Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF BOCA RATON REGIONAL HOSPITAL, INC., FOR 2011 AND 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

October 2015
A-04-14-07048

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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

Boca Raton Regional Hospital, Inc., did not fully comply with Medicare requirements for billing inpatient services, resulting in net overpayments of at least $2.6 million over 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and 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 this review was to determine whether Boca Raton Regional Hospital, Inc. (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 400-bed, not-for-profit, acute care facility located in Boca Raton, Florida. According to CMS's National Claims History data, Medicare paid the Hospital approximately $291 million for 18,726 inpatient and 406,136 outpatient claims for services provided to beneficiaries from January 1, 2011, through December 31, 2012 (audit period).

Our audit covered $12,621,208 in Medicare payments to the Hospital for 1,677 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 211 claims with payments totaling $1,867,467. These 211 claims had dates of service in our audit period and consisted of 206 inpatient and 5 outpatient claims.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 161 of the 211 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 50 inpatient claims, resulting in net overpayments of $514,449 for the audit period. The outpatient claims selected for review did not contain errors. This overpayment amount includes claim payment dates outside of the 3-year recovery 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 net overpayments of at least $2,628,112 for the audit period. This overpayment amount includes claim payment dates outside of the 3-year recovery period. Of the total estimated overpayments, at least $282,259 was within the 3-year recovery period and as much as $2,345,853 is outside the 3-year recovery period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare program $282,259 in estimated net overpayments for claims incorrectly billed that are within the 3-year recovery period;

- work with the contractor to return overpayments outside of the 3-year recovery period, which we estimate to be as much as $2,345,853 for our audit period, in accordance with the 60-day repayment rule; and

- strengthen controls to ensure full compliance with Medicare requirements.

BOCA RATON REGIONAL HOSPITAL, INC., COMMENTS

In written comments on our draft report, the Hospital did not agree with our first and second recommendations. In regard to our third recommendation, the Hospital described steps it takes to ensure compliance with Medicare billing requirements.

The Hospital maintained that the claims paid during CY 2011 are time-barred from recovery, but stated that the claims are also time-barred from reopening. Additionally, it stated that the time-barred claims do not constitute overpayments because the claims cannot be recovered, and they have not been reopened to date. The Hospital further stated that the Medicare contractor initially determined that the payment was authorized, and, accordingly, the claims hold the legal status of "payments," not "overpayments."

The Hospital also stated that extrapolation is legally unfounded, statistically unsound, and premature. Additionally, for 13 of the 20 inpatient claims paid during CY 2012, the Hospital did not agree with our error determinations and stated that it planned to contest the findings.

OUR RESPONSE

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid.

We recognize that, ultimately, CMS, as the cognizant Federal agency, has the authority to decide how to resolve these and the other recommendations in this audit report. Because statutory limits

on reopening and recovery may apply to certain claims, we recommend that the Hospital work with the contractor to refund payments for these claims in accordance with Federal laws and regulations.

Regarding our extrapolation methodology and statistical validity, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare.

In response to the Hospital's contestation that it improperly billed 13 inpatient claims, we used an independent medical review contractor to determine whether the 13 inpatient claims met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims in compliance with Medicare requirements. On the basis of the contractor's conclusions, we determined that the Hospital should have billed 8 of the 13 claims as outpatient or outpatient with observation services and that it billed 5 of the 13 claims with incorrect DRGs.

Therefore, we continue to recommend that the Hospital refund to the Medicare program $282,259 in estimated net overpayments for claims that were incorrectly billed and within the 3-year recovery period and work with the contractor to return overpayments outside of the 3-year recovery period in accordance with the 60-day repayment rule.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

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

OBJECTIVE

Our objective was to determine whether Boca Raton Regional Hospital, Inc. (the Hospital), complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Medicare Program

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

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

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services

within each APC group.[1] All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient short stays,
- inpatient same day discharges and readmissions,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims with transfers, and
- outpatient claims paid in excess of $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 review.

Medicare Requirements for Hospital Claims and Payments

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

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

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

Boca Raton Regional Hospital, Inc.

The Hospital is a 400-bed, not-for-profit, acute care facility located in Boca Raton, Florida. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital

[1] The health care industry uses HCPCS codes to standardize coding for medical procedures, services, products, and supplies.

approximately $291 million for 18,726 inpatient and 406,136 outpatient claims for services provided to beneficiaries from January 1, 2011, through December 31, 2012 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our audit covered $12,621,208 in Medicare payments to the Hospital for 1,677 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 211 claims with payments totaling $1,867,467. These 211 claims had dates of service in our audit period and consisted of 206 inpatient and 5 outpatient claims.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 45 inpatient claims to medical and coding reviews to determine whether the services were medically necessary and properly coded.

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

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

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

FINDINGS

The Hospital complied with Medicare billing requirements for 161 of the 211 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 50 inpatient claims, resulting in net overpayments of $514,449 for the audit period. The outpatient claims selected for review did not contain errors. This overpayment amount includes claim payment dates outside of the 3-year recovery 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 net overpayments of at least $2,628,112 for the audit period. This overpayment amount includes claim payment dates

outside of the 3-year recovery period.[2] Of the estimated overpayments, at least $282,259 was within the 3-year recovery period and as much as $2,345,853 is outside the 3-year recovery period.

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

BILLING ERRORS

The Hospital incorrectly billed Medicare for 50 of 206 sampled inpatient claims, which resulted in net overpayments of $514,449.

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 206 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. The Hospital did not provide a cause for these errors because it did not believe that it billed the claims in error.

As a result of these errors, the Hospital received overpayments of $494,815.[3]

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).

