Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# MEDICARE COMPLIANCE REVIEW OF METHODIST HEALTHCARE – MEMPHIS HOSPITALS FOR THE PERIOD JANUARY 1, 2011, THROUGH JUNE 30, 2012

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

Brian P. Ritchie
Assistant Inspector General
For Audit Services

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A-04-13-00093

# *Office of Inspector General*

http://oig.hhs.gov

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## OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

## EXECUTIVE SUMMARY

***Methodist Healthcare - Memphis Hospitals did not fully comply with Medicare requirements for billing inpatient services, resulting in overpayments of at least $5.8 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 (CY) 2012, Medicare paid hospitals $148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of our review was to determine whether Methodist Healthcare - Memphis Hospitals (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 1,293-bed acute care facility located in Memphis, Tennessee. According to CMS's National Claims History data, Medicare paid the Hospital approximately $474 million for 35,921 inpatient and 132,554 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012.

Our audit covered $29,002,241 in Medicare payments to the Hospital for 3,590 inpatient claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 150 claims with payments totaling $1,670,356 that had dates of service from January 2011, through June 2012 (audit period). We did not select any outpatient claims for review.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 102 of the 150 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in overpayments of $353,426 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 $5,893,302 for the audit period.

## WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare program $5,893,302 in estimated overpayments for claims that it incorrectly billed for the audit period and

- strengthen controls to ensure full compliance with Medicare requirements.

## METHODIST HEALTHCARE - MEMPHIS HOSPITALS COMMENTS

In written comments on our draft report, the Hospital agreed that 21 of the 48 claims were billed incorrectly and described the actions it had taken and planned to take to address them. The Hospital disagreed with our determination that it did not correctly bill the remaining 27 inpatient claims and stated that it intends to appeal denial of those claims. The Hospital further stated that the extrapolation should be invalidated because we did not follow our own sampling design and methodology due to the inclusion of claims reviewed by the Recovery Audit Contractors. In addition, the hospital stated that the sample selection was not valid, and the use of statistics violated statutory mandates prescribed for CMS and its contractors.

## OUR RESPONSE

We stand by the Medicare Administrative Contractor medical review staff's determinations and the auditors' professional judgments that the Hospital did not fully comply with Medicare billing requirements for the 27 disputed claims. In response to the Hospital's comments regarding invalidating the extrapolation used for this review, we acknowledge its comments; however, the extrapolation was appropriate for this review. Therefore, we continue to recommend that the Hospital refund to the Medicare program $5,893,302 in estimated overpayments and strengthen controls to ensure full compliance with Medicare requirements.

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# INTRODUCTION

## WHY WE DID THIS REVIEW

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

## OBJECTIVE

Our objective was to determine whether Methodist Healthcare - Memphis Hospitals (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

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

### Hospital 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 billed with high-severity-level DRG codes,
- inpatient claims paid in excess of charges,

- inpatient claims with same day discharges and readmissions,
- inpatient psychiatric facility emergency department adjustments,
- inpatient transfers, and
- inpatient manufacturer credits for replaced medical devices.

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

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

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2).

### Methodist Healthcare – Memphis Hospitals

The Hospital is a 1,293-bed acute care facility located in Memphis, Tennessee.[1] According to CMS's National Claims History data, Medicare paid the Hospital approximately $474 million for 35,921 inpatient and 132,554 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012.

## HOW WE CONDUCTED THIS REVIEW

Our audit covered $29,002,241 in Medicare payments to the Hospital for 3,590 inpatient claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 150 claims with payments totaling $1,670,356 that had dates of service from January 2011, through June 2012 (audit period). We did not select any outpatient claims for review.

[1] Data for this facility includes Le Bonheur Children's Medical Center, Methodist University, Methodist North, Methodist South, and Methodist Le Bonheur Germantown Hospitals.

We focused our review on the risk areas that we identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 28 claims to medical review to determine whether they met medical necessity and billing requirements.

