

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
HOUSTON METHODIST HOSPITAL FOR
2012 AND 2013**

*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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Office of Inspector General

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EXECUTIVE SUMMARY

Houston Methodist Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in estimated overpayments of approximately \$1.3 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 2013, Medicare paid hospitals \$156 billion, which represents 45 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 Houston Methodist Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected 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 915-bed acute-care facility located in Houston, Texas. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$558 million for 29,738 inpatient and 160,708 outpatient claims for services provided to beneficiaries during the period January 1, 2012, through December 31, 2013 (audit period).

Our audit covered \$6,589,665 in Medicare payments to the Hospital for 2,877 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 159 claims with payments totaling \$1,802,027. These 159 claims had dates of service in our audit period and consisted of 73 inpatient and 86 outpatient claims. Additionally, we reviewed five inpatient claims as a separate nonstatistical sample.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 111 of the 159 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in net overpayments of \$609,346 for the audit period. Specifically, 47 inpatient claims had billing errors, resulting in net

overpayments of \$608,686, and 1 outpatient claim had a billing error, resulting in an overpayment of \$660. Additionally, the Hospital did not fully comply with Medicare billing requirements for three of the five separate inpatient claims, resulting in overpayments of \$67,656. The overpayment amounts include claim payment dates that are 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 overpayments of at least \$1,266,805 for the audit period. This overpayment amount includes the claim payment dates that are outside of the 3-year recovery period. Of the total estimated overpayments, at least \$579,799 is within the 3-year recovery period, and as much as \$619,350 is outside the 3-year recovery period. Additionally, there was a \$19,054 overpayment for an incorrectly billed inpatient claim that is within the 3-year recovery period and \$48,602 in overpayments that are outside the 3-year recovery period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$579,799 in estimated net overpayments for claims that were incorrectly billed during the 3-year recovery period;
- refund to the Medicare contractor the \$19,054 overpayment for an incorrectly billed inpatient claim;
- work with the Medicare contractor to return overpayments that were made outside of the 3-year recovery period, which we estimate to be as much as \$619,350 for our audit period, in accordance with the 60-day repayment rule;
- work with the Medicare contractor to return \$48,602 in overpayments that were made outside of the 3-year recovery period for incorrectly billed inpatient claims, in accordance with the 60-day repayment rule; and
- strengthen controls to ensure full compliance with Medicare requirements.

HOUSTON METHODIST HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital agreed with our findings on 30 of the 51 claims for which we identified billing errors; it disagreed with our findings on the remaining 21 claims. The Hospital said that it would appeal our determinations for most of these claims on the basis of its independent physician reviewer's determinations and the clinical merits of these cases. The Hospital also described corrective actions that it had taken or planned to take.

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

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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 2013, Medicare paid hospitals \$156 billion, which represents 45 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 Houston Methodist Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected 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 Inpatient Rehabilitation Prospective Payment System

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for IRFs. CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the payment system, CMS established a Federal prospective payment rate for each of 92 distinct case-mix groups (CMGs). The assignment to a CMG is based on a beneficiary's clinical characteristics and expected resource needs. In addition to the basic prospective

payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.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 claims billed for rehabilitation facility services,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims billed for elective procedures,
- outpatient claims billed for evaluation and management services, and
- outpatient claims billed for intensity modulated radiation therapy planning services.

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)).

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

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

Houston Methodist Hospital

The Hospital is a 915-bed acute-care facility located in Houston, Texas. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$558 million for 29,738 inpatient and 160,708 outpatient claims for services provided to beneficiaries during the period January 1, 2012, through December 31, 2013 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$6,589,665 in Medicare payments to the Hospital for 2,877 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 159 claims with payments totaling \$1,802,027. These 159 claims had dates of service in our audit period and consisted of 73 inpatient and 86 outpatient claims. Additionally, we reviewed five inpatient claims as a separate nonstatistical sample.