[2] Our audit report represents the results for all claims within our audit period. Section 1870(b) of the Act governs the recovery of excess payments. This section provides that excess payments identified are barred from recovery 3 years after the year in which the original payment was made. In addition, the Hospital is responsible for reporting and returning overpayments they identified to their Medicare administrative contractor. The 2010 Patient Protection and Affordable Care Act requires the reporting and return of Medicare overpayments along with written notice of the reason for the overpayment within 60 days after the overpayment was identified (60-day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

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

For 14 of the 206 inpatient claims, the Hospital submitted claims to Medicare with incorrectly coded[4] claims that resulted in higher DRG payments to the Hospital. For example, the Hospital submitted a claim with a secondary diagnosis of hyponatremia.[5] However, the medical records did not support the coding of this diagnosis. By including this secondary diagnosis, the Hospital's Medicare reimbursement increased because the weight of the DRG increased,[6] which resulted in an overpayment. The Hospital did not provide a cause for these errors because it did not believe that it billed the claims in error.

As a result of these errors, the Hospital received net overpayments of $15,977.

Incorrect Discharge Status

Federal regulations state that a discharge of a hospital inpatient is considered to be a transfer for purposes of payment if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital paid under the IPPS (42 CFR § 412.4(b)). A hospital that transfers an inpatient under the above circumstance is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)). This policy is also effective for patients who leave against medical advice. For patients who are admitted to another IPPS hospital on the same day they leave an IPPS hospital, the "transferring" hospital will be subject to the payment outlined by the transfer policy (*CMS Manual System, Medicare Claims Processing,* Pub. 100-04, Transmittal 87).

For 1 of the 206 inpatient claims, Medicare overpaid the Hospital for a discharged patient that was readmitted the same day to another hospital paid under the IPPS. This overpayment occurred because the Hospital received the full DRG payment instead of the graduated per diem payment. The Hospital stated that this error occurred because it does not have access to information regarding patients who have left against medical advice and are subsequently admitted to other hospitals. However, because the policy is also effective for patients who leave against medical advice, Medicare should have paid the Hospital the graduated per diem payment instead of the full DRG payment, even though the Hospital was unaware at the time that another hospital had readmitted the patient.

As a result of this error, the Hospital received an overpayment of $3,657.

[4] For 1 of these 14 claims, the Hospital also billed the claim with an incorrect discharge status code. The Hospital coded the discharge status as to "Critical Access Hospital" instead of to "Other Short-term Hospital for Inpatient Care."

[5] Hyponatremia is a condition in which the amount of sodium in the blood is lower than normal.

[6] Each DRG has a payment weight assigned to it on the basis of the average resources used to treat Medicare patients in that DRG.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received net overpayments of at least $2,628,112 for the audit period, of which $282,259 was within the 3-year recovery period and as much as $2,345,853 is outside the 3-year recovery period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program $282,259 in estimated net overpayments for claims incorrectly billed that are within the 3-year recovery period;

- work with the contractor to return overpayments outside of the 3-year recovery period, which we estimate to be as much as $2,345,853 for our audit period, in accordance with the 60-day repayment rule; and

- strengthen controls to ensure full compliance with Medicare requirements.

BOCA RATON REGIONAL HOSPITAL, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

BOCA RATON REGIONAL HOSPITAL, INC., COMMENTS

In written comments on our draft report, the Hospital disagreed with some of our findings and recommendations.

First Recommendation

Regarding our first recommendation, of the claims that fell within the 3-year recovery period, the Hospital disagreed that it improperly billed 13 of the 20 inpatient claims. The Hospital intends to contest the findings.

It also stated that extrapolation is legally unfounded, statistically unsound, and premature. Furthermore, the Hospital stated that:

- The law is clear that CMS and its contractors may not use extrapolation to determine overpayment amounts unless the Secretary determines that there is a sustained or high level of payment error or documented educational intervention has failed to correct the payment error.

- Extrapolation is statistically unsound because claims in the population overlapped with claims reviewed by the Recovery Audit Contractor (RAC).

- Extrapolation should be postponed until the contractor has fully adjudicated all of the claims, and premature extrapolation resulted in an over-inflated estimated overpayment.

Second Recommendation

Regarding the second recommendation, the Hospital maintained that the claims paid during CY 2011 are time-barred from recovery, but stated that the claims are also time-barred from reopening. The Hospital objected to the recommendation that it work with the Medicare contractor to return overpayments outside of the 3-year recovery period in accordance with the 60-day repayment rule. The Hospital contended that the 2011 claims do not constitute overpayments because they were time-barred from recovery and they have not been reopened to date. The Hospital further stated that the Medicare contractor initially determined that the payment was authorized, and, accordingly, the claims hold the legal status of "payments," not "overpayments."

Third Recommendation

Regarding our third recommendation, the Hospital stated that its internal controls are fully operational and highly efficient. It also stated that it seeks opportunities for improvement and would strengthen its efforts to enhance compliance with respect to the risk areas included in this report.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

Contested Determinations of Claims

We used an independent medical review contractor to determine whether the 13 inpatient claims met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims in compliance with Medicare requirements. On the basis of the contractor's conclusions, we determined that the Hospital should have billed 8 of the 13 claims as outpatient or outpatient with observation services and that it billed 5 of the 13 claims with incorrect DRGs.

Statistical Sampling and Extrapolation

The Hospital's reference to the requirement that a determination of a sustained or high level of payment error or documented failed educational intervention must be made before extrapolation may be used applies only to Medicare contractors. *See* Social Security Act § 1893(f)(3); CMS Medicare Program Integrity Manual, chapter 8.4.1.4 (effective June 28, 2011).

