

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF JACKSON-MADISON  
COUNTY GENERAL HOSPITAL FOR  
CLAIMS PAID FROM JUNE 1, 2013,  
THROUGH MAY 31, 2015**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



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A-04-15-04042

# *Office of Inspector General*

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

## EXECUTIVE SUMMARY

***Jackson-Madison County General Hospital did not fully comply with Medicare requirements for billing inpatient services, resulting in estimated overpayments of at least \$1.4 million during a 2-year period.***

### 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 2015, Medicare paid hospitals \$163 billion, which represents 46 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 Jackson-Madison County General Hospital (the Hospital) complied with Medicare requirements for billing inpatient 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.

The Hospital is a 635-bed hospital located in Jackson, Tennessee. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$252 million for 25,819 inpatient claims between June 1, 2013, and May 31, 2015 (audit period).

Our audit covered \$17,615,919 in Medicare payments to the Hospital for 2,411 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 200 inpatient claims with payments totaling \$1,685,894. Medicare paid these 200 claims during our audit period.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 141 of the 200 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 59 claims, resulting in net overpayments of \$188,988 for the audit period. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,407,952 for the audit period.

## **WHAT WE RECOMMEND**

We recommend that the Hospital:

- refund to the Medicare contractor \$1,407,952 in estimated overpayments for the audit period for claims that it incorrectly billed;
- exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

## **JACKSON-MADISON COUNTY GENERAL HOSPITAL COMMENTS AND OUR RESPONSE**

In written comments on our draft report the Hospital stated that it agreed with our findings on 35 out of the 59 claims that we determined to be in error. For an additional 7 claims, the Hospital agreed there was a DRG error but disagreed with our corrected DRG assignment. The Hospital recalculated its own projected error of \$445,889 for stratum one and agreed to refund this amount but said that extrapolation was not warranted for strata two and three because its recalculated error rates were too low. Thus, the Hospital agreed only to refund its revised calculated errors on specific claims of \$14,984 and \$26,502 for strata two and three respectively. The Hospital said it would perform a review to identify and refund overpayments outside of our audit period for claims similar to those in stratum one but, because of its lower recalculated error rates, it would not do so for claims similar to those in strata two and three. The Hospital described actions that it has taken and plans to take to strengthen internal controls and ensure full compliance with Medicare requirements.

After reviewing the Hospital's comments, we continue to maintain that our findings and recommendations are valid. We used an independent medical reviewer to determine whether certain sampled claims were appropriately billed. Additionally, we used valid statistical sampling methodology in our sample selection and in determining the estimated Medicare overpayment for the audit period of \$1,407,952, which we continue to recommend that the Hospital refund. We also maintain that the Hospital should conduct its review for overpayments outside of our audit period without regard to whether claims resemble the claims included in a particular stratum. We agree with the steps the Hospital said it has taken and plans to take to strengthen internal controls and ensure full compliance with Medicare requirements.

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## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2015, Medicare paid hospitals \$163 billion, which represents 46 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

### **OBJECTIVE**

Our objective was to determine whether Jackson-Madison County General Hospital (the Hospital) complied with Medicare requirements for billing inpatient 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 Claims at Risk for Incorrect Billing**

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

- inpatient claims paid in excess of charges and
- inpatient claims billed with high-severity-level DRG codes.

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 (§ 1815(a)).

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

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

Under section 1128J(d) of the Social Security Act and 42 CFR part 401 subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR § 401.305(a)(2), (b)(1)(i), and (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

## **Jackson-Madison County General Hospital**

The Hospital is a 635-bed hospital located in Jackson, Tennessee. According to CMS’s National Claims History (NCH) data, Medicare paid the Hospital approximately \$252 million for 25,819 inpatient claims between June 1, 2013, and May 31, 2015 (audit period).

## **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$17,615,919 in Medicare payments to the Hospital for 2,411 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 200 inpatient claims with payments totaling \$1,685,894. Medicare paid these 200 claims during our audit period.