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 75 inpatient claims to medical review and coding review 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 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 111 of the 159 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in net overpayments of \$609,346 for the audit period. Specifically, 47 inpatient claims had billing errors, resulting in net overpayments of \$608,686, and 1 outpatient claim had a billing error, resulting in an overpayment of \$660. Additionally, the Hospital did not fully comply with Medicare billing requirements for three of the five separate inpatient claims, resulting in overpayments of \$67,656. The overpayment amounts include claim payment dates that are outside of the 3-year

recovery period.² 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 \$1,266,805 for the audit period. This overpayment amount includes claim payment dates that are outside of the 3-year recovery period. Of the total estimated overpayments, at least \$579,799 is within the 3-year recovery period, and as much as \$619,350 is outside the 3-year recovery period. Additionally, there was a \$19,054 overpayment for an incorrectly billed inpatient claim that is within the 3-year recovery period and \$48,602 in overpayments that are outside the 3-year recovery period.

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

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 47 of the 73 inpatient claims that we reviewed. These errors resulted in net overpayments of \$608,686. Additionally, the Hospital incorrectly billed Medicare for three of the five separate inpatient claims, which resulted in overpayments of \$67,656.

Incorrectly Billed Rehabilitation Facility Claims

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)).

The *Medicare Benefit Policy Manual* states that the IRF benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care (Pub. No. 100-02, chapter 1, § 110-110.1).

In addition, the *Medicare Benefit Policy Manual* states that a primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient’s IRF medical record must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs (Pub. No. 100-02, chapter 1, § 110.2.2).

² Section 1870(b) of the Act 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 it identified to its Medicare administrative contractor. The 2010 Patient Protection and Affordable Care Act requires the reporting and returning of a Medicare overpayment along with written notice of the reason for the overpayment within 60 days after the overpayment is identified (60-day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

For 32 of the 73 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation (30 errors) or for incorrect case-mix-group classifications (2 errors). Hospital officials stated that the claims that it agreed were in error occurred because of a lack of standardized physician documentation. As a result of these errors, the Hospital received net overpayments of \$492,271.

Incorrectly Billed 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 14 of the 73 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services (9 errors) or submitted claims with incorrect DRG codes (5 errors). The Hospital agreed that four claims had errors but that the errors were isolated instances and not indicative of a major control weakness. The Hospital did not offer a cause for the remaining errors because it did not believe that the claims were billed in error. As a result of these errors, the Hospital received net overpayments of \$112,415.

Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations require a reduction in the IPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of the device, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89(a)). The Manual states that to correctly bill for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50 (which identifies the replacement device) and value code FD (which identifies the amount of the credit or cost reduction received by the hospital for the replaced device) (chapter 3, § 100.8).

For 1 of the 73 inpatient claims, the Hospital received a reportable credit from the manufacturer for a replaced device but did not adjust its inpatient claim with the proper condition and value code to reduce payment. Hospital officials stated that the error occurred because of an incorrect determination on whether to report the credit. As a result of this error, the Hospital received an overpayment of \$4,000.

Incorrectly Billed Elective Procedures

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 three of the five elective procedure claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation

services. The Hospital agreed that the three claims were incorrectly billed and stated that the errors occurred because its external contractor at the time incorrectly recommended inpatient admission for these types of services. As a result of these errors, the Hospital received overpayments of \$67,656.³

BILLING ERROR ASSOCIATED WITH OUTPATIENT CLAIM

The Hospital incorrectly billed Medicare for 1 of the 86 outpatient claims that we reviewed. This error resulted in an overpayment of \$660.

Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45).

CMS guidance explains how a provider should report no-cost and reduced-cost devices under the OPPS.⁴

For services furnished on or after January 1, 2008, CMS requires the provider to report the modifier “FC” on a claim that includes a procedure code for the insertion of a replacement device if the provider receives a credit from the manufacturer of 50 percent or more of the cost of the replacement device. Partial credits for less than 50 percent of the cost of a replacement device need not be reported with any modifier.

