

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF  
NAPLES COMMUNITY HOSPITAL FOR  
2011 AND 2012**

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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*Naples Community Hospital did not fully comply with Medicare requirements for billing inpatient services, resulting in overpayments of at least \$4.5 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 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 Naples Community Hospital (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 420-bed acute care facility located in Naples, Florida. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$286 million for 26,824 inpatient and 113,938 outpatient claims for services provided to beneficiaries from January 1, 2011, through December 31, 2012 (audit period).

Our audit covered \$31,106,559 in Medicare payments to the Hospital for 4,192 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 225 inpatient claims with payments totaling \$1,574,369. These 225 claims had dates of service in our audit period. We did not select any outpatient claims for review.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 134 of the 225 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 91 claims, resulting in overpayments of \$409,366 for the audit period. 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 overpayments of at least \$4,584,571 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 \$1,513,868 is within the 3-year recovery period and as much as \$3,070,703 is outside of the 3-year recovery period.

## **WHAT WE RECOMMEND**

We recommend that the Hospital:

- refund to the Medicare program \$1,513,868 in estimated 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 \$3,070,703 for our audit period, in accordance with the 60-day repayment rule; and
- strengthen controls to ensure full compliance with Medicare requirements.

## **NAPLES COMMUNITY HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital did not agree with some of our findings and recommendations. It disagreed that it improperly billed 63 of the 91 inpatient claims that we stated did not fully comply with Medicare billing requirements. Regarding our first recommendation, of the 38 claims that we identified as improperly billed and as being within the 3-year recovery period, the Hospital disagreed that it improperly billed 24 claims. However, it acknowledged that it improperly billed 14 of the 38 claims and believed the amount that should be refunded was \$32,448. Additionally, the Hospital stated that we issued our draft report without the Hospital having the ability to question or refute the medical reviewer's findings from a clinical perspective. It also stated that it did not know the education, training, or experience of the independent medical reviewers, with respect to medical record coding and guidelines, or the clinical issues presented in the claims that the medical coders reviewed.

For the second recommendation, of the 53 claims that we identified as improperly billed and as being outside of the 3-year recovery period, the Hospital disagreed that it improperly billed 39 claims. However, it acknowledged that it improperly billed 14 of the 53 claims. In an attempt to follow the 60-day repayment rule, the Hospital complied with our recommendation and, under protest, repaid the Medicare contractor \$144,076, representing the 53 claims outside of the 3-year recovery period that were known to the Hospital to be in error. In addition, the Hospital objected to the use of statistical sampling and extrapolation to calculate the overpayment.

Regarding our third recommendation, the Hospital stated that it had taken steps to strengthen controls.

## **OUR RESPONSE**

In response to the Hospital's disagreement that it improperly billed 63 inpatient claims, we obtained an independent medical review of all of these claims for medical necessity and coding errors, and our report reflects the results of that review. In response to the Hospital's not having the ability to challenge the medical reviewer determinations, we informed the Hospital that it could contest the disallowances when responding to our draft report, and, finally, the last recourse is the appeals process. Further, we explained that the medical reviewers are qualified and meet the work experience requirements to conduct medical review of hospital claims.

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.

Therefore, we maintain that all of our findings and recommendations are valid.

## TABLE OF CONTENTS

INTRODUCTION .....	1
Why We Did This Review .....	1
Objective .....	1
Background .....	1
The Medicare Program .....	1
Hospital Inpatient Prospective Payment System .....	1
Hospital Outpatient Prospective Payment System .....	1
Hospital Claims at Risk for Incorrect Billing .....	2
Medicare Requirements for Hospital Claims and Payments .....	2
Naples Community Hospital .....	3
How We Conducted This Review .....	3
FINDINGS .....	3
Billing Errors Associated With Inpatient Claims .....	4
Incorrectly Billed as Inpatient .....	4
Incorrectly Billed Diagnosis-Related-Group Codes .....	4
Incorrect Source-of-Admission Code .....	5
Overall Estimate of Overpayments .....	5
RECOMMENDATIONS .....	5
NAPLES COMMUNITY HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE .....	6
Naples Community Hospital Comments .....	6
First Recommendation .....	6
Second Recommendation .....	6
Third Recommendation .....	7
Office of Inspector General Response .....	7
Contested Determinations of Claims .....	7
Statistical Sampling and Extrapolation .....	7
APPENDIXES	
A: Audit Scope and Methodology .....	9
B: Sample Design and Methodology .....	11