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 108 claims to coding review to determine whether the services were 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 scope and methodology.

## **FINDINGS**

The Hospital complied with Medicare billing requirements for 141 of the 200 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 59 claims, resulting in net overpayments of \$188,988 for the audit period. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,407,952 for the audit 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 review by risk area.

### **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 59 of the 200 inpatient claims that we reviewed. These errors resulted in net overpayments of \$188,988. Four claims contained more than one error.<sup>1</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 57 of the 200 inpatient claims, the Hospital submitted claims to Medicare with incorrect DRG codes. The Hospital did not agree that all 57 claims had errors. The Hospital stated that some of the errors occurred due to coders coding the claims without the discharge summary being available at the time of coding and due to coders failing to clarify diagnosis codes with physician queries. Additionally, the Hospital stated that it disagreed with some of our decisions and that their coders are not trained to question physicians regarding the clinical validity of consistently documented diagnoses.

As a result of these errors, the Hospital received net overpayments of \$170,853.

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<sup>1</sup> For sampled claims that contained more than one type of error, we used the total claim overpayment for error estimation. We did not estimate errors on the same claim twice.

## **Incorrect Discharge Status**

Federal regulations state that a discharge of a hospital inpatient is considered to be a transfer when the patient's stay is assigned to one of the qualifying DRGs and the discharge is to (1) hospitals or hospital units that are not reimbursed under the IPPS, (2) skilled nursing facilities, and (3) home under a written plan of care for home health services that begin within 3 days after the date of discharge (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 6 of the 200 inpatient claims, the Hospital incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. Specifically, the Hospital coded the discharge status as "to home" instead of "to home health" in five instances and "to home" instead of "to a skilled nursing facility" in the sixth. Thus, the Hospital received the full DRG payment instead of the graduated per diem payment it would have received if it had correctly coded the patient's discharge status.

The Hospital stated that some of these errors occurred because documentation in the chart does not always indicate that home health services were set up or resumed within 3 days of discharge. Additionally, the Hospital stated that it uses a contractor to assess the accuracy of its discharges, but the contractor does not review claims with a discharge status of "to home." In one instance, the Hospital followed a contractor's advice and adjusted a claim that had initially been correctly coded with a discharge status of "to a skilled nursing facility." The contractor advised the change because, although the patient did receive skilled nursing services, the patient did not qualify for Medicare Part A benefits for skilled nursing services.

As a result of these errors, the Hospital received overpayments of \$18,135.

## **OVERALL ESTIMATE OF OVERPAYMENTS**

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,407,952 for the audit period.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$1,407,952 in estimated overpayments for the audit period for claims that it incorrectly billed;

- exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

## **JACKSON-MADISON COUNTY GENERAL HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

### **JACKSON-MADISON COUNTY GENERAL HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital stated that it agreed with our findings on 35 out of 59 claims that we determined to be in error. For an additional 7 claims, the Hospital agreed there was a DRG error but disagreed with our corrected DRG assignment and disagreed with our findings on the remaining 17 claims. Additionally, using only the errors and DRG assignments it agreed with, the Hospital calculated its own error rate by strata and determined that, because of the low error rate for strata two and three, extrapolation was not justified for those strata. The Hospital said that its recalculated error rates for strata two and three were below the threshold of 5 percent that is stipulated in most OIG corporate integrity agreements as necessary to warrant full sample retrospective review. The Hospital also calculated a revised projected error of \$445,889 for stratum one (which it agreed to refund) but it agreed to refund only its revised calculated errors on specific claims of \$14,984 and \$26,502 for strata two and three respectively.

The Hospital said it would perform a review to identify and refund additional overpayments outside of our audit period for claims similar to those in stratum one (i.e., claims where the Medicare payments exceed charges). However, because of the Hospital's recalculated low error rate for strata two and three, the Hospital did not believe it is required to perform this review for claims similar to the claims in these strata (i.e., claims with high-severity-level DRG codes).