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

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

See Appendix A for the details on our scope and methodology, Appendix B for our sample design and methodology, and Appendix C for our sample results and estimates.

## FINDINGS

The Hospital complied with Medicare billing requirements for 102 of the 150 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in overpayments of $353,426 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.

Based on our sample results, we estimated that the Hospital received overpayments of at least $5,893,302 for the audit period.

For results of our review by risk area, see Appendix D.

## BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 48 of 150 sampled inpatient claims, which resulted in overpayments of $353,426.

### 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 35 of the 150 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. Hospital officials agreed that 13 of the sampled claims were errors. They stated that these errors occurred because of human error and a flawed process related to cancelled procedures in which the cancelled procedures were not reviewed prior to billing. For the remaining 22 sampled claims, Hospital officials did not offer a cause because they did not

agree that these claims were billed in error. As a result of these 35 errors, the Hospital received overpayments of $304,890.[2]

**Incorrectly Billed as a Separate Inpatient Stay**

The Manual, chapter 3, section 40.2.5, states:

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

For 4 of the 150 sampled inpatient claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. Hospital officials stated that, in all four instances, the readmissions were related to the previously discharged encounter on the same day. Hospital officials further stated that the hospital had not trained the Lead Coding Analyst to determine properly whether the encounters were related or unrelated. As a result of these four errors, the Hospital received overpayments of $27,429.

**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 7 of the 150 sampled inpatient claims, the Hospital billed Medicare with incorrect DRG codes. For example, Hospital staff coded one claim with chronic systolic heart failure; however, the medical record did not contain documentation to support coding chronic systolic heart failure, which resulted in a DRG change from 300 to 301. Hospital officials agreed that two of these claims were billed incorrectly and attributed such to coder error. For the remaining five claims, Hospital officials did not offer a cause because they did not agree these claims were incorrectly billed. As a result of these seven errors, the Hospital received net overpayments of $16,904.

**Incorrectly Billed Patient Discharge Status Codes**

A hospital inpatient discharge is considered to be a transfer if the patient is readmitted the same day to another hospital unless the readmission is unrelated to the initial discharge

[2] 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.

(42 CFR § 412.4 (b)). A hospital inpatient discharge is also, considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4 (c)). A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 2 of the 150 sampled inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers to other facilities. For these claims, the Hospital should have coded the discharge status as a transfer to an acute care hospital. In one instance, Hospital staff incorrectly coded the discharge status as home, but the Hospital actually transferred the patient to another hospital. The Hospital should have received the per diem payment instead of the full DRG payment in both instances. Hospital officials agreed that they had billed these two claims incorrectly and attributed such billings to coder error. As a result of these two errors, the Hospital received overpayments of $4,203.

## OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $5,893,302 for the audit period.

## RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program $5,893,302 in estimated overpayments for claims that it incorrectly billed for the audit period and

- strengthen controls to ensure full compliance with Medicare requirements.

## METHODIST HEALTHCARE - MEMPHIS HOSPITALS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

## METHODIST HEALTHCARE - MEMPHIS HOSPITALS COMMENTS

In written comments on our draft report, the Hospital agreed that 21 of the 48 claims were billed incorrectly and described the actions it had taken and planned to take to address them. The Hospital disagreed with our determination that it did not correctly bill the remaining 27 inpatient claims and stated that it intends to appeal the denial of those claims. The Hospital further stated that the extrapolation should be invalidated because we did not follow our own sampling design and methodology due to the inclusion of claims reviewed by the Recovery Audit Contractors (RAC). In addition, the hospital stated that the sample selection was not valid, and the use of statistics violated statutory mandates prescribed for CMS and its contractors. The Hospital's comments are included as Appendix E.

## OFFICE OF INSPECTOR GENERAL RESPONSE

We stand by the Medicare Administrative Contractor medical review staff's determinations and the auditors' professional judgments that the Hospital did not fully comply with Medicare billing requirements for the 27 disputed claims.