We made every effort to exclude RAC-reviewed and canceled claims from our sample population. However, we recognize that some RAC-reviewed or cancelled claims may be included in our population. To remedy this, our statistical analysis, if effective, estimates the total value of claims in our sampling frame that have been reviewed by the RAC and excludes

the resulting total from our overpayment estimate. This adjustment ensures that our final overpayment estimate accounts for these types of claims in a fair and unbiased manner.

Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare. *See Momentum EMS, Inc. v. Sebelius*, 2014 WL 199061 at *9 (S.D. Tex. 2014); *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). Additionally, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology. *See John Balko & Assoc. v. Sebelius*, 2012 WL 6738246 at *12 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012). We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

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

Claims Time-Barred From Reopening and Recovery

We recognize that, ultimately, CMS, as the cognizant Federal agency, has the authority to decide how to resolve these and the other recommendations in this audit report. Because statutory limits on reopening and recovery may apply to certain claims, we recommend that the Hospital work with the Medicare contractor to refund payments for these claims in accordance with Federal laws and regulations.

Therefore, we continue to recommend that the Hospital refund to the Medicare program $282,259 in estimated net overpayments for claims incorrectly billed that are within the 3-year recovery period and work with the contractor to return overpayments outside of the 3-year recovery period in accordance with the 60-day repayment rule.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $12,621,208 in Medicare payments to the Hospital for 1,677 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 211 claims with payments totaling $1,867,467. These 211 claims consisted of 206 inpatient and 5 outpatient claims with dates of service from January 1, 2011, through December 31, 2012.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 45 inpatient claims to medical and coding reviews to determine whether the services were medically necessary and properly coded.

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

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

We conducted fieldwork at the Hospital during April 2014.

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;
- selected a stratified random sample of 211 claims (206 inpatient and 5 outpatient) totaling $1,867,476 for detailed review (Appendix B);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;

- reviewed the Hospital's procedures for assigning DRG, HCPCS, admission, and discharge status codes for Medicare claims;

- used an independent medical review contractor to determine whether 45 sampled claims met medical necessity and coding requirements;

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

- calculated the correct payments for those claims requiring adjustments;

- used the results of the sample to estimate the total Medicare overpayments to the Hospital (Appendix C) for our audit period;

- used the results of the sample to estimate the Medicare overpayments to the Hospital (Appendix C) that are within the 3-year recovery period; and

- discussed the results of our review with Hospital officials.

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

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

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

SAMPLING FRAME

According to CMS's NCH data, Medicare paid the Hospital $290,653,913 for 18,726 inpatient and 406,136 outpatient claims for services provided to beneficiaries during the audit period.

We obtained a database of claims from CMS's NCH data totaling $151,687,685 for 11,321 inpatient and 44,304 outpatient claims for 26 risk areas. From these 26 areas, we selected 5 consisting of 8,052 claims totaling $48,922,110 for further review.

We performed data analyses of the claims within each of the five risk areas. For strata one and two, we removed claims with payment amounts less than $3,000. For strata two, we removed claims on the Inpatient-Only Procedure List.

We then removed the following:

- $0 paid claims,
- claims under review by the RAC,[7] and
- duplicated claims within individual risk areas.

We assigned each claim that appeared in multiple risk areas to just one area based on the following hierarchy: Inpatient Short Stays, Inpatient Claims Billed with High-Severity-Level DRG Codes, and Inpatient Same Day Discharges and Readmissions. This resulted in a sample frame of 1,677 unique Medicare claims in 5 risk areas totaling $12,621,208.

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

Table 1: Risk Areas Sampled

Risk Area	Number of Claims	Amount of Payment
Inpatient Claims Billed With High-Severity-Level DRG Codes	859	$6,474,870
Inpatient Short Stays	807	5,852,488
Inpatient Same Day Discharges and Readmissions	4	131,704
Inpatient Transfers	2	10,369
Outpatient Claims With Payments Greater Than $25,000	5	151,777
Total	**1,677**	**$12,621,208**

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 the risk area. All claims are unduplicated, appearing in only one area and only once in the entire sampling frame.

SAMPLE SIZE

We selected 211 claims for review as follows:

Table 2: Sampled Claims by Stratum

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Claims Billed With High-Severity-Level DRG Codes	859	100
2	Inpatient Short Stays	807	100
3	Inpatient Same Day Discharges and Readmissions	4	4
4	Inpatient Transfers	2	2
5	Outpatient Claims With Payments Greater Than $25,000	5	5
	Total Sampled Claims	**1,677**	**211**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments paid to the Hospital during the audit period and the amount of the overpayments paid within the 3-year recovery period. We also calculated a non-statistical estimate of the overpayment amount outside of the 3-year recovery period. To obtain this amount, we subtracted the lower limit of the overpayments within the 3-year recovery period from the lower limit of the total estimated overpayments.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

TOTAL MEDICARE OVERPAYMENTS

Table 3: Sample Details and Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Net Overpayments in Sample
1	859	$6,474,870	100	$739,032	18	$44,454
2	807	5,852,488	100	834,585	30	467,204
3	4	131,704	4	131,704	0	0
4	2	10,369	2	10,369	2	2,791
5	5	151,777	5	151,777	0	0
Total	**1,677**	**$12,621,208**	**211**	**$1,867,467**	**50**	**$514,449**

Table 4: Estimated Value of Overpayments

Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	$4,154,984
Lower limit	2,782,279[8]
Upper limit	5,527,690

MEDICARE OVERPAYMENTS WITHIN THE 3-YEAR RECOVERY PERIOD

Table 5: Sample Details and Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Net Overpayments in Sample
1	859	$6,474,870	100	$739,032	7	$10,679
2	807	5,852,488	100	834,585	13	116,585
3	4	131,704	4	131,704	0	0
4	2	10,369	2	10,369	0	0
5	5	151,777	5	151,777	0	0
Total	**1,677**	**$12,621,208**	**211**	**$1,867,467**	**20**	**$127,264**

[8] We calculated the total estimated overpayments by subtracting $154,167 corresponding to 38 claims in our sampling frame that the Hospital repaid, as a result of a RAC review, from the lower limit of $2,782,279. The resulting overpayment was $2,628,112.