The Hospital indicated that it has discussed the OIG findings on specific claims with its coders and that these discussions have been beneficial in providing insights to them. Additionally, the Hospital said that it would implement a mandatory prebilling secondary review of all applicable Medicare inpatient claims (excluding patients who expire, are transferred to another hospital, or leave against medical advice) in which it estimates that Medicare reimbursement will exceed total charges. The Hospital also indicated that it would include in its education of coders examples of claims similar to the ones that were determined to be in error in strata two and three.

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

### **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the Hospital's comments, we continue to maintain that our findings and recommendations are valid. We used an independent medical review contractor to determine whether certain sampled claims were appropriately billed. Additionally, we used valid statistical

sampling methodology in our sample selection and in determining the estimated Medicare overpayment for the audit period of \$1,407,952 which we continue to recommend that the Hospital refund. We agree with the Hospital's performing a review to identify and refund additional overpayments outside of our audit period. However, we maintain that the Hospital should conduct this review without regard to whether claims resemble claims in a particular stratum. We also agree with the steps the Hospital said it has taken and plans to take to strengthen internal controls and ensure full compliance with Medicare requirements.

As we indicated in Appendix A, during our audit, we used an independent medical review contractor to determine whether 108 claims met coding requirements. The contractor examined all of the medical records documentation submitted for these claims and carefully determined whether the Hospital billed the inpatient claims according to Medicare requirements. The contractor ultimately determined that the Hospital incorrectly billed 57 of these claims.<sup>2</sup> On the basis of the contractor's conclusions, we maintain that the Hospital billed the disputed claims incorrectly. We provided our contractor's conclusions to the Hospital.

The Hospital's assertion that we should not extrapolate because of its calculated low error rates (below 5 percent) for strata two and three is unpersuasive for two reasons. First, there is no mandated minimum error rate to justify extrapolation for OIG audits. The terms that OIG negotiated in the corporate integrity agreements (CIAs), which establish a 5 percent threshold between a "Discovery Sample" and a "Full Sample," as defined in those agreements, are not relevant to the statistical validity of the extrapolation in this audit. OIG's CIAs that include a 5 percent error rate threshold specifically state that the use of the 5 percent guideline in the CIA does not imply that 5 percent is an "acceptable error rate," and note that OIG may, in its discretion, review or analyze errors identified in a provider's Discovery Sample, regardless of the error rate. Secondly, even if there were an applicable 5 percent threshold, the error rates for both strata two and three exceed 5 percent based on the OIG findings, which, as previously stated, we continue to maintain are correct.

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<sup>2</sup> Two of the fifty-nine errors we identified were for claims for which the only error was the incorrect discharge status. We did not send these claims to the medical review contractor.

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

### **SCOPE**

Our audit covered \$17,615,919 in Medicare payments to the Hospital for 2,411 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 200 inpatient claims with payments totaling \$1,685,894. Medicare paid these 200 claims from June 1, 2013, through May 31, 2015 (audit period).

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 108 claims to coding review to determine whether the services were 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 the 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 fieldwork included contacting the Hospital in Jackson, Tennessee, from October 2015 through September 2016.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient 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 200 inpatient claims totaling \$1,685,894 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;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;

- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning DRG and admission status codes for Medicare claims;
- used an independent medical review contractor to determine whether 108 claims met 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); 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

### TARGET POPULATION

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

### SAMPLING FRAME

According to CMS's NCH data, Medicare paid the Hospital \$251,771,355 for 25,819 inpatient claims during the audit period.

We obtained a database of claims from the NCH data totaling \$97,977,002 for 9,267 inpatient claims in 9 risk areas. From these 9 areas, we selected 2 consisting of 3,286 claims totaling \$26,441,464 for further review. We then removed the following:

- claims billed with high-severity-level DRG codes with payment amounts less than \$3,000,
- claims under review by the Recovery Audit Contractor (RAC), and
- claims duplicated within individual risk categories.<sup>3</sup>

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: Inpatient Claims Paid in Excess of Charges and Inpatient Claims Billed With High-Severity-Level DRG Codes. This assignment hierarchy resulted in a sample frame of 2,411 unique Medicare paid claims in 2 risk categories totaling \$17,615,919. We further separated Inpatient Claims Billed With High-Severity-Level DRG Codes into two categories based on the amount paid.<sup>4</sup> (See Table 1.)