For 1 of the 86 outpatient claims, the Hospital received a partial credit from the manufacturer for a replaced medical device but did not include the “FC” modifier and reduce charges on its claim. Hospital officials stated that the error occurred because the credit was not tracked in its purchasing system. As a result of this error, the Hospital received an overpayment of \$660.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments totaling at least \$1,266,805 for the audit period. This overpayment amount includes claim payment dates that were outside of the 3-year recovery period. Of the total estimated overpayments, at least \$579,799 was within the 3-year claims recovery period, and as much as \$619,350 was outside the 3-year recovery period. Additionally, for the five inpatient claims that were not part of our

³ The Hospital may be able to bill Medicare Part B for all of the 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 before issuing our report.

⁴ CMS Transmittal 1103, dated Nov. 3, 2006, and the Manual, chapter 4, § 61.3.

sample, there was a \$19,054 overpayment for a claim that was within the 3-year recovery period, and as much as \$48,602 in overpayments for two claims that were outside the 3-year recovery period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$579,799 in estimated overpayments for claims that were incorrectly billed during the 3-year recovery period;
- refund to the Medicare contractor the \$19,054 overpayment for the additional incorrectly billed inpatient claim;
- work with the Medicare contractor to return overpayments that were made outside of the 3-year recovery period, which we estimate to be as much as \$619,350 for our audit period, in accordance with the 60-day repayment rule;
- work with the Medicare contractor to return \$48,602 in overpayments that were made outside of the 3-year recovery period for the additional incorrectly billed inpatient claims, in accordance with the 60-day repayment rule; and
- strengthen controls to ensure full compliance with Medicare requirements.

HOUSTON METHODIST HOSPITAL COMMENTS

In written comments on our draft report, the Hospital agreed with our findings on 30 of the 51 claims for which we identified billing errors; it disagreed with our findings on the remaining 21 claims. Specifically, the Hospital disagreed with our findings on seven of the nine inpatient claims with high-severity-level DRGs, which we found lacked medical necessity for the inpatient stay. The Hospital also disagreed with our findings on 14 of the 32 inpatient rehabilitation facility claims, 30 of which did not meet Medicare criteria for acute inpatient rehabilitation and 2 of which were coded with incorrect case-mix-group codes. The Hospital said that it would appeal our determinations for most of these claims on the basis of its independent physician reviewer's determinations and the clinical merits of the cases. The Hospital also described corrective actions that it had taken or planned to take.

Regarding our sampling methodology, the Hospital stated that our basis for determining whether to extrapolate was inconsistent and appeared arbitrary, noting that the majority of hospital compliance reviews did not result in extrapolated results. Also, the Hospital said that it had requested that we report on actual results and not extrapolate.

Additionally, the Hospital said that the error amount was overstated because it did not take into account the reimbursement the Hospital could receive under Medicare Part B for the inpatient rehabilitation facility claims. Therefore, the Hospital suggested that we postpone issuing the final report until the claims appeal and adjudication process has occurred. Lastly, the Hospital

stated that the inpatient claims with high-severity-level DRGs and inpatient rehabilitation facility risk areas should not be eligible for extrapolation because we denied its request for due process to allow the Hospital's independent physician reviewer and our independent medical reviewer to attempt to reconcile their differences.

The Hospital's comments appear in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, we maintain that all of our findings and recommendations remain valid. We used an independent medical reviewer to determine whether the 21 inpatient claims in question met medical necessity requirements and included the proper case-mix-group codes. 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 according to Medicare requirements.

Regarding the Hospital's comparison of this audit with the audits of other hospitals, each hospital review is unique, and the sampling method used in each of these reviews will vary. As a result, the refinement of audit methodologies will also vary. In addition, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare. The legal standard for the use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology. Furthermore, no statutory or other authority limits OIG's ability to recommend to CMS a recovery based on sampling and extrapolation.

With respect to the Hospital's assertion that we may have overstated the amount of overpayments for the Medicare Part B claims, we are unable to determine the effect that billing Part B would have on the overpayment amount because the Hospital had not billed for these services and the Medicare contractor had not adjudicated the claims before we issued the report. We acknowledge, though, that the Hospital may rebill Part B for the incorrectly billed inpatient claims.