With respect to the Hospital's concerns about RAC claims being in our sampling frame and sample, we treated the single claim in our sample as a non-error. Therefore, its inclusion in our sample did not increase the number of errors identified or the overpayment estimate. To the contrary, its inclusion reduced the sample error rate that was statistically applied to the sampling frame.

Regarding the Hospital's objections to our statistical sampling and extrapolation, 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.

Additionally, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare. *See Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

Finally, the Hospital's argument that the use of statistics violated statutory mandates prescribed for CMS and its contractors is not applicable because the OIG is not a Medicare contractor.

Therefore, we continue to recommend that the Hospital refund to the Medicare program $5,893,302 in estimated overpayments and strengthen controls to ensure full compliance with Medicare requirements.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered $29,002,241 in Medicare payments to the Hospital for 3,590 inpatient claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 150 claims with payments totaling $1,670,356 that had dates of service from January 2011, through June 2012. We did not select any outpatient claims for review.

We focused our review on the risk areas that we identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 28 claims to medical review to determine whether the services were medically necessary.

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 National Claims History file (NCH), but we did not assess the completeness of the file.

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

We conducted our fieldwork at the Hospital from May 2013 through March 2014.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's NCH file for the audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 150 inpatient claims (Appendix B) totaling $1,670,356 for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;

- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;

- reviewed the Hospital's procedures for submitting Medicare claims;

- used CMS's Medicare contractor medical review staff to determine whether 28 sampled claims met medical necessity and billing requirements;

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

- calculated the correct payments for those claims requiring adjustments;

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

- discussed the results of our review with Hospital officials.

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

## APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

### POPULATION

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

### SAMPLING FRAME

According to CMS's NCH data, for 32 risk areas, Medicare paid the Hospital $214,023,061 for 15,463 inpatient and 68,681 outpatient claims for services provided to beneficiaries during the audit period.

From these 32 risk areas, we selected 7 inpatient risk areas consisting of 11,810 claims totaling $130,452,145 for further refinement. We did not select any outpatient risk areas for review.

We then removed claims as follows:

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

We assigned each claim that appeared in multiple risk areas to just one risk area based on the following hierarchy: Inpatient Medical Devices, Inpatient Claims Billed with high-severity-level DRG Codes, Inpatient Claims Paid in Excess of Charges, and then Inpatient Short Stays.

Removing these claims resulted in a sampling frame of 3,590 unique Medicare claims in 7 risk areas totaling $29,002,241.

**Risk Areas Sampled**

| Risk Area | Number of Claims | Amount of Payments |
|---|---|---|
| Inpatient Short Stays | 1,372 | $10,418,132 |
| Inpatient Claims Billed with High-Severity-Level DRG Codes | 2,168 | 17,759,795 |
| Inpatient Claims Paid In Excess of Charges | 20 | 417,021 |
| Inpatient Claims with Same Day Discharges and Readmissions | 8 | 86,145 |
| Inpatient Psychiatric Facility Emergency Departments Adjustments | 16 | 208,205 |
| Inpatient Transfers | 4 | 95,809 |

| Risk Area | Number of Claims | Amount of Payments |
|---|---|---|
| Inpatient Manufacturer Credits for Replaced Medical Devices | 2 | 17,134 |
| **Total** | **3,590** | **$29,002,241** |

**SAMPLE UNIT**

The sample unit was a Medicare paid claim.