Table 6: Estimated Value of Overpayments
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	$1,032,579
Lower limit	350,862[9]
Upper limit	1,714,295

[9] We calculated the total estimated overpayments by subtracting $68,603 corresponding to 17 claims in our sampling frame that were within the 3-year recovery period that the Hospital repaid, as a result of a RAC review, from the lower limit of $350,862. The resulting overpayment was $282,259.

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Underpayments /Overpayments	Value of Net Overpayments
Inpatient Short Stays	100	$834,585	30	$467,204
Inpatient Claims Billed With High-Severity-Level DRG Codes	100	739,032	18	44,454
Inpatient Transfers	2	10,369	2	2,791
Inpatient Same Day Discharges and Readmissions	4	131,704	0	0
Outpatient Claims With Payments Greater Than $25,000	5	151,777	0	0
Totals	**211**	**$1,867467**	**50**	**$514,449**

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.

DENTONS

Gadi Weinreich
Partner

gadi.weinreich@dentons.com
D +1 202 408 9166

Dentons US LLP
1301 K Street, NW
Suite 600, East Tower
Washington, DC 20005-3364 USA

T +1 202 408 6400
F +1 202 408 6399

Salans FMC SNR Denton
dentons.com

June 10, 2015

By FedEx and Electronic Mail

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

Re: Response to the Draft Audit Report "Medicare Compliance Review of Boca Raton Regional Hospital, Inc., for 2011 and 2012," Report Number: A-04-14-07048 ("Draft Report")

Dear Ms. Pilcher:

Dentons US LLP ("Dentons"), acting as the authorized agent and on behalf of Boca Raton Regional Hospital, Inc. ("Boca Regional" or the "Hospital") respectfully submits this letter in response to the above referenced Draft Report, as sent to Boca Regional by letter dated April 28, 2015. The Hospital appreciates the opportunity to respond to the Draft Report, as it is committed to furnishing high quality care to the communities and patients that it serves in compliance with applicable laws and regulations, including those relating to proper documentation and coding.

The Hospital believes that the Audit results to date demonstrate the strength of its compliance program and attendant integrity controls. Among other things, of the five risk areas examined by the U.S. Department of Health and Human Services, Office of Inspector General ("HHS-OIG"), the Audit resulted in no errors (*i.e.*, 100 percent compliance) with respect to two: (i) outpatient claims greater than $25,000, and (ii) inpatient same day discharges and readmissions. It also found only 20 allegedly erroneous inpatient claims that are not time barred out of a sample of 206 inpatient claims, an error rate of less than 10 percent (prior to any appeals).

In light of the Hospital's strong compliance record, and its full cooperation with the Audit, it is the Hospital's hope that HHS-OIG will carefully review and seriously consider Boca Regional's response (the "Response") in its entirety. For the reasons set forth in greater detail below, the Hospital respectfully disagrees with the findings in the Draft Report on several grounds, including: (1) there is no legal basis for HHS-OIG's suggestion that time-barred claims may somehow constitute identified "overpayments" subject to the report and return provisions of

the 60-Day Overpayment Statute;[1] (2) of the remaining twenty (20) allegedly erroneous claims, thirteen (13) were correctly determined on their merits in the first instance (*i.e.*, in 2012); (3) some of the remaining twenty (20) claims may also be time-barred; (4) use of extrapolation is unsupported both as a matter of law and statistical validity, and, in any event, is premature.

I. Draft Report: Background

The Audit was part of a national HHS-OIG auditing initiative designed to identify whether hospitals have been complying with Medicare billing requirements for certain types of claims that HHS-OIG believed were at risk for noncompliance. The Audit focused on five (5) claim categories: (1) inpatient claims with high-severity diagnosis-related group ("DRG") codes, (2) inpatient claims for "short stays",[2] (3) inpatient claims with same day discharges and readmissions, (4) inpatient claims with transfers, and (5) outpatient claims greater than $25,000 ("Risk Areas").[3]

The Audit involved claims with dates of services in calendar years 2011 and 2012 (the "Audit Period"). For reasons not explained in the Draft Report, it appears that the Audit sample design and methodology first involved removing (i) claims with payment amounts less than $3,000 from Risk Areas (1) and (2) and (ii) claims on the "Inpatient-Only Procedure List" from Risk Area (2).[4] HHS-OIG then removed $0 paid claims, duplicate claims and (apparently intended to remove) claims under Recovery Audit Contractor ("RAC") review from all five Risk Areas.[5] According to HHS-OIG, after removing these categories of claims, it ended up with a total universe of 1,677 claims (the "Universe of Claims"), representing a total of $12,621,208 in Medicare payments.[6] Thereafter, HHS-OIG selected a purportedly random sample of 211 claims (206 inpatient claims and five (5) outpatient claims) for review. Of the 206 inpatient claims, HHS-OIG subjected 45 to focused medical and coding review.[7]

II. Draft Report: Findings

The Draft Report sets forth the following findings:

A. Inpatient Claims

HHS-OIG found that fifty (50) of the two hundred six (206) inpatient claims contained at least one error. Specifically:

---

1 Social Security Act ("SSA") § 1128J(d).

2 It is the Hospital's understanding that a "short stay" for purposes of the Audit included a claim with an admission and discharge on the same calendar day and a claim in which discharge occurred on the day immediately following the day of admission.