Regarding the Hospital's independent physician reviewer and our independent medical reviewer not reconciling their differences on the findings related to the inpatient claims with high-severity-level DRGs and inpatient rehabilitation facility risk areas, it does not violate due process because the auditee is given the opportunity to first contest these disallowances with the CMS action official and then, if it chooses, to appeal the disallowances through the Medicare appeals process.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$6,589,665 in Medicare payments to the Hospital for 2,877 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 159 claims with payments totaling \$1,802,027. These 159 claims consisted of 73 inpatient and 86 outpatient claims that had dates of service from January 1, 2012, through December 31, 2013. Additionally, we reviewed five elective procedures billed as inpatient claims as a separate nonstatistical sample.

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 75 claims to medical review and coding review 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 and outpatient 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 National Claims History (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.

Our audit work included contacting the Hospital in Houston, Texas, from September 2014 through December 2015.

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 159 claims (73 inpatient and 86 outpatient claims) totaling \$1,802,027 for detailed review;
- selected a nonstatistical sample of 5 elective procedures billed as inpatient claims totaling \$93,790 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;
- used an independent medical review contractor to determine whether 75 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 review to calculate the estimated Medicare overpayment to the Hospital (Appendix C);
- used the results of the sample to estimate the Medicare overpayments to the Hospital (Appendix C) that were 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

We obtained a database of claims from CMS's NCH file totaling \$557,568,490 for 29,738 inpatient and 160,708 outpatient claims in 29 risk areas. From these 29 areas, we selected 6, consisting of 36,933 claims totaling \$172,434,684 for further review.

Per the audit plan, we performed data analysis of the claims within each of the six high-risk areas. We removed claims with payment amounts of zero. The specific audit steps performed varied, depending on the Medicare issue, but included such things as removing claims with certain patient discharge status codes and billing types. We also took into consideration such things as problem diagnosis codes and procedure codes. We then removed the following:

- inpatient claims billed with high-severity-level DRG codes with payment amounts less than \$3,000,
- outpatient claims billed for evaluation and management services with payment amounts less than \$250, and
- claims under review by the Recovery Audit Contractor as of August 22, 2014.

We assigned each claim that appeared in multiple high-risk areas to just 1 area based on the following hierarchy and deleted duplicate claims accordingly: inpatient manufacturer credits for replaced medical devices, inpatient claims billed with high-severity-level DRG codes, inpatient rehabilitation facility, outpatient manufacturer credits for replaced medical devices, outpatient intensity modulated radiation therapy planning services, and then outpatient claims billed with evaluation and management services. This resulted in a sample frame of 2,877 unique Medicare claims in 6 risk areas totaling \$6,589,665.

The initial version of the frame contained a stratum for elective procedures billed as inpatient. Fifty-eight of the sixty-four claims in this stratum did not belong there, and we removed them. We also removed this stratum from the frame and the statistical sample. We reviewed five of the claims for elective procedures billed as inpatient as a separate nonstatistical sample and found three errors. The errors for the risk category are reported directly rather than extrapolated.

Table 1: Risk Categories

| Medicare Risk Area | Number of Claims | Amount of Payments |
|--|-------------------------|---------------------------|
| 1. Inpatient Manufacturer Credits for Replaced Medical Devices | 3 | \$111,749 |
| 2. Inpatient Claims Billed With High-Severity-Level DRG Codes ⁵ | 261 | 3,328,914 |
| 4. Inpatient Rehabilitation Facility | 49 | 816,167 |
| 5. Outpatient Manufacturer Credits for Replaced Medical Devices | 26 | 476,342 |
| 6. Outpatient Intensity Modulated Radiation Therapy Planning Services | 86 | 413,552 |
| 7. Outpatient Claims Billed With Evaluation and Management Services | 2,452 | 1,442,941 |
| Total | 2,877 | \$6,589,665 |

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

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

SAMPLE SIZE

We selected 159 claims for review as follows:

⁵ Stratum 3, elective procedures billed as inpatient, was removed from the stratified random sample.

