

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
MAYO CLINIC FLORIDA FOR 2013 AND
2014**

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Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Mayo Clinic Florida did not fully comply with Medicare requirements for billing inpatient services, resulting in overpayments of at least \$103,000 over nearly 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 2014, Medicare paid hospitals \$159 billion, which represents 46 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.

The objective of this review was to determine whether Mayo Clinic Florida (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 304-bed, not-for-profit, acute care facility located in Jacksonville, Florida. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$87 million for 6,279 inpatient and 35,065 outpatient claims paid from January 2013 through September 2014 (audit period).

Our audit covered \$11,796,449 in Medicare payments to the Hospital for 1,145 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 199 paid claims with payments totaling \$2,885,429. These claims consisted of 170 inpatient and 29 outpatient claims with claims paid during the audit period.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 185 of the 199 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 14 claims, resulting in overpayments of \$71,396 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 \$103,091 for the audit period.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare program \$103,091 in estimated overpayments on claims incorrectly billed for our audit period;
- exercise reasonable diligence to identify and return any additional similar overpayments 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.

MAYO CLINIC FLORIDA COMMENTS AND OUR RESPONSE

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 1 of the 14 inpatient claims that we identified as not fully complying with Medicare billing requirements. However, it acknowledged that it improperly billed the remaining 13 inpatient claims. The Hospital stated that coding subjectivity and human error contributed to several of the coding discrepancies but also stated that there was “no pattern of error that indicates any systemic errors or a sustained or high error rate.” In addition, the Hospital objected to the use of statistical sampling and extrapolation to calculate the overpayment.

The Hospital also stated that it voluntarily refunded overpayments for claims with billing errors that it identified during its internal review to the Medicare Administrative Contractor (MAC). The Hospital’s internal review came about as a result of claims that it identified with billing errors and disclosed to us while we were onsite, per our request. Because it had refunded the overpayments, the Hospital believes further extrapolation was not appropriate.

Furthermore, the Hospital disagreed that it did not have adequate controls to prevent the incorrect billing of Medicare claims and stated that it had a strong compliance program and culture.

In response to the Hospital’s disagreement that it improperly billed one inpatient claim, we obtained an independent medical review for medical necessity and coding errors, and our report reflects the results of that review.

Regarding our extrapolation methodology and statistical validity, Federal courts have consistently upheld statistical sampling and extrapolation as a valid method to determine overpayment amounts in Medicare. Additionally, we reduced the estimated overpayments by the portion of the amount that the Hospital had refunded to the MAC on the basis of its internal review, which pertained to the claims in our sample frame. At our request, the Hospital

conducted its own review of the sampled claims to determine whether the services were billed correctly.

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

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2014, Medicare paid hospitals \$159 billion, which represents 46 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 Mayo Clinic Florida (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

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

Hospital Outpatient Prospective Payment System

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

¹ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Hospital Claims at Risk for Incorrect Billing

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

- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims paid in excess of charges,
- inpatient hospital-acquired conditions and “present on admission”² indicator reporting,
- outpatient claims with payments greater than \$25,000, and
- outpatient billing for dental services.

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

Medicare Requirements for Hospital Claims and Payments

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

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), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

² “Present on admission” refers to diagnoses that are present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are also considered present on admission. Acute care hospitals are required to complete the present on admission indicator field on the Medicare inpatient claim for every diagnosis billed.

Mayo Clinic Florida

The Hospital is a 304-bed, not-for-profit, acute care facility located in Jacksonville, Florida. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately \$87 million for 6,279 inpatient and 35,065 outpatient claims from January 2013 through September 2014 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$11,796,449 in Medicare payments to the Hospital for 1,145 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 199 paid claims with payments totaling \$2,885,429. These 199 claims had payment dates in our audit period and consisted of 170 inpatient and 29 outpatient claims.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 24 claims to medical and coding reviews to determine whether the services were correctly 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 185 of the 199 inpatient and outpatient claims that we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 14 claims, resulting in overpayments of \$71,396 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.