3 Draft Report, at 2.

4 Id. at 9.

5 Id.

6 Id.

7 Id. at 7.

- Thirty-five (35) of the fifty (50) inpatient errors involved claims that in HHS-OIG's view were incorrectly billed as inpatient stays, resulting in an alleged overpayment of $494,815.[8]

- Fourteen (14) of the fifty (50) inpatient errors were found to have incorrect DRG codes, resulting in an alleged overpayment of $15,977.[9]

- One (1) of the fifty (50) inpatient claims was found to have an incorrect discharge status, due to a patient transfer, resulting in an alleged overpayment of $3,657.[10]

B. Outpatient Claims Greater than $25,000

HHS-OIG did not identify any errors in the five (5) outpatient claims.[11]

C. HHS-OIG Adjustments

1. RAC Duplication

According to the Draft Report, the fifty (50) inpatient claims resulted in net overpayments totaling $514,449.[12] HHS-OIG extrapolated its findings with respect to the 50 inpatient claims across the Universe of Claims to reach an estimated overpayment amount of $2,782,279 (which represents the lower limit of the 90 percent confidence interval).[13] However, although HHS-OIG had intended to remove all claims under review by the RAC from the "random" sample, these efforts failed, requiring the *post hoc* "extra precaution" of removing thirty-eight (38) claims (valued at $154,167) after the Hospital pointed out that it had previously repaid those claims in the course of one or more RAC reviews.[14] Thus, the estimated overpayment was adjusted downward to $2,628,112.

2. Time Barred Claims

As discussed above, the Audit Period included claims with dates of service in 2011 and 2012. Pursuant to section 1870(b) of the Social Security Act ("SSA"), HHS-OIG adjusted the alleged net overpayment to remove claims not subject to recoupment due to the passage of three years since the date the claim was paid. Of the fifty (50) allegedly erroneous claims, HHS-OIG determined that thirty (30) had been determined in 2011 and, as such, were time barred and not subject to recovery. The value of the remaining twenty (20) alleged inpatient claims errors was determined to be $127,264.[15] HHS-OIG extrapolated its findings with respect to the twenty (20) claims across the Universe of Claims to reach an estimated overpayment

---

8 Id. at 4.
9 Id. at 5.
10 Id.
11 Id. at 3.
12 Id. at i.
13 Id. at 12.
14 Id. at 9.
15 Id. at 12.

amount of $350,862 (which represents the lower limit of the 90 percent confidence interval).[16] However, seventeen (17) RAC claims previously repaid by the Hospital (valued at $68,603) had to be removed from the sample, reducing the estimated overpayment amount to $282,259.[17]

3. HHS-OIG Recommendations

HHS-OIG recommends that the Hospital: (1) refund the extrapolated amount of $282,259, (2) work with the contractor to return alleged overpayments outside of the available recovery period "in accordance with the 60-day repayment rule," and (3) strengthen its Medicare billing controls.[18]

III. Hospital's Response

A. Claims From 2011 Are Time Barred

As discussed above, the Draft Report identifies thirty (30) allegedly erroneous claims with 2011 dates of services "that are barred from recovery" because "3 years after the year in which the original payment was made" have passed.[19]

1. Reopening and Recovery of Claims: An Overview

Under the Medicare program, contractors are permitted to recoup identified overpayments only if certain criteria are met. The determination of whether a claim constitutes an "overpayment" and, if so, whether it may be recouped involves two separate, but related, rules: the rule for reopening claims and the rule for recovering claims.

a. Initial Determination

The Medicare program claim adjudication and decision-making process commences with an "initial determination" that establishes whether the items and services are covered and otherwise reimbursable.[20] The decision of a Medicare contractor to make payment to a provider of items and services (*e.g.*, a hospital) constitutes an "initial determination," which is binding upon all parties to the claim, unless it is properly and timely reopened and revised.[21]

Because the Medicare contractor had originally authorized payment with respect to the fifty (50) original claims identified as allegedly erroneous by HHS-OIG, those initial determinations must stand, unless revised by the contractor in compliance with legally mandated time-frames and procedures. To change or alter an initial determination, the Medicare contractor (not HHS-OIG) must formally "reopen" and revise the claim.[22]

---

16 Id. at 13.
17 Id.
18 Id. at ii.
19 Id. at 4.
20 See 42 C.F.R. §§ 405.803, 405.920.
21 Id. § 405.928.
22 Id. § 405.980(a)(1).

b. Reopening Rules

The reopening rules permit a Medicare contractor to reopen and revise a claim:

- "for any reason" within the first 12 months after initial payment;[23]
- for "good cause" shown (by the Medicare contractor) if the claim is less than four years old;[24] and
- based on reliable evidence that the provider procured the initial determination by "fraud or similar fault."[25]

None of the fifty (50) claims at issue has been reopened, as yet.

c. Recovery Rules

The recovery rules govern the ability of a Medicare contractor to recover (or recoup) an overpayment after the contractor has reopened the claim. Under the recovery rules, a provider is deemed to be "without fault," — and thus not subject to recoupment — after a certain number of years have passed.[26] Prior to January 2013 (*i.e.*, for both of the years at issue in this Response, 2011 and 2012), claims were presumed to be time barred subsequent to the third calendar year after the year of initial payment.[27] Applying this recovery rule, the Draft Report excludes the 30 claims that were determined in 2011 because the third calendar year thereafter is 2014. The Medicare manual confirms that in calculating the three year limitations period:

> Only the year of payment and the year it was found to be an overpayment enters into the determination . . . The day and the month are irrelevant. With respect to payments made in 2000, the third calendar year is 2003. For payments made in 2001, the third calendar year thereafter is 2004, etc. Thus, the rules apply to payments made in 2000 and discovered overpayments made after 2003, to payments made in 2001 and discovered to be overpayments after 2004, etc.[28]

---

23 42 C.F.R. § 405.980(b)(1);see also Medicare Claims Processing Manual (CMS Pub. 100-04), ch. 34, § 10.6.1.