Table 2: Claims by Stratum

| Stratum | Medicare Risk Area | Claims in Sample Frame | Claims in Sample |
|----------------|--|-------------------------------|-------------------------|
| 1 | Inpatient Manufacturer Credits for Replaced Medical Devices | 3 | 3 |
| 2 | Inpatient Claims Billed With High-Severity-Level DRG Codes | 261 | 30 |
| 4 | Inpatient Rehabilitation Facility | 49 | 40 |
| 5 | Outpatient Manufacturer Credits for Replaced Medical Devices | 26 | 26 |
| 6 | Outpatient Intensity Modulated Radiation Therapy Planning Services | 86 | 30 |
| 7 | Outpatient Claims Billed With Evaluation and Management Services | 2,452 | 30 |
| | Total | 2,877 | 159 |

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate our estimates. We used the lower limit of the 90-percent confidence interval to estimate the amount of improper Medicare payments in our sampling frame during the audit period.

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 will recommend recovery of any error amount for the five claims for elective procedures billed as inpatient. We calculated our final recovery amount by adding any error amount for these five claims to the lower limit of the statistical estimate.

We also calculated a nonstatistical estimate of the overpayment amount outside the 3-year recovery period. To obtain the 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

Table 3: Sample Results

| Stratum | Frame Size (Claims) | Value of Frame | Sample Size | Total Value of Sample | Number of Incorrectly Billed Claims in Sample | Value of Overpayments in Sample |
|----------------|----------------------------|-----------------------|--------------------|------------------------------|--|--|
| 1 | 3 | \$111,749 | 3 | \$111,749 | 1 | \$4,000 |
| 2 | 261 | 3,328,914 | 30 | 359,526 | 14 | 112,415 |
| 4 | 49 | 816,167 | 40 | 680,667 | 32 | 492,271 |
| 5 | 26 | 476,342 | 26 | 476,342 | 1 | 660 |
| 6 | 86 | 413,552 | 30 | 156,373 | 0 | 0 |
| 7 | 2,452 | 1,442,941 | 30 | 17,370 | 0 | 0 |
| Total | 2,877 | \$6,589,665 | 159 | \$1,802,027 | 48 | \$609,346 |

**Table 4: Estimates of Overpayments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)**

| | |
|----------------|--------------------------|
| Point estimate | \$1,585,968 |
| Lower limit | \$1,199,149 ⁶ |
| Upper limit | \$1,972,247 |

⁶ We calculated the total estimated overpayments by adding the \$67,656 paid for the three elective procedures billed as inpatient to the lower limit of \$1,199,149. The resulting overpayment was \$1,266,805.

MEDICARE OVERPAYMENTS WITHIN THE 3-YEAR RECOVERY PERIOD

Table 5: Sample 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 | 3 | \$111,749 | 3 | \$111,749 | 1 | \$4,000 |
| 2 | 261 | 3,328,914 | 30 | 359,526 | 9 | 60,436 |
| 4 | 49 | 816,167 | 40 | 680,667 | 21 | 294,003 |
| 5 | 26 | 476,342 | 26 | 476,342 | 1 | 660 |
| 6 | 86 | 413,552 | 30 | 156,373 | 0 | 0 |
| 7 | 2,452 | 1,442,941 | 30 | 17,370 | 0 | 0 |
| Total | 2,877 | \$6,589,665 | 159 | \$1,802,027 | 32 | \$359,099 |

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

| | |
|----------------|-------------|
| Point estimate | \$890,603 |
| Lower limit | \$579,799 |
| Upper limit | \$1,201,407 |

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 | | | | |
| Inpatient Manufacturer Credits for Replaced Medical Devices | 3 | \$111,749 | 1 | \$4,000 |
| Inpatient Claims Billed With High-Severity-Level DRG Codes | 30 | 359,526 | 14 | 112,415 |
| Inpatient Rehabilitation Facility | 40 | 680,667 | 32 | 492,271 |
| Elective Procedure Billed as Inpatient ⁷ | 5 | 93,790 | 3 | 67,656 |
| Inpatient Totals | 78 | \$1,245,732 | 50 | \$676,342 |
| Outpatient | | | | |
| Outpatient Manufacturer Credits for Replaced Medical Devices | 26 | \$476,342 | 1 | \$660 |
| Outpatient Intensity Modulated Radiation Therapy Planning Services | 30 | 156,373 | 0 | 0 |
| Outpatient Claims Billed With Evaluation and Management Services | 30 | 17,370 | 0 | 0 |
| Outpatient Totals | 86 | \$650,085 | 1 | \$660 |
| Inpatient and Outpatient Totals | 164 | \$1,895,817 | 51 | \$677,002 |

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk area we reviewed. However, we have organized this report’s findings by the type 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.