C: Sample Results and Estimates .....14

D: Results of Review by Risk Area.....16

E: Naples Community Hospital Comments .....17

## **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 Naples Community Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

### **BACKGROUND**

#### **The Medicare Program**

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

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

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

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

#### **Hospital Outpatient Prospective Payment System**

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

within each APC group.<sup>1</sup> All services and items within an APC group are comparable clinically and require comparable resources.

### **Hospital Claims at Risk for Incorrect Billing**

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

- inpatient short stays,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims billed for kyphoplasty services,<sup>2</sup>
- inpatient claims paid in excess of charges,
- inpatient claims with cancelled surgical procedures, and
- inpatient psychiatric facility (IPF) emergency department adjustments.

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.” We reviewed these risk areas as part of this review.

### **Medicare Requirements for Hospital Claims and Payments**

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

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

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

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

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

## **Naples Community Hospital**

The Hospital is a 420-bed acute care facility located in Naples, Florida. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately \$286 million for 26,824 inpatient and 113,938 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 \$31,106,559 in Medicare payments to the Hospital for 4,192 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 225 inpatient claims with payments totaling \$1,574,369. These 225 claims had dates of service in our audit period. We did not select any outpatient claims for review.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 77 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 134 of the 225 inpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 91 claims, resulting in overpayments of \$409,366 for the audit period. 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 overpayments of at least \$4,584,571 for the audit period. This overpayment amount includes claim payment dates

that are outside of the 3-year recovery period.<sup>3</sup> Of the total estimated overpayments, at least \$1,513,868 is within the 3-year recovery period and as much as \$3,070,703 is outside of 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 91 of 225 sampled inpatient claims, which resulted in overpayments of \$409,366.

### **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 68 of the 225 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. The Hospital stated that the claims that it agreed were in error occurred due to a lack of timely review.

As a result of these errors, the Hospital received overpayments of \$359,470.<sup>4</sup>

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

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

For 19 of the 225 selected claims, the Hospital submitted claims to Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. These errors occurred because the hospital did not ensure that the codes submitted were substantiated by the medical

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<sup>3</sup> 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 it identified to its Medicare administrative contractor. The 2010 Patient Protection and Affordable Care Act requires the reporting and returning 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.

<sup>4</sup> The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor prior to the issuance of our draft report.

record documentation. As a result of these errors, the Hospital received overpayments of \$49,571.

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

CMS increases the Federal per diem rate for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary used emergency department services; however, the IPF should not receive the additional payment if the beneficiary was discharged from the acute care section of the same hospital (42 CFR § 412.424 and the Manual, chapter 3, § 190.6.4). The Manual also states that IPFs report source-of-admission code "D" to identify patients who have been transferred to the IPF from the same hospital (chapter 3, § 190.6.4.1). An IPF's proper use of this code is intended to alert the Medicare administrative contractor not to apply the emergency department adjustment.

For 4 of the 225 inpatient claims, the Hospital incorrectly coded the source-of-admission for beneficiaries who were admitted to its IPF upon discharge from its acute care section. The Hospital stated that these errors occurred because its system edits did not process the claims correctly. Specifically, its system edits did not receive a timely update, and the source-of-admission code "D" was not used.

As a result of these errors, the Hospital received overpayments of \$325.

### **OVERALL ESTIMATE OF OVERPAYMENTS**

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$4,584,571 for the audit period, of which at least \$1,513,868 was within the 3-year recovery period and as much as \$3,070,703 is outside of the 3-year recovery period.