24 42 C.F.R. § 405.980(b)(2);see also Medicare Claims Processing Manual (CMS Pub. 100-04), ch. 34, § 10.6.1.

25 42 C.F.R. § 405.980(b)(3);see also Medicare Claims Processing Manual (CMS Pub. 100-04), ch. 34, § 10.6.1.

26 In essence, this created a rebuttable presumption of no-fault on the part of the provider (and hence no recovery) after the passage of three calendar years following the year of initial determination. Mt. Sinai Hospital of Greater Miami, Inc. v. Weinberger, 517 F.2d 329, 342 (5th Cir. 1975).

27 See 42 U.S.C. § 1395gg(b) (2003) (amended 2013); see also Medicare Financial Management Manual (CMS-Pub. 100-06), ch. 3, §§ 80, 90.

28 See Medicare Financial Management Manual (CMS-Pub. 100-06), ch. 3, § 80.1. Effective January 2, 2013, the recovery rules' limitations period was extended by two additional years. 42 U.S.C. § 1395gg(b)-(c) (2013) (emphasis added); American Taxpayer Relief Act of 2012,

2. Analysis

The Hospital accepts HHS-OIG's conclusions regarding the 30 time-barred claims,[29] but makes the following observations. The 2011 claims are also time barred from *reopening* (not just recovery) because there is no "good cause" to reopen the claims and no reliable evidence that the initial determinations were procured by "fraud or similar fault." As set forth above, an "overpayment" may only be recouped if the underlying claim has been reopened pursuant to the reopening rules. Where, as here, more than one year has passed since the date of initial determination, a Medicare contractor may only reopen a claim: (1) if it possesses "reliable evidence" that the initial determination was "procured by fraud or similar fault", or (2) if it establishes "good cause," and the reopening occurs within four years of the initial determination.[30]

The Draft Report findings do not include (or allude in any way to) any evidence of fraud or similar fault. Certainly, none of the HHS-OIG representatives discussed, mentioned or referenced any such evidence or concern. Moreover, in order to show "good cause," the Medicare contractor would have to establish one of two things, neither of which is present here:

- that the evidence that was considered in making the initial determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision;[31] or
- that there is "new and material evidence" that was not available or known at the time of the initial determination and may result in a different conclusion.[32] (According to the Medicare Financial Management Manual, "good cause" does not exist if a provider complied with all pertinent regulations, made full disclosure of all material facts, and on the basis of the information available, had a reasonable basis for assuming that the payment was correct.)[33]

B. Time Barred Claims Are Not Overpayments

Although HHS-OIG sets out to exclude all claims determined in 2011 — from both the sample of 211 claims and from the Universe of Claims — in calculating the recoverable "estimated net overpayments," it recommends that the Hospital "work with the contractor" to refund alleged overpayments that are time barred under the "3-year recovery period in accordance with the 60-day repayment rule."[34] This recommendation is confusing, at best, but,

---

Pub. L. No. 112-240, § 638, 126 Stat. 2313 (2013). However, the statutory amendment did not provide for retroactive application of the new time limit to claims — like the one at issue here — adjudicated and paid prior to January 2, 2013

29 Draft Report, at 4.

30 42 C.F.R. § 405.980(b).

31 See 42 C.F.R. § 405.986(a)(2).

32 See id. § 405.986(a)(1).

33 See Medicare Financial Management Manual (CMS-Pub. 100-06), ch. 3, § 90.

34 Draft Report, at 6.

in any event, legally without foundation. Specifically, it is unclear whether HHS-OIG takes the position that:

- The Hospital somehow has a legal obligation — under the 2010 Patient Protection and Affordable Care Act ("ACA") — to refund the 2011 claims that cannot be recovered (and, possibly, cannot be reopened or recovered) as a matter of law; or
- The Hospital should voluntarily refund the 2011 payments, which as a matter of law are no longer "overpayments," but, under different circumstances (*i.e.*, the passage of less time) may have constituted overpayments.

Under Section 1128J(d) of the SSA (the "Overpayment Statute"),[35] if a person has received an "overpayment" under Medicare or Medicaid, the person must report and return the overpayment to the appropriate government agency or contractor within sixty (60) days from the date the overpayment was identified. The Overpayment Statute defines an "overpayment" as "any funds that a person receives or retains [under Medicare or Medicaid] to which the person, *after applicable reconciliation*, is not entitled."[36] As discussed above, federal law places certain time limits on the reopening and recovery of alleged overpayments. Specifically, a Medicare contractor's initial claim determination *is binding on all parties* unless a party (whether the provider or contractor/adjudicator) reopens and revises the initial determination within certain prescribed timeframes.

With respect to all of the allegedly erroneous 2011 claims at issue, the Medicare contractor initially determined that payment was authorized. By law, those initial determinations must stand, unless revised by the contractor within the legally mandated time frames. In other words, based upon the initial determinations, the Hospital is "entitled" to funds associated with the claims unless and until the paid claims are properly reopened and revised by a contractor. As described in detail above, however, the 2011 claims cannot be "recovered" and, even if they could still be reopened as a matter of law, they have not been lawfully reopened to date. As such, the initial 2011 determinations remain binding on all parties, meaning that the claims hold the indisputable legal status of "payments," not "overpayments."

The Hospital also notes that it has not "identified" overpayments relating to any claims paid in 2011 because in addition to being time barred under the recovery limitations rule, the claims may not be erroneous due to a combination of other legal and clinical arguments. Moreover, when dealing with alleged and estimated overpayments based on extrapolation, the Hospital cannot "identify" any of the claims at issue because HHS-OIG has not identified any specific claim that is allegedly erroneous beyond the 30 time barred claims discussed in the Draft Report.