**Table 1: Risk Categories**

<b>Medicare Risk Area</b>	<b>Number of Claims</b>	<b>Amount of Payments</b>
1. Inpatient Claims Paid in Excess of Charges	630	\$5,786,477
2. Inpatient Claims Billed With High-Severity-Level DRG Codes – Low Dollar	1,388	7,174,229
3. Inpatient Claims Billed With High-Severity-Level DRG Codes – High Dollar	393	4,655,213
<b>Total</b>	<b>2,411</b>	<b>\$17,615,919</b>

<sup>3</sup> Any claims that were found to be under RAC review within the sample after it was pulled were treated as non-errors. This approach ensured that our estimates accurately accounted for these types of claims.

<sup>4</sup> Paid claims less than \$7,260 are in Stratum 2 and paid claims \$7,260 or greater are in Stratum 3.

## **SAMPLE UNIT**

The sample unit was a Medicare paid claim.

## **SAMPLE DESIGN**

We used a stratified sample. We stratified the sampling frame into three strata on the basis of Medicare risk area and amount paid. All claims were unduplicated, appearing in only one area and only once in the entire sampling frame.

## **SAMPLE SIZE**

We selected 200 claims for review as follows in Table 2:

**Table 2: Claims by Stratum**

<b>Stratum</b>	<b>Medicare Risk Area</b>	<b>Claims in Sample Frame</b>	<b>Claims in Sample</b>
1	Inpatient Claims Paid in Excess of Charges	630	70
2	Inpatient Claims Billed With High-Severity-Level DRG Codes – Low Dollar	1,388	70
3	Inpatient Claims Billed With High-Severity-Level DRG Codes – High Dollar	393	60
	<b>Total</b>	<b>2,411</b>	<b>200</b>

## **SOURCE OF RANDOM NUMBERS**

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

## **METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the claims within each stratum. After generating the random numbers we selected the corresponding claims in each stratum.

## **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.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 3: Sample Results**

<b>Stratum</b>	<b>Frame Size (Claims)</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Total Value of Sample</b>	<b>Number of Incorrectly Billed Claims in Sample</b>	<b>Value of Overpayments in Sample</b>
1	630	\$5,786,477	70	\$607,509	31	\$121,243
2	1,388	7,174,229	70	353,329	14	19,466
3	393	4,655,213	60	725,056	14	48,279
<b>Total</b>	<b>2,411</b>	<b>\$17,615,919</b>	<b>200</b>	<b>\$1,685,894</b>	<b>59</b>	<b>\$188,988</b>

**ESTIMATES**

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

Point Estimate	\$1,793,393
Lower limit	\$1,407,952
Upper limit	\$2,178,835

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

**Table 5: Sample Results by Risk Area**

<b>Inpatient Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Underpayments/Overpayments</b>	<b>Value of Net Overpayments</b>
Inpatient Claims Paid in Excess of Charges	70	\$607,509	31	\$121,243
Inpatient Claims Billed With High-Severity-Level DRG Codes – Low Dollar	70	353,329	14	19,466
Inpatient Claims Billed With High-Severity-Level DRG Codes – High Dollar	60	725,056	14	48,279
<b>Inpatient Totals</b>	<b>200</b>	<b>\$1,685,894</b>	<b>59</b>	<b>\$188,988</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.