**SAMPLE DESIGN**

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

**SAMPLE SIZE**

We selected 150 claims as follows:

**Sampled Claims by Stratum**

| Stratum | Risk Area | Claims in Sampling Frame | Claims in Sample |
|---|---|---|---|
| 1 | Inpatient Short Stays | 1,372 | 50 |
| 2 | Inpatient Claims Billed with High-Severity-Level Diagnosis Related Group Codes | 2,168 | 50 |
| 3 | Inpatient Claims Paid In Excess of Charges | 20 | 20 |
| 4 | Inpatient Claims with Same Day Discharges and Readmissions | 8 | 8 |
| 5 | Inpatient Psychiatric Facility Emergency Departments Adjustments | 16 | 16 |
| **6** | Inpatient Transfers | 4 | 4 |
| **7** | Inpatient Manufacturer Credits for Replaced Medical Devices | 2 | 2 |
| | **Total** | **3,590** | **150** |

## SOURCE OF RANDOM NUMBERS

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

## 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 frame items. We selected all claims in strata 3, 4, 5, 6, and 7.

## ESTIMATION METHODOLOGY

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

## APPENDIX C: SAMPLE RESULTS AND ESTIMATES

### SAMPLE RESULTS

| Stratum | Frame Size (Claims) | Value of Frame | Sample Size | Total Value of Sample | Number of Improperly Billed Claims in Sample | Value of Overpayments in Sample |
|---|---|---|---|---|---|---|
| 1 | 1,372 | $10,418,132 | 50 | $442,060 | 25 | $203,148 |
| 2 | 2,168 | 17,759,795 | 50 | 403,982 | 13 | 71,819 |
| 3 | 20 | 417,021 | 20 | 417,021 | 4 | 46,827 |
| 4 | 8 | 86,145 | 8 | 86,145 | 4 | 27,429 |
| 5 | 16 | 208,205 | 16 | 208,205 | 0 | 0 |
| 6 | 4 | 95,809 | 4 | 95,809 | 2 | 4,203 |
| 7 | 2 | 17,134 | 2 | 17,134 | 0 | 0 |
| **Total** | **3,590** | **$29,002,241** | **150** | **$1,670,356** | **48** | **$353,426** |

### ESTIMATES

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

| | |
|---|---|
| Point Estimate | $8,766,930 |
| Lower limit | $5,893,302 |
| Upper limit | $11,640,558 |

## APPENDIX D: RESULTS OF REVIEW BY RISK AREA

| Risk Area | Selected Claims | Value of Selected Claims | Claims With Over-payments | Value of Over-payments |
|---|---|---|---|---|
| Short Stays | 50 | $442,060 | 25 | $203,148 |
| Claims Billed with High-Severity-Level DRG Codes | 50 | 403,982 | 13 | 71,819 |
| Claims Paid In Excess of Charges | 20 | 417,021 | 4 | 46,827 |
| Claims with Same Day Discharges and Readmissions | 8 | 86,145 | 4 | 27,429 |
| Transfers | 4 | 95,809 | 2 | 4,203 |
| Psychiatric Facility Emergency Departments Adjustments | 16 | 208,205 | 0 | 0 |
| Manufacturer Credits for Replaced Medical Devices | 2 | 17,134 | 0 | 0 |
| **Totals** | **150** | **$1,670,356** | **48** | **$353,426** |

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

## APPENDIX E: METHODIST HEALTHCARE - MEMPHIS HOSPITALS COMMENTS

Methodist Le Bonheur Healthcare

September 19, 2014

Via FEDEX and Electronic Email Submission

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

**RE: Report: A-04-13-00093**
**Response of Methodist Healthcare – Memphis Hospitals**

Dear Ms. Pilcher:

Please accept this correspondence on behalf of Methodist Healthcare – Memphis Hospitals ("MHMH") in response to the U.S. Department of Health and Human Services, Office of the Inspector General ("OIG") draft report entitled *Medicare Compliance Review of Methodist University Hospital for the Period January 1, 2011 Through June 30, 2012* ("Draft Report"). Methodist University Hospital, the only MHMH facility identified in the Medicare Compliance Review, is one of five hospital facilities that is licensed as Methodist Healthcare – Memphis Hospitals. Since there is no separate legal entity named "Methodist University Hospital", Methodist Healthcare – Memphis Hospitals ("MHMH") will be the entity referenced throughout this correspondence as responding to the specific findings in the Compliance Review.