---

[35] SSA § 1128J(d), codified as amended at 42 U.S.C. § 1320a-7k(d) [hereinafter "Overpayment Statute"].

[36] Overpayment Statute § 1128J(d)(4)(B) (emphasis added).

C. Extrapolation is Legally Unfounded, Statistically Unsound and Premature

The Hospital respectfully disagrees to HHS-OIG's recommendation that its findings with respect to the 2012 "overpayments" be extrapolated to the 1,677 claims that make up the Universe of Claims. The Hospital objects to extrapolation as a matter of law, statistical integrity and prematurity. These grounds of objection are addressed sequentially.

1. Extrapolation Is Legally Unfounded

The law is clear that the Centers for Medicare & Medicaid Services ("CMS") and its contractors may not use extrapolation to determine overpayment amounts:

> *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.[37]

Neither the Social Security Act nor any applicable regulation defines the terms "high rate of error" or "documented educational intervention has failed . . ." CMS's sub-regulatory guidance (in the form of the various Medicare manuals) does not define these terms, either. That said, in at least one case, Cabarrus Podiatry Clinic, an administrative law judge rejected the use of an extrapolated overpayment where neither CMS nor the contractor could produce *any documentation* concerning a finding of a high error rate or a documented failure of education.[38] Thus, at a bare minimum, HHS-OIG must document these specific findings in the Draft Report if it is to recommend the use of extrapolation in compliance with Medicare law.

To date, HHS-OIG has not met this burden. The reason for this is straightforward. An alleged error of rate of 20 claims out of an original 211 claims (*i.e.*, less than 10 percent) is simply not a high error rate by any stretch of the imagination. There are dozens upon dozens of hospitals nationwide that had much higher error rates in the very same national Medicare Compliance Review and, yet, were not subjected to extrapolation.[39]

Similarly, HHS-OIG cannot maintain that previous educational attempts have failed to remedy the payment error for the simple reason that there has been no prior educational initiative, at least not prior to the Audit. And, when it comes to the Audit itself, the Hospital cooperated with the initiative in full and, ultimately, performed very well, *i.e.*, achieved a very low

---

[37] See 42 U.S.C. § 1395ddd(f)(3) (emphasis added).

[38] Cabarrus Podiatry Clinic (Appellant) (Beneficiaries) Claim for Part B Benefits, ALJ Appeal No. 1-127356701 (Dec. 14, 2007).

[39] With respect to high error rates, HHS-OIG has conducted 129 "Medicare Compliance Review" audits over the past four years, recommending extrapolation in only twenty-two (22) audits. Importantly, extrapolation was not recommended in at least thirty-seven (37) audits that involved error rates of 50 percent or more, of which fourteen (14) produced error rates in excess of 70 percent. As explained by the Secretary of HHS, extrapolation is a method of calculation, not an unchecked sanction. Thus, HHS-OIG must at the very least remain consistent in its application of the "high rate of error" criterion. Such consistency is seriously called into question if providers presenting double or triple the error rate of the Hospital were not found to have a "high rate of error" or were not, for some other undocumented reason, subject to extrapolation.

error rate. In light of HHS-OIG's failure to address evidence, or provide a legal basis for either of the specific statutory criteria required for use of extrapolation, HHS-OIG should reconsider and reverse its preliminary decision to recommend extrapolation.

2. Extrapolation is Statistically Unsound Due to RAC Overlap

Even if extrapolation were supportable as a matter of law, the Hospital posits that HHS-OIG committed a number of procedural errors that have fatally tainted the agency's estimation efforts.

First, HHS-OIG's assurances notwithstanding, the Draft Report concedes that at least 38 claims (valued at $154,167) in the Universe of Claims were previously adjudicated by the RAC and repaid by the Hospital.

Second, HHS-OIG's efforts to remedy the taint discussed above did not address or identify how many claims were previously reviewed and affirmed by the RAC. The latter results in inherent unfairness in that it subjects a certain number of unspecified claims to trebled review — once upon original determination, a second time by the RAC, and then, yet again, by HHS-OIG.

Third, HHS-OIG does not fully contend with the full impact of the three year recovery period limitation. The unspoken impact is that all claims in the Universe of Claims and all claims in the sample of claims with payment dates of 2011 should have been extracted from the Universe of Claims (and the 211 claim sample) *ab initio* in order to prevent irretrievably tainting the integrity of both the Universe of Claims and the sample.

Finally, the Draft Report provides no recourse with respect to any *subsequently identified* RAC review claims. Specifically, since every claim that may currently or in the near future (meaning, prior to HHS-OIG issuing a final version of the Draft Report) be subject to RAC review and repayment was not removed from the Universe or sample, there is a possibility that the Hospital may be required to defend and pay twice for the same alleged errors.

In sum, under the totality of the circumstances, it would be statistically invalid and patently unfair to proceed with the extrapolation suggested in the Draft Report.

3. Extrapolation is Premature

At the very minimum, extrapolation should be postponed until all claims have been fully adjudicated on their merits. As noted above, HHS-OIG has determined that twenty (20) 2012 claims (all inpatient) out of an allegedly random sample of 211 were erroneously paid in the course of their initial determination. According to HHS-OIG, this error rate should be extrapolated against the Universe of Claims in order to achieve audit efficiency. Separate and apart from all of Boca Regional's other arguments, the Hospital posits that extrapolation at this stage of the proceedings would be highly inefficient. In a nutshell, it is premature to extrapolate errors at this stage because the Hospital intends to contest many of the findings on a variety of grounds. Inevitably, the number of erroneous claims is likely to keep shifting (downward) at the various levels of adjudication and appeal, requiring repeated monetary adjustments and

reconciliations between the Hospital and its Medicare contractor. Among other things, Boca Regional believes in good faith that thirteen (13) of twenty (20) 2012 claims were correctly adjudicated in the first instance. Accordingly, the Hospital requests that HHS-OIG either abandon the extrapolation recommendation in its entirety or, at a minimum, change the recommendation as follows:

> We recommend that the Hospital refund to the Medicare program all overpayments using the following formulation: (the total dollar amount of actual overpayments remaining after each of the contested sample claims has been fully adjudicated) applied across (the total dollar amount associated with the 2012 Universe of Claims).