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December 8, 2016

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

**RE: Report Number: A-04-15-04042**

Dear Ms. Pilcher:

This correspondence is intended to serve as our formal response to the draft report issued on November 7, 2016, entitled Medicare Compliance Review of Jackson-Madison County General Hospital for Claims Paid From June 1, 2013 Through May 31, 2015. Before addressing the recommendations for which our responses have been requested, please know that we are most appreciative of the professional manner in which this review was conducted, and of the respect and congeniality extended to us by members of your staff. Although we are not in agreement with all of your staff's audit determinations, we are of the opinion that this review went about as smoothly as it possibly could have, due, in large part, to the excellent working relationship that was maintained throughout the review process. And for that, we are extremely grateful.

Each of the three recommendations for which our comments have been requested will be addressed separately below. Please also note that our comments are further segregated among the three distinct strata encompassed by this review, since the results of each strata warrant separate and distinct actions relative to the refund of identified overpayments, any additional retrospective review activities, and the necessary corrective actions (or strengthened controls).

**Recommendation Regarding the Refund of Identified Estimated Overpayments to the Medicare Contractor**

Upon issuance of the OIG's final report relative to the subject compliance review, we will

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|---|------------------------------------|--|---|
| • Ayers Children's Medical Center         | • Kirkland Cancer Center           | • Milan General Hospital               | • West Tennessee Imaging Center               |
| • Bolivar General Hospital                | • Lift Wellness Center             | • Pathways Behavioral Health Services  | • West Tennessee Neurosciences & Spine Center |
| • Camden Family Medical Center            | • Managed Care                     | • Sleep Disorders Center               | • West Tennessee OB/GYN Services              |
| • Camden General Hospital                 | • Medical Center EMS               | • Sports Plus AquaTherapies            | • West Tennessee Outpatient Center            |
| • Cardio Thoracic Surgery Center          | • Medical Center Infusion Services | • Sports Plus Rehab Centers            | • West Tennessee Rehabilitation Center        |
| • East Jackson Family Medical Center      | • Medical Center Laboratory        | • Strategic Development                | • West Tennessee Surgery Center               |
| • Emergency Services                      | • Medical Center Medical Products  | • Therapy & Learning Center            | • West Tennessee Women's Center               |
| • Employer Services                       | • Medical Clinic of Jackson        | • Trenton Medical Center               | • Work Partners                               |
| • Humboldt Medical Center                 | • Medical Specialty Center         | • West Tennessee EP Cardiology Clinic  | • Work Plus Rehab Center                      |
| • Jackson-Madison County General Hospital | • MedSouth Medical Center          | • West Tennessee Healthcare Foundation |   |

immediately commence the requisite actions (i.e. a lump-sum repayment or corrected claim submissions) to ensure that the overpayments identified in conjunction with this review are refunded to our Medicare contractor in a timely manner (i.e. within 60 days, and more likely, within 15-30 days). Please know, however, that we concur with the OIG's audit findings and net overpayment calculations for only 35 of the 59 claims that the OIG determined to have been coded, billed and paid in error, as further explained below for each of the three affected strata.

- **Stratum #1 – Inpatient Claims Paid in Excess of Charges**

With respect to stratum #1, we are in agreement with the OIG's audit findings regarding the six claims which were billed with an incorrect discharge status, as well as the OIG's overpayment determinations for five of these six claims, although it should be noted that four of these claims were also determined to have been coded in error (which we are also in agreement with). However, of the 29 claims which the OIG had concluded were coded incorrectly, and were therefore overpaid, we are in agreement with the OIG's audit findings for only 16 of these claims, and are disputing the audit findings for the other 13 claims. We, and our external consultant, are of the opinion that our initial coding assignments and DRG designations were correct for seven of the 13 disputed claims, and were therefore not overpaid by Medicare. For the other six disputed claims (one of which also involved an incorrect discharge status), we agree with the OIG that our original coding assignments and claim submissions were in error, but disagree with the OIG's recommended coding assignments, DRG designations, and resulting overpayment calculations, as we believe that other principal and/or secondary diagnosis codes are more appropriate.