MHMH is committed to a culture of compliance. It takes very seriously its obligation to comply with regulations and requirements governing participation in federally funded health care programs. We appreciate the opportunity that the audit process has provided to identify specific areas relating to our billing processes where additional processes to improve our current internal controls can be implemented. Further, we would like to acknowledge the professionalism and courtesy that we were shown by the OIG's audit team throughout the audit process.

Below please find the response of MHMH to the OIG's specific findings and recommendations.

OIG Summary of Findings and Recommendations and MHMH's Response

OIG Summary of Findings:

The Hospital complied with Medicare billing requirements for 102 of the 150 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in overpayments of $353,426 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 $5,893,302 for the audit period.

**OIG Recommendations:**

We recommend that the Hospital:

- refund to the Medicare program $5,893,302 in estimated overpayments for claims that it incorrectly billed for the audit period and
- strengthen controls to ensure full compliance with Medicare requirements.

**MHMH Response:**
**THE EXTRAPOLATION SHOULD BE INVALIDATED**

**I. OIG Did Not Follow Its Own Stated Sampling Design and Methodology**

OIG did not follow its stated sampling design and methodology when conducting this audit, thus corrupting the sample, sampling frame, and any extrapolated results.

Appendix B, entitled "*Sample Design and Methodology*," defined the methodology endorsed by and purportedly used by OIG when developing the sample and resulting extrapolation. The Sampling Frame was described as follows:

> *According to CMS's NCH data, for 32 risk areas, Medicare paid the Hospital $214,023,061 for 15,463 inpatient and 68,681 outpatient claims for services provided to beneficiaries during the audit period.*
>
> *From these 32 risk areas, we selected 7 inpatient risk areas consisting of 11,810 claims totaling $130,452,145 for further refinement. We did not select any outpatient risk areas for review.*
>
> *We then removed claims as follows:*
>
> - *all $0 paid claims,*
> - ***all claims under review by the Recovery Audit Contractor,***[1] *and*
> - *all duplicate claims within individual risk areas.*

[1] Emphasis added.

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*We assigned each claim that appeared in multiple risk areas to just one risk area based on the following hierarchy: Inpatient Medical Devices, Inpatient Claims Billed with high-severity-level DRG Codes, Inpatient Claims Paid in Excess of Charges, and then Inpatient Short Stays.*

*Removing these claims resulted in a sampling frame of 3,590 unique Medicare claims in 7 risk areas totaling $29,002,241.*

The OIG chose a sample size of 150 paid claims.

Contrary to the stated methodology, claims included as part of this audit were indeed reviewed by a Recovery Audit Contractor (RAC). One of the claims in the sample (#19) was reviewed by a RAC and seven additional claims, reviewed by a RAC, have been identified in the sampling frame.

The presence of claims outside of the audit definition makes it impossible to replicate the sample and overpayment. We expect that you would agree that an error of this magnitude contaminates the entire sampling and extrapolation process and makes the proposed extrapolation of a repayment obligation invalid.

The Medicare program has established specific guidelines in its Program Integrity Manual (MPIM) governing use of statistical sampling for overpayment estimation in the Medicare program, which the OIG has previously cited to substantiate its sampling practices in other audit reports. Section 8.4.4.4.1 of the MPIM, for example, states that "[s]ufficient documentation shall be kept so that the sampling frame can be re-created, should the methodology be challenged." These documentation requirements, as well as other MPIM instructions regarding proper use of sampling in Medicare audits, have not been met. A sampling frame that includes data outside of an audit definition cannot be re-created, thus invalidating the extrapolation based on the sample drawn.

## II. OIG Failed to Obtain a Valid Probability Sample

We respectfully contend that the OIG failed to obtain a valid probability sample in this case. The sample selected in this case cannot be a probability sample for the stated universe of claims, since the likelihood of it occurring would be zero, which is clearly not the same as an appropriately chosen sample.