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare program \$1,513,868 in estimated 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 \$3,070,703 for our audit period, in accordance with the 60-day repayment rule; and
- strengthen controls to ensure full compliance with Medicare requirements.

## **NAPLES COMMUNITY HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

### **NAPLES COMMUNITY HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital did not agree with some of our findings and recommendations. It disagreed that it improperly billed 63 of the 91 inpatient claims that we stated did not fully comply with Medicare billing requirements. However, it agreed that it improperly billed 28 of the 91 claims. Additionally, the Hospital stated that we issued our draft report without the Hospital having the ability to question or refute the medical reviewer's findings from a clinical perspective. It also stated that it did not know the education, training, or experience of the independent medical reviewers with respect to medical record coding and guidelines, or the clinical issues presented in the claims that the medical coders reviewed. Furthermore, the Hospital stated that our method of extrapolating, to determine the final recommended repayment amount, differed from other hospitals undergoing similar reviews. Lastly, the Hospital questioned why the number of selected claims was higher in one stratum as compared to another.

#### **First Recommendation**

Regarding our first recommendation, of the 38 claims that we identified as improperly billed and as being within the 3-year recovery period, the Hospital disagreed that it improperly billed 24 claims. However, it acknowledged that it improperly billed 14 of the 38 claims and believed the amount that should be refunded was \$32,448. It also stated that, for most cases, the coding was proper and consistent with Medicare guidance, or the services met medical necessity for inpatient stays.

Furthermore, the Hospital stated:

- It is contrary to the law and Medicare policy for the OIG and the independent medical reviewers to make medical necessity determinations based on a hindsight review.
- Its physicians' clinical decisions are based on all information available at the time and they use their professional judgment to determine whether inpatient care is necessary.
- It followed guidelines in billing the claims and determining whether an inpatient admission was appropriate.
- It requested to question or challenge the third party reviewer's findings, but the request was denied.

#### **Second Recommendation**

For the second recommendation, of the 53 claims that we identified as improperly billed and as being outside of the 3-year recovery period, the Hospital disagreed that it improperly billed 39 claims. However, it acknowledged that it improperly billed 14 of the 53 claims. In an attempt to

follow the 60-day repayment rule, the Hospital complied with our recommendation and, under protest, repaid the Medicare contractor \$144,076, representing the 53 claims outside of the 3-year recovery period that were known to the Hospital to be in error. In addition, the Hospital objected to the use of statistical sampling and extrapolation to estimate the overpayment.

It further objected that we identified the entire amount as having been overpaid for each of the improperly billed claims, without offsetting the claim by the amount the Hospital would have been paid had it been correctly billed.

### **Third Recommendation**

Regarding our third recommendation, the Hospital stated that it had taken steps to strengthen controls. These steps included the following: adding electronic communication between the coder and physician so that the physician's clinical opinion and intent is reflected properly in the medical record, enhancing its internal reviews to include the review of adherence to the two midnight rule guidelines, and adding a new billing system that has stronger internal controls and current billing edits.

We included the Hospital's comments as Appendix E; however, we did not include the attachments because they are too voluminous.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

### **Contested Determinations of Claims**

In response to the Hospital's disagreement that it improperly billed 63 inpatient claims, we obtained an independent medical review of all of these claims for medical necessity and coding errors, and our report reflects the results of that review. We provided the Hospital with the results of the independent medical review determinations.

In response to the Hospital's not having the ability to challenge the medical reviewer determinations because it disagrees with the results, we subjected those claims to a focused medical review to determine whether the services met medical necessity and coding requirements. We continue to stand by those determinations. We also informed the Hospital that it could contest the disallowances when responding to our draft report, and finally, the last recourse is the appeals process. Further, we explained that the medical reviewers are qualified and meet the work experience requirements to conduct medical review of hospital claims.

### **Statistical Sampling and Extrapolation**

Regarding our extrapolation methodology and statistical validity, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare. 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. These formulas accurately account for the number of claims selected from each of the strata.