Although we are contending that the hospital was reimbursed appropriately for seven of the 13 disputed claims, we have computed the applicable DRG rates and resulting net overpayments for the other six aforementioned disputed claims. We have also calculated a revised error rate for stratum #1, which, based upon the Medicare program reimbursement only (i.e. exclusive of any applicable patient deductible balances), now stands at 11.90%. Because the revised error rate still exceeds 5%, and because we are not disputing the statistical validity of the OIG's compliance review or the underlying sampling methodology, we have also computed revised, estimated net overpayment projections for stratum #1, utilizing the variable appraisal application of the OIG's RAT-STATS statistical software. These calculations yield an overpayment point estimate of \$650,694, and a 90% confidence interval lower limit estimate of \$445,889.

With respect to the estimated overpayment refund recommendation, please know that, for stratum #1, it is our intention to issue a lump-sum refund to our Medicare contractor in the amount of \$445,889, along with the requisite correspondence indicating that the refund is being issued in conjunction with the OIG's compliance review.

- **Stratum #2 – Inpatient Claims Billed with High Severity Level DRG Codes – Low Dollar**

With respect to stratum #2, we are in agreement with the OIG's audit findings for nine of the 14 claims which were determined to have been coded incorrectly. However, for the other five claims, we and our consultant are of the opinion that the hospital's initial

coding assignments and DRG designations were correct, and that the payments received from Medicare were appropriate. As such, we believe that the overpayments associated with stratum #2 are limited to the nine claims with which we are in agreement. These nine overpayments, on a combined basis, total \$14,983.75, utilizing the net overpayment amounts calculated by the OIG (which we did verify). You should know that this combined overpayment amount corresponds to an error rate for stratum #2 (based upon the total Medicare program reimbursement, exclusive of any patient deductible balances) of 4.24%. It is worth noting that this error rate is less than the 5% threshold stipulated in the vast majority of Corporate Integrity Agreements executed by the OIG as the determinant of expanded, “full Sample” retrospective reviews. And although an error rate of 4.24% is not necessarily acceptable (since we continually strive for 100% accuracy rates with respect to the hospital’s claim submissions), it is also not, in our opinion, indicative of a pervasive trend or pattern of purposeful or negligent improper coding practices. As such, we do not believe that this error rate warrants a statistically based overpayment extrapolation.

With respect to the estimated overpayment refund recommendation, please know that, for stratum #2, it is our intention to either submit corrected UB-04 claim forms for the nine claims with identified and agreed upon coding errors, or issue a lump-sum check to the Medicare contractor in the amount of \$14,983.75, depending upon the contractor’s preference.

- **Stratum #3 – Inpatient Claims Billed with High Severity Level DRG Codes – High Dollar**

With respect to stratum #3, we are in agreement with the OIG’s audit findings for eight of the 14 claims which were determined to have been coded incorrectly, but are disputing the OIG’s findings for the other six claims. We, and our consultant, are of the opinion that our initial coding assignments and DRG designations were correct for five of the six disputed claims. For the other disputed claim, we agree with the OIG that our original coding assignments were in error, but disagree with the OIG’s recommended coding assignment, DRG designation, and resulting overpayment determination, as we believe that different principal and secondary diagnosis codes are more appropriate.

Therefore, we believe that only nine of the 60 claims included in this stratum were coded in error and overpaid by Medicare, and for eight of which, we agree with the overpayment amounts computed by the OIG. For the ninth claim, we computed the applicable DRG rate and resulting net overpayment based upon our revised coding assignments. The total overpayment for stratum #3 amounts to \$26,501.06, which corresponds to an error rate of 3.66% (based upon the Medicare program reimbursement, exclusive of any patient deductible balances). For the reasons cited above for stratum #2, we believe that an error rate of 3.66% is not indicative of a pervasive trend of non-compliant coding practices, and does not warrant a statistically based overpayment projection.

With respect to the estimated overpayment refund recommendation, please know that, for stratum #3, it is our intention to either submit corrected UB-04 claim forms for the six

claims with identified and agreed upon coding errors, or issue a lump-sum refund to the Medicare contractor in the amount of \$26,501.60.