The MPIM guidance regarding use of sampling for overpayment estimation in Medicare audits provides an instructive description of the requirements for a valid probability sample. Section 8.4.2 of the MPIM states, in part, the following:

*Regardless of the method of sample selection used, the PSC, ZPIC BI unit or the contractor MR unit shall follow a procedure that results in a probability sample. For a procedure to be classified as probability sampling the following two features must apply:*

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- *It must be possible, in principle, to enumerate a set of distinct samples that the procedure is capable of selecting if applied to the target universe. Although only one sample will be selected, each distinct sample of the set has a known probability of selection. It is not necessary to actually carry out the enumeration or calculate the probabilities, especially if the number of possible distinct samples is large – possibly billions. It is merely meant that one could, in theory, write down the samples, the sampling units contained therein, and the probabilities if one had unlimited time; and*

- *Each sampling unit in each distinct possible sample must have a known probability of selection. For statistical sampling for overpayment estimation, one of the possible samples is selected by a random process according to which each sampling unit in the target population receives its appropriate chance of selection. The selection probabilities do not have to be equal but they should all be greater than zero….*

These statistical standards were not followed in the Compliance Review.

### III. No Evidence Was Provided of a High Error Rate or Documented Educational Efforts Failing to Correct a Payment Error

The OIG determined that less than 1/3 of the claims reviewed (48 of 150) were found to be overpaid by Medicare contractors. We anticipate many of these claims being overturned on appeal. MHMH historically has a high success rate during the appeals process.

Pursuant to Medicare law, extrapolation may generally not be used absent a significant error rate on the part of a provider. Under the Medicare Integrity Program, "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." 42 U.S.C §1395ddd(f)(3).

The OIG has not alleged that there is a "sustained or high level of payment error" nor is there any evidence that "documented educational intervention has failed to correct the payment error." To the contrary, MHMH has taken proactive steps to address claim denials and will appeal all denials in which they disagree with the findings.

Congress did not grant the Medicare program blanket authority to utilize extrapolation. We respectfully urge the OIG to follow Congress's lead and discard any use of extrapolation in this case.

**BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

**Incorrectly Billed as Inpatient**

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OIG Findings: For 35 of the 150 sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. Hospital officials agreed that 13 of the sampled claims were errors. They stated that these errors occurred because of human error and a flawed process related to cancelled procedures in which the cancelled procedures were not reviewed prior to billing. For the remaining 22 sampled claims, Hospital officials did not offer a cause because they did not agree that these claims were billed in error.

MHMH Response: MHMH concurred with the OIG's findings with respect to claims with the following Sample Numbers: 26, 27, 33, 38, 43, 44, 45, 47, 48, 49, 97, 114 and 118. Three of these claims were cancelled procedures that were billed as inpatient in error. MHMH has added a "bill hold" edit into our billing system that prevents billing of all claims with a LOS of 1 day or less and contains an ICD code for a cancelled procedure. When these claims are identified, they are referred to Case Management for further review to determine if documentation supports medically necessary Inpatient Services despite the cancelled procedure or if the claim needs to be billed as Part B Only.

MHMH concurs with the OIG's findings that ten of these claims could have been provided in an alternate setting. In response to this finding, MHMH has developed a Short Stay report to identify all discharges with a LOS of 2 days or less that is automatically generated and distributed daily for review by Case Management. Case Management reviews each case on this report to determine if documentation supports medical necessity. If medical necessity criteria is not supported, Case Management notifies Patient Financial Services to adjust the claim accordingly to bill for Part B Only.

All Case Management departments have also participated in several educational opportunities both internally and externally including, but not limited, to webinars, on-site education provided by external consultants as well as several "refresher" courses for appropriate application of Milliman Criteria. We have purchased a Case Management system which will be implemented later this year.

