regulations. FMC concurs with the recommendation that it continue to do so. As explained in our responses to the Internal Controls Questionnaires related to this audit, we have already implemented significant changes and

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improvements, some of which would have prevented errors identified in this audit (e.g., we now have an in-house coding team that works to immediately code cases post-operatively, ensuring the admission status order post-operatively is the appropriate billing status, which would have prevented the error that led to overpayment in Claim B10). We will continue to review our controls and systems and continue to strengthen them, both before and after final resolution of this audit.

#### Other Matters

The audit initially identified six additional claims as allegedly incorrectly billed pursuant to the two midnight rule. Although the Draft Report explains that these overpayments are not being pursued, we have reviewed all the claims. We disagree with five, and submitted relevant documentation and explanation with our responses to the Internal Controls Questionnaires related to this audit. However, we identified one claim that we agree was incorrectly billed and accordingly overpaid, and already provided additional education to the specific utilization nurse who made the error that led to the overpayment. Because that claim was identified in this pending audit and Draft Report, we will await completion of the current review process before refunding and billing for Medicare Part B services.

#### Conclusion

Flagstaff Medical Center is committed both to providing high-quality care to Medicare patients, and to fully complying with Medicare requirements in providing and billing for that care. As we hope these written comments underscore, we took this audit seriously, have spent significant time and effort in reviewing every potential overpayment in the audit, and – both before and after receiving notice of the audit – have worked to refine and improve controls relevant to this audit and to Medicare claims more broadly.

Please do not hesitate to contact me with questions or concerns regarding these written comments and the Draft Report.

Sincerely,

*/s/Colleen E. Maring*

Colleen E. Maring  
Chief Legal Counsel