- **Recommendation Regarding the Exercise of Reasonable Diligence to Identify and Return Any Additional Overpayments Received Outside of the Audit Period**

Our responses to this recommendation for each of the three distinct strata are as follows:

- **Stratum #1**

In light of the above referenced 11.90% error rate for this stratum, we recognize our obligation to identify other inpatient claims for which the Medicare payments exceeded the charges during the previous six year look-back period, and to conduct an extensive and thorough review of all such claims for purposes of assessing the accuracy of the hospital's coding assignments and DRG designations. In conjunction with this retrospective review, we will identify any overpayments received from Medicare as a result of detected coding errors, and will refund all such overpayments to the Medicare contractor within 60 days of our having confirmed and quantified the extent of all such overpayments. We will also inform the Medicare contractor that any such refund is being made in accordance with the recommendation made by the OIG in conjunction with this compliance review.

For purposes of clarification, you should know that we are intending to limit our review to the six-year period beginning on November 1, 2010 and ending on October 31, 2016, which is approximately the date on which the hospital implemented certain corrective actions (as described elsewhere in this report). However, because the OIG's compliance review covered the 24-month period of June 1, 2013 through May 31, 2015, it is our expectation that the scope of our review should encompass the 31-month period prior to the OIG's review (i.e. from November 1, 2010 – May 31, 2013), plus the 17-month period subsequent to the OIG's review (i.e. June 1, 2015 – October 31, 2016), for a total of 48 months.

You should know that we have already initiated a process to identify the claims to be included within this review, but do not intend to commence the coding review until the OIG finalizes its report. Please also know that the volume of claims to be encompassed by this review will likely be large enough to warrant the deployment of a statistically based review methodology, for which we possess and/or will obtain the skills required to ensure the statistical validity of our random sample selection and the resulting overpayment projection (if any).

- **Stratum #2**

We do not believe that the OIG's findings for this stratum, expressed in terms of the above referenced 4.24% payment based error rate, warrant an expanded, retrospective review. As such, we do not intend to review any additional "low dollar claims with high severity level DRG codes" that had previously been billed to and paid by the Medicare program. We do, however, intend to make a

concerted effort to maintain, and hopefully improve upon, the accuracy of our coding assignments for all such claims in the future.

- **Stratum #3**  
Similar to the above response, we are of the opinion that the 3.66% error rate which was derived for stratum #3 does not present an obligation, on our part, to conduct any additional retrospective review of “high dollar claims with high severity level DRG codes” that had previously been billed to and paid by Medicare. We will, however, strive to maintain and improve upon the coding accuracy for these, and all inpatient claims submitted to the Medicare program in the future.

- **Recommendation Regarding the Strengthening of Controls to Ensure Full Compliance with Medicare Requirements**

Our responses to this recommendation for each of the three distinct strata are as follows:

- **Stratum #1**  
As you would expect, all of the 70 claims included in this stratum were reviewed by members of our coding staff in anticipation of the OIG’s audit determinations. In addition, all of the 29 claims that had been identified by the OIG as having been coded in error were re-reviewed by our coding staff, and were discussed, at length, with our external consultant. These follow-up reviews and discussions served as excellent learning opportunities for the hospital’s coders, as did their thoughtful consideration of the OIG’s audit findings and the OIG staff’s supporting rationale for their alternative coding recommendations. It is my understanding that these types of follow-up reviews and intense discussions often provide coders with more helpful insight and instruction than textbooks and/or seminars. Thus, I would expect that the OIG’s compliance review, in and of itself, will yield considerable benefit to our coders, which should therefore serve to enhance their coding proficiency, and the hospital’s coding accuracy.