Finally, MHMH is presently engaged in the process of implementing ongoing audits for high risk cases which are identified by monitoring our PEPPER and by monitoring the outcomes of other external audits such as the RACs and MACs.

MHMH respectfully disagrees with the findings of the OIG and its medical review contractor regarding the following Sample claim numbers: 1, 3, 5, 11, 15, 25, 31, 35, 36, 39, 40, 42, 58, 60, 65, 67, 74, 75, 79, 82, 86 and 113.

MHMH intends to appeal the denial of these 22 claims. The documentation in each medical record for these claims supports the appropriate level of care as originally billed. In compliance with CMS Conditions of Participation, we follow our UM plan and have Case Management/UR personnel review all admissions for inpatient and observation patients. Their review checks for the presence of an order and confirms that the order matches

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the assigned status - inpatient or outpatient/observation services. They then compare physician documentation against Milliman Care Guidelines for appropriateness of the assigned status. Cases not meeting the screening criteria for the current status prompt either a call to the physician for clarification of documentation (if unclear), or referral to a physician reviewer (either the CMO or contracted outside consultant ) If, after physician second level review, it was felt that the status was inappropriate, a discussion would be held with the attending physician. If the attending physician agrees with the reviewer's recommendation, the physician enters the appropriate order and supporting documentation into Cerner, and the CM or Patient Access associate updates the patient's status to match the order. If the change in level of care results in a change from Inpatient to Outpatient Observation the Condition Code 44 process is followed.

For patients who are converted by the attending physician to inpatient status after a period of observation, case management/UR again would review the documentation and order for appropriateness as above before changing the status.

MHMH's current Medicare appeals success rate is 93% for all appeals which have been processed at this point in time regarding appropriate level of care. We have no reason to believe that the success rate for appeal on these 22 claims will fall below that historical level, and in fact believe that all of these cases will be resolved in MHMH's favor.

**Incorrectly Billed as a Separate Inpatient Stay**

**OIG Findings:** For 4 of the 150 sampled inpatient claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. Hospital officials stated that, in all four instances, the readmissions were related to the previously discharged encounter on the same day. Hospital officials further stated that the Hospital had not trained the Lead Coding Analyst to determine properly whether the encounters were related or unrelated.

**MHMH Response**: MHMH concurs with the OIG's findings for claims identified as Sample Numbers 121, 123, 124 and 128. During the period of this review, our billing system held all claims with overlapping service dates and prevented billing until the claim was reviewed by the Lead Coding Analyst. Based upon best judgment, the Lead Coding Analyst would determine if these accounts were related or unrelated. If found unrelated, the bills were processed separately. If found related, the claims for these episodes of care were combined and submitted for payment.

This mechanism of holding one hundred percent hold of the overlapping claims by our billing system is a positive internal control system. Upon retrospective analysis, however, we have concluded that the Lead Coding Analyst may not have received sufficient relevant clinical training necessary to properly determine whether the episodes were related or unrelated in these specific examples.

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Overlapping episodes such as these are now referred to the Case Management department for review by clinically trained personnel for determination instead of to the Lead Coding Analyst. If the decision is unclear, a referral of the case is made to the facility Chief Medical Officer.

Going forward, on an annual basis, an audit sample will be reviewed by the Chief Medical Officer at each facility to monitor this process and ensure ongoing compliance with appropriate billing of claims with overlapping episodes.

**Incorrectly Billed Diagnosis Related Group Codes**

**OIG Findings:** For 7 of the 150 sampled inpatient claims, the Hospital billed Medicare with incorrect DRG codes. For example, Hospital staff coded one claim with chronic systolic heart failure; however, the medical record did not contain documentation to support coding chronic systolic heart failure, which resulted in a DRG change from 300 to 301. Hospital officials agreed that two of these claims were billed incorrectly and attributed such to coder error. For the remaining five claims, Hospital officials did not offer a cause because they did not agree these claims were incorrectly billed.