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

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

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

In response to the Hospital's inquiry about the disparity between the sample sizes of the first and second strata, because we are not calculating estimates for individual stratum, only the overall sample size is relevant to our estimate. Furthermore, in response to the Hospital's observation that we used statistical sampling when other hospital reviews did not, each hospital review is unique, and the sampling method used in each of these reviews will vary. As a result, the refinement of our audit methodologies will also vary.

Therefore, we maintain that all of our findings and recommendations are valid.

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

### **SCOPE**

Our audit covered \$31,106,559 in Medicare payments to the Hospital for 4,192 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 225 inpatient claims with payments totaling \$1,574,369. These 225 claims had dates of service from January 1, 2011, through December 31, 2012 (audit period). We did not select any outpatient claims for review.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 77 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 225 inpatient claims totaling \$1,574,369 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 medical record documentation provided by the Hospital to support the sampled claims;
- reviewed the Hospital's procedures for admission, utilization management, and inpatient coding;
- used an independent contractor and the Medicare Administrative Contractor to determine whether 77 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 \$285,941,406 for 26,824 inpatient and 113,938 outpatient claims for services provided to beneficiaries during the audit period.

We obtained a database of claims from CMS's NCH data totaling \$142,000,667 for 12,403 inpatient and 69,844 outpatient claims in 36 risk areas. From these risk areas, we selected 6 consisting of 7,254 claims totaling \$48,909,940 for further review.

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

- \$0 paid claims;
- claims duplicated within individual risk areas by assigning each inpatient claim that appeared in multiple risk areas to just one category based on the following hierarchy:
  - IPF Emergency Department Adjustments,
  - Inpatient Claims Billed for Kyphoplasty Services,
  - Inpatient Claims With Cancelled Surgical Procedures,
  - Inpatient Claims Paid in Excess of Charges,
  - Inpatient Short Stays, and
  - Inpatient Claims Billed With High-Severity-Level DRG Codes; and
- claims under review by the Recovery Audit Contractor (RAC) as of February 9, 2014.<sup>5</sup>

Removing these claims resulted in a sampling frame of 4,192 unique Medicare claims in 6 risk areas totaling \$31,106,559.

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<sup>5</sup> To ensure that our overpayment extrapolation is valid, any sample items that a RAC has reviewed or is currently reviewing 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 reviewed by the RAC that are in the sampling frame will be subtracted from the total overpayments.

**Table 1: Risk Areas Sampled**

<b>Risk Area</b>	<b>Number of Claims</b>	<b>Amount of Payments</b>
Inpatient Claims Billed With High-Severity-Level DRG Codes	2,830	\$23,606,517
Inpatient Short Stays	1,317	7,027,618
Inpatient Claims Paid in Excess of Charges	30	381,907
Inpatient Claims Billed for Kyphoplasty Services	7	65,852
Inpatient Claims With Cancelled Surgical Procedures	4	13,361
IPF Emergency Department Adjustments	4	11,304
<b>Total</b>	<b>4,192</b>	<b>\$31,106,559</b>

**SAMPLE UNIT**

The sample unit was a Medicare paid claim.

**SAMPLE DESIGN**

We used a stratified random sample. We stratified the sampling frame into six 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 225 claims for review as follows:

**Table 2: Sampled Claims by Stratum**

<b>Stratum</b>	<b>Risk Area</b>	<b>Claims in Sampling Frame</b>	<b>Claims in Sample</b>
1	Inpatient Claims Billed With High-Severity-Level DRG Codes	2,830	75
2	Inpatient Short Stays	1,317	105
3	Inpatient Claims Paid in Excess of Charges	30	30
4	Inpatient Claims Billed for Kyphoplasty Services	7	7
5	Inpatient Claims With Cancelled Surgical Procedures	4	4
6	IPF Emergency Department Adjustments	4	4
	<b>Total</b>	<b>4,192</b>	<b>225</b>

## **SOURCE OF RANDOM NUMBERS**

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

## **METHOD FOR SELECTING SAMPLE UNITS**

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

## **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 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 Results**