However, we also recognize that an error rate of nearly 12% (even if it is applicable to only those cases with low charges and high reimbursement) is not acceptable and most assuredly warrants definitive corrective actions beyond additional training and education of our coding staff. We will, therefore, implement a mandatory, pre-billing, secondary review of all applicable Medicare inpatient claims (excluding patients who expire, are transferred to another hospital, or leave AMA) for which the estimated Medicare reimbursement (based upon our initial coding assignments and preliminary DRG-based payment estimations) exceeds the total charges. Having implemented other, similar pre-billing confirmatory reviews in the past (involving claims with other coding or billing challenges), we are confident that the above described review process will effectively mitigate the future re-occurrence of any Medicare overpayments similar to those identified in stratum #1.

We will also strive to be more diligent in determining the ultimate discharge disposition of the hospital’s Medicare patients and more accurate in the assignment of each patient’s discharge status code. However, as I’m sure you can appreciate, it is not always possible to know when a patient who returns home

subsequently elects to receive home health services, or when a patient who returns to a long-term care facility subsequently receives skilled care. Thus, we must sometimes rely on the Medicare contractor to recognize these occurrences (via claim submissions from other providers), and reimburse or adjust the hospital's claims accordingly. Fortunately, I am told that our Medicare contractor, as well as Medicare contractors throughout the country, are increasingly able to identify these types of occurrences, and thereby ensure that the affected providers are reimbursed appropriately.

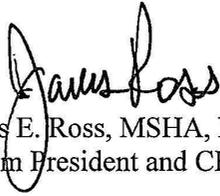
- **Stratum #2**  
All 70 claims included in this stratum were also reviewed by members of our coding staff upon having learned of the OIG's sample selection. Additionally, the 14 claims with identified coding errors were re-reviewed by our coders, and were discussed with our external consultant, as were the written justifications provided by the OIG's staff. These interactions will undoubtedly help the hospital's coding staff to maintain, and perhaps improve upon their demonstrated nearly 96% coding accuracy rate for Medicare inpatient claims with high severity level DRGs. Please also know, however, that these types of cases will purposefully be included in the hospital's future compliance monitoring reviews in order to ensure that the aforementioned accuracy rate is maintained.
- **Stratum #3**  
Rather than further extend the length of this already lengthy correspondence, please know that the response provided above for stratum #2 also pertains to stratum #3, particularly since the accuracy rate for this strata, which also involved high severity level DRGs, exceeds 96%.

Since it is my understanding that this correspondence will be included in the OIG's forthcoming, publically available, final report regarding the Medicare Compliance Review of our hospital, I have purposefully not enclosed any additional documentation evidencing the determinations and calculations referenced above. Please know, however, that we will gladly provide you and/or your staff with the case summaries that we have prepared in support of our coding determinations for the 24 disputed claims, as well as the resulting net overpayment calculations for all three strata, and the revised RAT-STATS projections for stratum #1.

Please also know that the above referenced overpayment refunds are intended to fulfill the hospital's repayments obligation for those claims, which all involved parties have agreed and acknowledged were coded in error, and were therefore overpaid by Medicare. While we, and our external consultant, are of the opinion that the underlying claim specific coding assignments, DRG designations, and payment calculations are accurate and appropriate, we understand that further verification of our findings and determinations may be required. As such, please know that we will most assuredly undertake whatever actions the OIG or CMS deems to be appropriate for purposes of bringing final resolution to the 24 disputed cases and to this review. In the event that any of our coding determinations or our calculations are found to be inappropriate or inaccurate, we will promptly refund any ensuing overpayment amounts including, as applicable, any increase in the statistically derived overpayment projection for stratum #1.

Ms. Pilcher, as I had indicated at the outset of this correspondence, my colleagues and I are most grateful for the kindness and courtesies extended to us throughout this audit process. I would ask that you please extend our gratitude to the appropriate members of your staff. Please also know that we appreciate the opportunity to provide this formal response to the OIG's review findings and recommendations. If you have any questions regarding this response, or if any follow-up discussions are desired by you or members of your staff, please feel free to contact either me, directly, or our Compliance Officer, Amy Garner.

Sincerely,



James E. Ross, MSHA, BSN, AEMT  
Interim President and CEO