⁷ The five elective procedures billed as inpatient claims were not part of the stratified random sample.

APPENDIX E: HOUSTON METHODIST HOSPITAL COMMENTS



May 2, 2016

Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services – Region VI
1100 Commerce Street, Room 632
Dallas, Texas 75242

Report Number: A-06-14-00074

Dear Ms. Wheeler:

We are in receipt of the U.S. Department of Health and Human Services Officer of Inspector General (OIG) draft report issued on April 11, 2016 and entitled Medicare Compliance Review of Houston Methodist Hospital for Calendar Years 2012 and 2013. Houston Methodist Hospital appreciates the opportunity to respond to the draft report, as we are committed to furnishing unparalleled safety, quality, and service to our patients in compliance with all applicable laws and regulations governing Federal health care programs.

The Medicare Compliance review covered a variety of inpatient and outpatient areas. While the initial sample of claims was for 219, it was subsequently increased by the OIG to include all claims for risk area 8 (compromised beneficiary) below. So HMH provided the 819 claims, 219 medical records, and 16 independent third party medical review determinations to the OIG.

| Original Risk Area | Original Sample |
|---|-----------------|
| 1. Inpatient manufacturer credits for replaced medical devices | 3 claims |
| 2. Outpatient manufacturer credits for replaced medical devices | 26 claims |
| 3. Inpatient claims billed with high severity level DRG group codes (MCC/CC) ¹ | 30 claims |
| 4. Elective procedures billed as inpatient ¹ | 30 claims |
| 5. Inpatient rehabilitation facility ¹ | 40 claims |
| 6. Outpatient claims billed with E&M services | 30 claims |
| 7. Outpatient intensity modulated radiation therapy (IMRT) planning services | 30 claims |
| 8. Inpatient and outpatient compromised beneficiaries (30 beneficiaries) | 630 claims |
| Total | 819 Claims |

Note 1: During our entrance meeting with the OIG auditors in September 2014, we asked what the basis was for sample selection, the OIG Auditors indicated that the sample selection methodology was judgmentally based for items 1,2,6,7,8, and was randomly selected for items 3,4, and 5.

During a follow-up communication with the OIG Audit Manager on November 6, 2014, we inquired about the OIG's intention to extrapolate or report actual results. The OIG Manager stated that the OIG plan was to extrapolate results for items 3, 5, 6, and 7 below.

| Original Risk Area | Selection Method | OIG Reviewer | OIG Plans to Extrapolate or Report Actual Results |
|--|------------------|----------------------|---|
| 1. Inpatient credits replaced medical devices | Judgmental | OIG staff | Report actual results |
| 2. Outpatient credits replaced medical devices | Judgmental | OIG staff | Report actual results |
| 3. Inpatient claims high severity level DRGs | Random | OIG Medical Reviewer | Extrapolation |
| 4. Elective procedures billed as inpatient | Random | OIG Medical Reviewer | Report actual results |
| 5. Inpatient rehabilitation facility | Random | OIG Medical Reviewer | Extrapolation |
| 6. Outpatient claims billed with E&M services | Judgmental | OIG staff | Extrapolation |
| 7. Outpatient IMRT planning services | Judgmental | OIG staff | Extrapolation |
| 8. Compromised beneficiaries | Judgmental | OIG staff | Report Actual Results |

During the OIG's onsite visit in September 2015, they shared with us their preliminary results of the claims that they reviewed. They noted that there were no deficiencies noted in the 630 claims reviewed for the compromised beneficiary risk area and therefore they would not be reporting on it. They also noted that the elective procedures billed as inpatient sample included claims that did not belong on the list, therefore they would only review 5 claims as a separate non-statistical sample. As a result, the OIG's Draft Report reflects a reduced number of risk areas audited and claims sampled.