<b>Stratum</b>	<b>Frame Size (Claims)</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Incorrectly Billed Claims in Sample</b>	<b>Value of Overpayments in Sample</b>
1	2,830	\$23,606,517	75	\$564,036	21	\$63,963
2	1,317	7,027,618	105	537,909	52	251,155
3	30	381,907	30	381,907	6	37,774
4	7	65,852	7	65,852	5	46,840
5	4	13,361	4	13,361	3	9,309
6	4	11,304	4	11,304	4	325
<b>Total</b>	<b>4,192</b>	<b>\$31,106,559</b>	<b>225</b>	<b>\$1,574,369</b>	<b>91</b>	<b>\$409,366</b>

**ESTIMATES**

**Table 4: Estimated Value of Overpayments for the Audit Period**  
*Limits Calculated for a 90-Percent Confidence Interval*

Point Estimate	\$5,658,004
Lower Limit	4,584,571
Upper Limit	6,731,437

**MEDICARE OVERPAYMENTS WITHIN THE 3-YEAR RECOVERY PERIOD**

**Table 5: Sample Results**

<b>Stratum</b>	<b>Frame Size (Claims)</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Incorrectly Billed Claims in Sample</b>	<b>Value of Overpayments in Sample</b>
1	2,830	\$23,606,517	75	\$564,036	8	\$22,455
2	1,317	7,027,618	105	537,909	22	103,826
3	30	381,907	30	381,907	6	37,774
4	7	65,852	7	65,852	1	8,693
5	4	13,361	4	13,361	1	2,938
6	4	11,304	4	11,304	0	0
<b>Total</b>	<b>4,192</b>	<b>\$31,106,559</b>	<b>225</b>	<b>\$1,574,369</b>	<b>38</b>	<b>\$175,686</b>

**ESTIMATES**

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

Point Estimate	\$2,198,985
Lower limit	1,513,868
Upper limit	2,884,103

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

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Over-payments</b>	<b>Value of Over-payments</b>
<b>Inpatient</b>				
Short Stays	105	\$537,909	52	\$251,155
Claims Billed With High-Severity-Level DRG Codes	75	564,036	21	63,963
Claims Billed for Kyphoplasty Services	7	65,852	5	46,840
Claims Paid in Excess of Charges	30	381,907	6	37,774
Claims With Cancelled Surgical Procedures	4	13,361	3	9,309
IPF Emergency Department Adjustments	4	11,304	4	325
<b>Inpatient Totals</b>	<b>225</b>	<b>\$1,574,369</b>	<b>91</b>	<b>\$409,366</b>

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

## APPENDIX E: NAPLES COMMUNITY HOSPITAL COMMENTS

NCH Downtown Naples Hospital  
350 Seventh Street N.  
Naples, FL 34102  
(239) 624-5000



NCH North Naples Hospital  
11190 Healthpark Blvd.  
Naples, FL 34110  
(239) 552-7000

June 23, 2015

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

VIA : OIG secure server transmittal

RE: Report number: A-04-14-07049

Dear Ms. Pilcher,

This letter sets forth Naples Community Hospital, Inc.'s (NCH) response to the Office of Inspector General (OIG) May 21, 2015 draft report titled *Medicare Compliance Review of Naples Community Hospital for 2011 and 2012*. For ease of reference we have included the Executive Summary and the Recommendations from that report below.

### **OIG Executive Summary**

*The Hospital complied with Medicare billing requirements for 134 of the 225 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 91 claims, resulting in overpayments of \$409,366 for the review period. 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 overpayments of at least \$4,584,571 for the review period. This overpayment amount includes claim payment dates that are outside of the 3-year recovery period. Of the total estimated overpayments, at least \$1,513,868 is within the 3-year recovery period.*

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## **OIG Recommendations**

*We recommend that the Hospital:*

- *refund to the Medicare program \$1,513,868 in estimated 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 in accordance with the 60-day repayment rule, and*
- *Strengthen controls to ensure full compliance with Medicare requirements.*

## **NCH Response**

NCH takes the care that we provide to our patients and our compliance with the numerous regulations which govern the manner in which we provide, and seek reimbursement for, that care very seriously. NCH has received many national and state awards and recognitions for our high quality patient care. We are committed to a culture of compliance. This OIG review has provided NCH with an opportunity to further examine and improve our billing processes and internal controls.