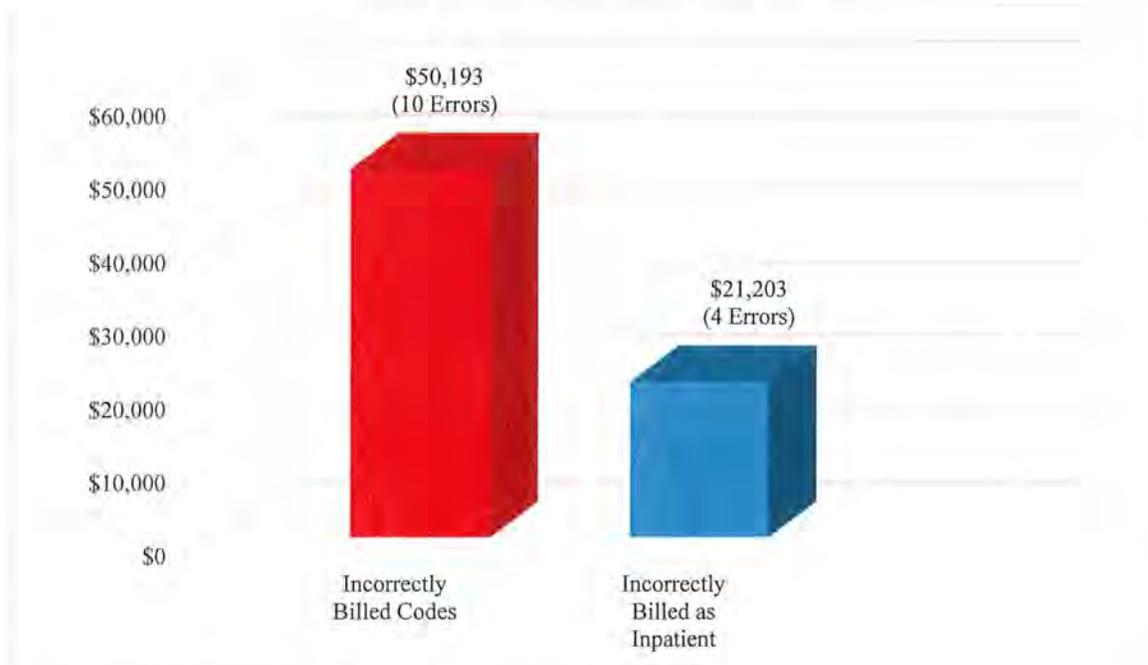
On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$103,091 for the audit period.

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

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 14 of 170 inpatient claims that we reviewed. These errors resulted in overpayments of \$71,396 as shown in the figure.

Figure: Inpatient Billing Errors



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)). The Manual requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (chapter 1, § 80.3.2.2).

For 10 of the 170 inpatient claims, the Hospital billed Medicare for incorrect DRG codes. For example, the Hospital submitted a claim with the secondary diagnosis code 202.80 (Other Malignant Lymphomas). The medical record indicated that the patient’s Non-Hodgkin’s Lymphoma was a previous condition contained in the patient’s medical history, not a current problem. Therefore, the hospital should have assigned code V10.79 (personal history of other lymphatic and hematopoietic neoplasms) rather than code 202.80. The Hospital stated that these errors occurred because the coders did not consistently follow policies and procedures, which are based on industry coding guidance. As a result of these errors, the Hospital received overpayments of \$50,193.

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 4 of the 170 inpatient claims, the Hospital incorrectly billed Medicare for beneficiaries who were scheduled for surgery that was never performed. The Hospital stated that these errors occurred because the surgical changes may not have been communicated to the case manager by the operating room staff when the case manager was out of the office. As a result of these errors, the Hospital received overpayments of \$21,203.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$103,091 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$103,091 in estimated overpayments on claims incorrectly billed for our audit period;
- exercise reasonable diligence to identify and return any additional similar overpayments 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.

MAYO CLINIC FLORIDA COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Mayo Clinic Florida Comments

In written comments on our draft report, the Hospital did not agree with some of our findings. Furthermore, it did not concur with our first and third recommendations, and remained silent on whether it concurred with our second recommendation.

It disagreed that it improperly billed 1 of the 14 inpatient claims that we identified as not fully complying with Medicare billing requirements. However, it acknowledged that it improperly billed the remaining 13 inpatient claims. For these 13 inpatient claims, the Hospital stated that it billed some with an incorrect diagnosis-related-group (DRG) code and others as inpatient, instead of outpatient. For those claims billed with an incorrect DRG code, the Hospital stated that coding subjectivity and human error contributed to several of the coding discrepancies but

also stated that there was “no pattern of error that indicates any systemic errors or a sustained or high error rate.”

In addition, the Hospital objected to the use of statistical sampling and extrapolation to calculate the overpayment. It further mentioned that our report incorrectly stated its use of a stratified random sample for 199 claims that represented 6 strata. According to the Hospital, 2 strata with frame sizes of 27 and 2 were judgmental samples, not random samples. It also questioned the fairness and integrity of the process because we changed extrapolation methodology from extrapolation on strata with six or more errors to extrapolation to all strata regardless of the numbers of errors.