| Modified Risk Area | OIG Error Noted | Modified Sample |
|---|-----------------|-----------------|
| 1. Inpatient credits replaced medical devices | 1 | 3 |
| 2. Outpatient credits replaced medical devices | 1 | 26 |
| 3. Inpatient claims high severity level DRGs | 14 | 30 |
| 4. Inpatient rehabilitation facility | 32 | 40 |
| 5. Outpatient claims billed with E&M services | 0 | 30 |
| 6. Outpatient IMRT planning services | 0 | 30 |
| Subtotal | 48 | 159 |
| Elective procedures billed as inpatient - Non Statistical Sample of 5 claims removed from the list of risk areas. | 3 | |
| Total | 51 | |

The draft report of the HMM Medicare Compliance Review noted 51 potential claim errors, resulting in an extrapolated overpayment of \$1,266,805. The recommendations contained in the report included:

- Refunding the Medicare contractor for the overpayments, and
- Strengthening controls to ensure full compliance with Medicare requirements.

Houston Methodist Hospital has a strong and effective compliance program, referred to as our Business Practices Program. We carefully reviewed the claims selected by the OIG with our

independent third party physician reviewer and we also consulted a statistician. Based upon advice from our industry experts, we respectfully disagree with many of the OIG findings in the draft report and with the misuse and misapplication of the statistical sampling results and the use of extrapolation.

I. Background

This Medicare Compliance Review was part of the national OIG auditing work plan initiative to determine if hospitals are complying with Medicare billing requirements. The audit focused initially on the 8 risk areas noted above later reduced to 6 risk areas. The audit period involved claims with dates of service in calendar years 2012 and 2013.

II. OIG Findings & Concurrence or Non-concurrence

a. Inpatient credits replaced medical devices

The OIG identified 1 inpatient claim error associated with a manufacturer credit for a replaced medical device. Houston Methodist Hospital has invested considerable effort in putting the necessary controls and processes in place to address this risk area. We agree that this was an isolated error and corrected the claim in May 2014.

b. Outpatient credits replaced medical devices

The OIG identified 1 outpatient claim error associated with a manufacturer credit for a replaced medical device. Houston Methodist Hospital has invested considerable effort in putting the necessary controls and processes in place to address this risk area. We agree that this was an isolated error and corrected the claim in September 2015.

c. Inpatient claims high severity level DRGs

The OIG noted that there were 14 errors, 9 claims lacked the medical necessity for the inpatient stay, and 5 claims lacked the supporting documentation for the secondary diagnosis. Houston Methodist disagrees with 7 of the 9 claims that the OIG alleged lacked medical necessity. We will correct the 2 claims and appeal 7 claims based upon our independent third-party physician reviewer's determination and the clinical merits of these cases. For the 5 claims that the OIG alleged were miscoded we determined that one was under-coded and 4 were over-coded and will correct them. The hospital enhanced its case management review process prior to the start of this audit. The hospital has also provided additional education for coding staff.

d. Inpatient rehabilitation facility

Of the sample of 40 narrowly targeted short stay inpatient rehab cases, the OIG noted that 30 lacked medical necessity for admission and 2 had incorrectly coded case mix group (CMG) codes. Based upon our independent third-party physician review of these claims, Houston Methodist Hospital disagrees with the OIG's determinations for 12 claims and will appeal them. For these 12 claims, we will exercise our right to appeal them based on our independent third-party physician reviewer's determination and the clinical merits of these cases. For the remaining 18 claims we agree and are rebilling them for eligible Part B reimbursement. For the two alleged CMG errors, we disagree that these were coded in error. The hospital has taken corrective action and performs physician documentation reviews as well as education and feedback for physicians and the RN admission liaison. Patients whose conditions do not meet medical necessity criteria for admission to the IRF are reviewed by the IRF Medical Director and an outside consultant.

- e. Elective Procedures Billed as Inpatient
The OIG stated that 3 errors were identified out of the 5 claims reviewed outside the stratified random sample. We agree with the findings and will make the necessary claim corrections. The hospital enhanced its case management review process prior to the start of this audit.
- f. Outpatient claims billed with E&M services
The OIG noted that there were 0 errors out of the 30 claims sampled.
- g. Outpatient IMRT planning services
The OIG noted that there were 0 errors out of the 30 claims sampled.