While we disagree with some of the findings in the OIG's draft report, we would like to acknowledge the professional and courteous manner in which the OIG review team has handled themselves throughout this process. To the extent that we concur with their findings related to specific claims that were reviewed, we will refund the appropriate amounts to our Medicare Administrative Contractor.

As noted in the OIG Executive Summary above, the OIG team examined 225 NCH claims during this review process. These 225 claims were separated by the OIG into six different "Stratum." Of those 225 claims, the OIG reviewers have opined that 134 of the claims were billed correctly and 91 were billed incorrectly. NCH agrees with the OIG reviewers' findings that the 134 were billed correctly. NCH only agrees with the OIG reviewers' conclusions with respect to 28 of the 91 claims which the OIG reviewers have alleged were billed incorrectly. NCH respectfully disagrees with the OIG's findings for the remaining 63 claims of the 91 claims which the OIG reviewers have alleged were billed incorrectly.

The OIG also correctly notes that only 38 of the 91 claims which the OIG reviewers allege were incorrectly billed are within the three year recovery period. Those 38 claims are categorized by the OIG into the following Stratum:

- Stratum One - 8 claims were incorrectly billed for a total of \$22,455 in overpayments.
- Stratum Two - 22 claims were incorrectly billed for a total of \$103,826 in overpayments.
- Stratum Three- 6 claims were incorrectly billed for a total of \$37,774 in overpayments.
- Stratum Four - 1 claim was incorrectly billed for a total overpayment of \$8,693.
- Stratum Five - 1 claim was incorrectly billed for a total overpayment of \$2,938.
- Stratum Six – No claims were incorrectly billed.

These 38 claims represent \$175,686 in alleged overpayments.

NCH's position with respect to the OIG's findings for the 38 claims is as follows:

Stratum One – NCH agrees that 5 claims were incorrectly billed for a total of \$12,159 in overpayments. The remaining claims were billed correctly.

Stratum Two – NCH agrees that 5 claims were incorrectly billed for a total of \$27,364 in overpayments. The remaining claims were billed correctly.

Stratum Three – NCH agrees that 3 claims were incorrectly billed for a total of \$22,239 in overpayments. The remaining claims were billed correctly.

Stratum Four – NCH agrees that the 1 claim was incorrectly billed for a total overpayment of \$8,693.

Stratum Five – NCH does not agree that this 1 claim was incorrectly billed.

Stratum Six – NCH agrees that this one claim was correctly billed.

It is NCH's position that the amount which should be refunded as a result of this review is \$32,448. This amount represents the difference between what was paid and what should have been paid on the 14 claims which NCH agrees were incorrectly billed and which are still within the three year recovery period.<sup>1</sup>

The OIG's draft report was issued without NCH having the ability to question or refute the reviewers' findings from a clinical perspective. Although the OIG reviewers were pleasant and professional during this process, to our knowledge they did not have any clinical training or medical record coding certifications. Nevertheless, they performed the first review of the medical records and made medical determinations on both the Diagnostic Related Grouping (DRG) and the medical necessity of inpatient care. A number of the claims which are in dispute were also sent to the government's third party reviewers. Again, as with the OIG reviewers, we do not know the education, training or experience of these third party reviewers with respect to medical record coding, coding guidelines, or the clinical issues present in the claims that were reviewed.

NCH's request to question or challenge the third party reviewer's findings were denied. The rationale for the denial was that the government's contract with the third party reviewer had ended. NCH was informed that any questions or challenges to the opinions of the "experts" who reviewed the medical records could be included with our response to the draft report. See Attachment A. In some instances the OIG reviewers and third party reviewers disagreed with each other's findings. Yet NCH had no opportunity to challenge or discuss any of the findings with any of the reviewers.