**MHMH Response:** MHMH concurs with the findings with respect to the following two claims identified as Sample Numbers 9 and 87. Training and education has been provided to coding staff on MS-DRG 300. Additionally, MS-DRG 300 is included in focused DRG monthly audits.

Since the period of this review, MHMH has implemented a Clinical Documentation Improvement program that concurrently reviews medical records providing another review of documentation and coding data prior to billing. A concurrent review of records that have a discrepancy between the DRG assigned by the Clinical Documentation Specialist and the Clinical Coding Analyst is performed to ensure the DRG assignment is accurate.

Additionally, MHMH has policies in place which state that the Clinical Coding Analysts must maintain an accuracy rate of greater than or equal to 98% in DRG assignment. If there are repetitive errors identified during the audit process or the accuracy rate is not maintained, corrective action will be issued.

MHMH respectfully disagrees with the OIG's findings regarding claims identified with Sample Numbers 2, 6, 54, 68 and 120. MHMH intends to appeal the denial of these five claims.

MHMH believes strongly in its controls used to ensure accuracy of coding. DRG audits are performed on random DRGs as well as focused DRGs that have been identified nationally or internally as highly susceptible to errors. Audits include a review of the medical record documentation to ensure the documentation in the record supports the coding that is submitted on the claim. When conflicting documentation appears in the medical record at the time of coding, the Clinical Coding Analyst queries the physician in order to clarify documentation.

Continuing Education is provided at monthly Corporate Coding meetings in the form of handouts, in-services, and coding practice examples. Information that needs to be shared between meetings is distributed via email. Each quarter, an in-depth review of the latest Coding Clinic is also provided to the coding staff.

**Incorrectly Billed Patient Discharge Status Codes**

**OIG Findings:** For 2 of the 150 sampled inpatient claims, the Hospital incorrectly billed Medicare for patient discharges that it should have billed as transfers to other facilities. For these claims, the Hospital should have coded the discharge status as a transfer to an acute care hospital. In one instance, Hospital staff incorrectly coded the discharge status as home, but the Hospital actually transferred the patient to another hospital. The Hospital should have received the per diem payment instead of the full DRG payment in both instances. Hospital officials agreed that they had billed these two claims incorrectly and attributed such billings to coder error.

**MHMH Response**: MHMH concurs with the OIG findings for claims identified as Sample numbers 145 and 147. During the coding process, each record is reviewed for the assignment of a discharge status.

Ten percent of all discharges are audited to ensure coding accuracy but these two claims were not within the audit sample. Additionally, discharge status reviews are conducted during DRG validation audits by lead coders, management, and/or an external consulting firm on each Clinical Coding Analyst on all types of charts on a monthly basis.

Continuing Education is provided at monthly Corporate Coding meetings in the form of handouts, in-services, and coding practice examples. Information that needs to be shared between meetings is distributed via email.

**Conclusion**

As part of its commitment to a culture of compliance, MHMH routinely reviews and examines its coding and billing practices to improve accuracy and compliance.

In addition to our internal controls, in order to insure that patients are appropriately categorized as either inpatient or outpatient, MHMH retains the services of outside clinical consultants to provide concurrent review of medical records and the presence of medical necessity, in order to make any necessary adjustments prior to a patient discharge. As previously noted, MHMH has an impressive success rate in connection with its RAC appeals and obtaining reversals of RAC error findings. This highly suggests that MHMH has efficient and meaningful internal controls in place. MHMH does recognize its obligations and reaffirms its commitment to appropriately bill for services and will use the outcome of this audit as a guideline to institute any necessary process improvements.

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On behalf of MHMH, we thank you in advance for consideration of our response. We will make ourselves available to you should you have any questions or would like any additional information.

Sincerely,

Loretta M. Hinton
Assistant General Counsel and
Chief Compliance Officer

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