III. Houston Methodist Response

- a. Inconsistent and Arbitrary use of Extrapolation
The basis and methodology for determining whether the OIG will extrapolate is inconsistent and appears arbitrary. The vast majority of published Medicare Compliance Review reports do not result in extrapolated results. While we recognize that statistical sampling is well supported in case law, we wholeheartedly disagree with the arbitrary use of extrapolation, and do not understand the OIG's thresholds, basis or limitations for when they will or will not use extrapolation. The OIG report does not provide the justified basis for the use of extrapolation.

Congress has limited the use of extrapolation by MAC, RAC and other CMS contractors to situations involving sustained or high payment error; or when documented educational intervention has failed to correct the payment error. When considering that Houston Methodist produced 819 claims for review, we believe that our low error rate does not justify the use of extrapolation. As a result, we respectfully requested that the OIG Auditors only report on actual results and not extrapolate; however, that request was denied during our exit conference call in Dec. 2015. When we asked the OIG for the threshold or rationale that they use to determine when to extrapolate, they indicated that they can extrapolate on just 1 error if they so choose.

Houston Methodist continues to support the American Hospital Association's ongoing advocacy efforts involving the hospital industry's concerns over the OIG's use of extrapolation.

- b. Overstatement of Extrapolated Errors
The error amount is overstated as it failed to take into account eligible Part B Reimbursement. The OIG should postpone issuing its final report until the claim appeal and adjudication process has occurred. The OIG audit process already has spanned more than a year. Allowing Houston Methodist Hospital the necessary time and due process to resolve the Part B reimbursement which we initiated prior to the OIG Draft report will avoid the inappropriate mischaracterization and overstatement of the error amounts published in these reports as well as allow Houston Methodist to receive the eligible reimbursement that we are entitled to.

- c. Misuse of Medicare Compliance Review Risk Area Selection Protocol
The selection of a compromised beneficiary risk area was unjustified and unduly burdensome. We were asked to produce all of the corresponding claims (630) and medical records for 30 beneficiaries. This request far exceeded the regulatory limits established by other government contract auditors (e.g, RAC). The OIG notes that they focus their reviews on risk areas identified as a result of prior OIG reviews at other hospitals. However, the compromised beneficiary risk area has not been addressed in any prior published OIG Medicare Compliance reviews.
- d. Due Process for the Medical Reviewers to Reconcile Differences
We requested during our exit meeting that our independent third party medical determinations be shared with the OIG's medical reviewer and offered for the two physician advisors to discuss the clinical merits for the cases we plan to appeal and for the two parties to reconcile their differences. The OIG auditors did not respond or honor our request. Since the OIG's medical reviewer and Houston Methodist's independent physician reviewer were not permitted to discuss and reconcile their differences for their complex medical determinations, we believe that these cases should not be eligible for extrapolation for risk areas noted in the table below. This denial of due process is unduly burdensome on providers, results in the mischaracterization and overstatement of errors and leads to backlogging the regulatory appeal system.

| Risk Area | OIG Reviewer | OIG Plans to Extrapolate or Report Actual Results |
|---|----------------------|---|
| Inpatient claims high severity level DRGs | OIG Medical Reviewer | Extrapolation |
| Inpatient rehabilitation facility | OIG Medical Reviewer | Extrapolation |

IV. Conclusion

Houston Methodist Hospital has a deep commitment to compliance to operating within all applicable laws and regulations. As part of this commitment, Houston Methodist Hospital devotes resources toward the ongoing auditing and monitoring of claims and services. If errors are identified, refunds are made and processes are modified to remedy any control deficiencies. We ask that that OIG and their medical reviewer reconsider their findings, not use extrapolation, and modify the final report so as not to mischaracterize or overstate their results.

On behalf of Houston Methodist Hospital, we thank you in advance for your consideration and openness during the audit process. Please do not hesitate to contact me if you have any questions or need any additional information.

Sincerely,

Daniel W. Pantera,
Vice President, Business Practices Officer & Chief Audit Officer
Houston Methodist