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<sup>1</sup> NCH does not agree with the OIG's assertion that the 53 claims that were outside of the three year recovery period were billed in error. However, since the OIG has put NCH on notice that the "60 day repayment rule" clock has begun, we have complied with the OIG's recommendation that we repay any claims known to us to be in error that were outside of the three year recovery period. Please note that we have repaid those claims under protest and with a reservation of our rights to contest the findings of the OIG Report. On June 16th we issued a check in the amount of \$144,076 and provided the claim documentation to the Medicare contractor First Coast Service Options. See Attachment C.

Many of the cases in which the OIG determined that an overpayment occurred, involved inpatient care in which a physician wrote an order for the admission after a face to face evaluation of the patient. The OIG reviewers and/or the third party reviewers are now stating 3-4 years after the patient encounter that these patients should have been cared for as outpatients. Such a determination of a lack of medical necessity based on a hindsight review is contrary to the law and Medicare policy. The very first section of the Medicare statute states: "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided...." 42 U.S.C. §1395. The Medicare Benefit Policy Manual, chapter 1, section 10 at page 9 directs QIOs reviewing the medical necessity of hospital admissions to "consider only the medical evidence which was available to the physician at the time an admission decision had to be made" and "not take into account other information (e.g., test results) which became available after admission." Likewise, CMS has stated that Medicare review contractors should evaluate the physician's expectation of the need for inpatient services "based on the information available to the admitting practitioner at the time of the inpatient admission." (CMS FAQs dated November 4, 2013). The physician does not know, nor can he or she anticipate at the time a patient is examined, what will occur in the future. Physicians' clinical decisions are based on all information available at the time, and they use their professional judgment as to whether inpatient care is necessary. Retrospective knowledge that there were no subsequent setbacks or deterioration of the patient's condition should not undercut the physician's assessment and decisions which were made at the time the care was initially provided.

In Florida the "FMQAI", a Medicare Quality Improvement Organization contracted by CMS, provides hospitals with a "Chest Pain Admission Guidance Tool" which is one of the guidelines we follow to determine if an inpatient admission is proper. On some of the claims in question we followed these FMQAI guidelines in billing the claims, yet the OIG report alleges that we billed these claims in error. On other claims, the OIG alleges we improperly billed claims as inpatients even though the patient's hospital admission met InterQual criteria for inpatient admission. The InterQual guidelines were, at the time, another nationally recognized guideline which was regularly used by hospitals to determine whether the patient's care should be billed as inpatient or outpatient care. Another example of a situation where we disagree with the reviewer's conclusion involves a claim for a patient who had a procedure which was on Medicare's "inpatient only" list. That designation requires hospitals to bill the claim in question as an inpatient claim. Although the patient was admitted as an inpatient in accordance with these guidelines and the physician's order, the OIG reviewer incorrectly determined that the patient should have been treated as an outpatient and found the claim to be in error. If NCH had at the time billed this claim as an outpatient claim it would have been denied. These are just some examples where we believe the reviewers, who did not have adequate training or the ability to discuss the details of each claim with NCH, incorrectly concluded that the claims were not billed in compliance with the Medicare requirements.

In arriving at the final recommended repayment amount of \$1,513,868 the OIG reviewers incorrectly extrapolated their findings in Stratum One, Two and Three out to a larger population of "similar" claims. Additionally, in Stratum Two, Three, Four and Five the OIG in calculating the repayment amount, failed to include an offset for the amount which NCH would have been paid had the claim, which was allegedly improperly billed, been billed and paid correctly.

The OIG's method of "estimating" the final recommended repayment amount is troubling in a number of ways. First we are unaware of any authority that would permit the OIG to extrapolate or estimate overpayments in a Medicare Compliance Review such as this. This extrapolation or estimation treats NCH in a disparate manner when compared to other hospitals undergoing similar reviews. Specifically, it should be noted that extrapolation was not used in determining the final repayment amounts in the majority of the Medicare Compliance Reviews which are published on the OIG website for 2015. The law pertaining to the Medicare Integrity program only permits extrapolation in cases of sustained or high level of payment error or where documented educational intervention has failed to correct the payment error. 42 U.S.C. §1395ddd(f)(3). No such situation is present or even alleged to have occurred here.