4. Premature Extrapolation Resulted in an Overinflated Estimated Overpayment

The Final Report does not dispute the medical necessity of any services rendered. Thus, even for 13 short-stay cases (of the current twenty (20) 2012 claims at issue) that HHS-OIG found to be in error, HHS-OIG conceded that these claims may be eligible for Part B payment.[40] Medicare rules are clear that where a hospital bills Medicare for inpatient services, which, upon review, should have been furnished (and charged) on an outpatient basis, a hospital may rebill those services to receive Medicare Part B reimbursement. The relevant CMS rules are set forth in: (1) CMS Final Rule on Inpatient Prospective Payment System, addressing the policy of billing under Medicare Part B following the denial of a Medicare Part A hospital inpatient claim;[41] (2) CMS Ruling 1455 (issued March 13, 2013);[42] (3) CMS' Technical Decision Letter (issued July 13, 2012);[43] and (4) numerous Administrative Law Judge and Medicare Care Appeals Council decisions.[44]

As such, and consistent with both law and equity, HHS-OIG should recommend that once it is determined (i.e., after full adjudication) which claims should have properly been paid

---

40 See Draft Report at 4, n.3.

41 78 Fed. Reg. 50496, 50908-938 (Aug 19, 2013).

42 Centers for Medicare & Medicaid Services, Ruling No. CMS-1455-R (Mar. 13, 2013)

43 This Technical Decision Letter is not publically available, but Boca Regional understands that such a document provides that: There have been a number of Administrative Law Judge decisions in recent months that uphold a claims administration contractor's denial of inpatient services as not reasonable and necessary, but require the contractor to pay for the services on an outpatient basis and/or at an "observation level of care" . . . Medicare pays for observation services under the outpatient prospective payment system ("OPPS"). However, observation services are generally bundled and not paid separately.

44 See e.g., In the case of O'Connor Hospital, Med & Med GD (CCH) P 122133 (H.H.S. Feb. 1, 2010), 2010 WL 425107, consistent with In the case of UMDNJ - University Hospital, 2005 WL 6290383 (H.H.S. Mar. 14, 2005) (directing the CMS contractor to reimburse the hospital for outpatient services pursuant to Medicare Part B after payment was denied for inpatient services pursuant to Medicare Part A); In the case of Indiana University Health Methodist Hospital, Docket No. M-12-872 (H.H.S. May 17, 2012), 2012 WL 3067987, at *10; In the case of Montefiore Medical Center, Docket No. M-10-1121 (H.H.S. May 10, 2011), 2011 WL 6960290, at *22.

by Medicare Part B (as opposed to Medicare Part A), the Medicare contractor should work in good faith with the Hospital to calculate and deduct from the Part A overpayment the amount that would have been paid by Part B. A recommendation that does not provide for this to be done prior to extrapolation, if any, will give rise to a logistical nightmare because once the Part A payments are extrapolated there will be no practical way to determine the Part B set-off. This would be inconsistent with the current state of the law and would be unfair.

D. Contested Claims

With respect to the twenty (20) remaining 2012 claims, the Hospital objects to the validity and reasonableness of HHS-OIG's clinical findings regarding many of the individual claims.

1. Allegedly Incorrectly Billed as Inpatient

The Hospital intends to contest — on the clinical merits — eight (8) of the thirteen (13) claims which HHS-OIG contends were "medically unnecessary" – i.e., that should have been billed as outpatient or outpatient with observation.

2. Allegedly Incorrect Diagnosis-Related Codes

The Hospital also intends to contest — on the clinical merits — five (5) of the seven (7) claims which HHS-OIG concludes had incorrect Diagnosis-Related Codes.

IV. Hospital's Internal Controls

Boca Regional is, and always has been, a responsible provider of healthcare items and services with a deep commitment to operating in compliance with applicable rules and regulations. As part of this commitment, the Hospital routinely examines its coding and billing practices and procedures with the objective of achieving ever-improved accuracy and completeness.

In order to ensure that patients are properly categorized as either inpatients or outpatients, the Hospital routinely examines its coding and billing practices and procedures with the objective of achieving ever-improved accuracy and compliance. In addition, the Hospital uses outside clinical consultants to undertake a concurrent review of the medical record and the presence of medical necessity, thereby enabling adjustments before patient discharge. The HHS-OIG's determinations notwithstanding, the Hospital has an impressive record in connection with appealing and reversing RAC findings of error. In particular, the Hospital notes its success in properly coding inpatient stays, as evidenced in its high RAC appeal turnover rate of 88 percent. This strongly suggests that the Hospital's internal controls are fully operational and highly efficient. That said, Boca Regional always seeks to capitalize on any opportunity for improvement and it will redouble its efforts to even further enhance compliance with respect to the Risk Areas included in the Draft Report.

* * *

On behalf of Boca Regional, we thank you in advance for your consideration of our various arguments and concerns. We, and our client, will make ourselves available to you in the event that you have any questions or require further information.

Sincerely,

Gadi Weinreich

Gadi Weinreich

cc: Alexander Eremia, Esq.
Mary Matthews-Martin

84223947\V-8