If we were to assume for a moment that it was appropriate to use extrapolation to determine the estimation of the recommended repayment amount, then if extrapolation is properly done, the sampling of claims should be random or performed in another statistically valid manner. Here, however, on page 6 of the OIG's Draft Report, the OIG states that it "used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements." In other words, the pool of claims from which the sample was taken was biased toward potentially incorrect claims. Claims that had zero to low risk of non-compliance were not captured in the pool to be sampled. NCH is limited in commenting further on the OIG's sampling method because we have not been provided the entire pool of claims from which the "stratified random sample" was chosen, nor has the OIG disclosed the computer matching, data mining, and analysis techniques referred to in the report. When asked why 225 claims were selected for review and how the OIG decided how many claims to include in each Stratum, the OIG responded that it was the review team's choice. We also inquired why there were fewer claims reviewed from Stratum One compared to Stratum Two, especially in light of the fact that Stratum One had a much higher number of claims and payments in the total pool compared to Stratum Two. The OIG again responded that the size and scope of the Stratum and the number of claims reviewed within each Stratum was determined by the reviewers. Consequently, NCH disputes whether there was a proper sampling and pooling of the claims which formed the basis for the extrapolation.

Again, assuming that it is permissible for the OIG to use extrapolation to determine the final recommended repayment amount, the Stratum which the OIG constructed for review were flawed because, with the exception of Stratum Two, each of the Stratum contained less than 100 claims. The OIG's Provider Self Disclosure Protocol states that the size of a sample used to estimate damages must be at least 100. Selection of small sample sizes from an already biased pool of claims only serves to increase the risk of overestimating potential overpayments.

The methodology for the "estimation" is further flawed because for those claims which the OIG is alleging were incorrectly billed, the OIG has determined that the entire amount that was allegedly incorrectly billed should be repaid to Medicare without any offset for the amount which NCH would have been paid had the claim been correctly billed. The OIG reviewers agree that these patients received the care that was described in the claims and that the care was appropriate and medically indicated. The only matter at issue here is whether NCH's bills for the care which was provided were submitted in compliance with the Medicare regulations and consequently, how much NCH should have been paid by Medicare for providing that care. Assuming for a moment that the OIG is correct and the claims were billed under an incorrect

DRG code or as an inpatient hospital stay when it should have been billed as outpatient hospital stay, then NCH at a minimum should receive the proper payment for the services provided. Otherwise this take back by the OIG would result in NCH providing the care to these patients for free. For example, in reviewing the 22 disputed claims in Stratum Two, if NCH were to agree with the third party reviewer's conclusion that the 22 inpatient claims in question should have been billed as outpatient care, the actual overpayment for these claims would have been \$103,826, less the outpatient payment of \$39,388, for a net overpayment of \$64,438. See Attachment B.

### **Strengthen controls**

In April 2015 we responded to the *Office of Inspector General Internal Controls Questionnaire*. Below is a summary of our April 2015 response.

**Stratum One** - We agree that upon hindsight review we could benefit from stronger documentation. We have improved our electronic health record significantly since 2012. We have also added electronic communication between the Coder and Physician so that the Physician's clinical opinion and intent is reflected properly in the medical record.

**Stratums Two and Four** – Like all hospitals, NCH had previously tightened internal controls due to the “two midnight rule” of 2013. NCH has a team of multidisciplinary personnel that review each short inpatient stay to assure we abide by these new guidelines.

**Stratums Three and Five** - We are enhancing our internal reviews to include the review of adherence to the two midnight rule.

**Stratum Six** - We replaced our billing system in 2011. The new system has stronger internal controls and current billing edits.

NCH is committed to continuously reviewing and finding opportunities to improve all aspects of the services that we provide. This includes not only the quality of the care that we provide, but also how we code and bill for those services.

Thank you for allowing us this opportunity to respond to your draft report.

Sincerely,



Kevin D. Cooper  
Chief of Staff