The Hospital also stated that it voluntarily refunded overpayments, for claims with billing errors that it identified during its internal review, to the Medicare Administrative Contractor (MAC). The Hospital’s review came about as a result of the claims that it identified with billing errors and disclosed to us while we were onsite, per our request. Because it had refunded the overpayments, the Hospital believes further extrapolation was not appropriate.

Furthermore, the Hospital disagreed that it did not have adequate controls to prevent the incorrect billing of Medicare claims and stated that it had a strong compliance program and culture.

We included the Hospital’s comments in their entirety as Appendix E.

Office of Inspector General Response

In response to the Hospital’s disagreement that it improperly billed one inpatient claim, we obtained an independent medical review for medical necessity and coding errors, and our report reflects the results of that review.

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 and Medicaid. *See Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *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); *Maxmed Healthcare, Inc. v. Burwell*, 2016 U.S. Dist. LEXIS 6816 at *31-33, 37-39 (W.D. Tex. 2016); *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.

As a factual matter, OAS policy has been consistent from the start of the audit period in allowing for statistical estimates in cases in which fewer than 6 errors are observed per stratum. Even if the policy had changed during the audit period, the change would not have affected the validity of the lower limit as applied here.

The Hospital asserted that claims in two of the strata were judgmentally rather than randomly selected. This comment confuses the stratification of the frame with the selection of the sample. As in this case, a valid statistical sample may include strata that are constructed using auditor judgment. The sample is still statistically valid as long as samples are selected from each stratum using a random sample or 100 percent review. In this present audit, we met this requirement by pulling random samples from 3 of the strata and reviewing 100 percent of the items in the remaining 3 strata.

Regarding the Hospital's concerns that, because it had voluntarily refunded overpayments to the MAC, further extrapolation would not be appropriate, we initially told the Hospital that we would not report on some of the errors that it had identified because the errors fell into a risk area that we were no longer reviewing as part of this hospital compliance series of reviews. However, upon further review, we contacted the Hospital and informed them that we would report these claims as findings because we determined that the Hospital did not provide the services billed on the claims. However, by that time, the Hospital had voluntarily refunded overpayments to the MAC. To give the Hospital credit for what it refunded to the MAC, we reduced the estimated overpayments by the portion that pertained to the claims in our sample frame. Of the amount refunded to the MAC, we calculated that \$5,658 pertained to 248 claims in our sample frame. Therefore, we subtracted \$5,658 from the lower limit of the estimated value of the overpayments we identified for the audit period. The resulting overpayment was \$103,091.

In response to the Hospital's exception to our statement that the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims, we reassert that our statement is correct based on our findings.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$11,796,449 in Medicare payments to the Hospital for 1,145 claims during January 2013 through September 2014 (audit period) that were potentially at risk for billing errors. We selected for review a stratified random sample of 199 claims with payments totaling \$2,885,429. These claims consisted of 170 inpatient and 29 outpatient claims that had claims paid dates during the 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 24 claims to medical and coding reviews to determine whether the services were correctly coded.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from CMS's 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 September 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's NCH file for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 199 claims totaling \$2,885,429 for detailed review (Appendix B);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- reviewed the Hospital's procedures for inpatient and outpatient coding, conditions of admission, medical service revenue cycle, and medical record requirements;
- used an independent contractor to determine whether 24 sampled 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 to estimate the Medicare overpayments to the Hospital (Appendix C); and
- discussed the results of our review with Hospital officials.

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

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was inpatient and outpatient claims paid to the Hospital from January 2013, through September 2014 (audit period), for services provided to Medicare beneficiaries.

SAMPLING FRAME

Inpatient Claims

According to CMS's NCH data, Medicare paid the Hospital approximately \$77 million for 6,279 inpatient claims in 13 risk areas during the audit period.

From these 13 risk areas, we selected 3 consisting of 2,647 claims totaling \$30,061,077 for further refinement. We performed data filtering and analysis of the claims within each of the three risk areas. The specific filtering and analysis steps performed varied depending on the risk area, but included such procedures as removing:

- \$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:
 - inpatient claims paid in excess of charges,
 - inpatient hospital-acquired conditions and present on admission indicator reporting, and
 - inpatient claims billed with high-severity-level DRG codes; and
- claims under review by the Recovery Audit Contractor (RAC) as of June 12, 2015.

This data filtering resulted in a sampling frame of 1,116 unique Medicare claims totaling \$11,019,447.

Outpatient Claims

According to CMS's NCH data, Medicare paid the Hospital approximately \$10 million for 35,065 outpatient claims in 11 risk areas during the audit period.

From these 11 risk areas, we selected for further refinement claims from 2 risk areas consisting of 68 claims totaling \$1,901,711. The risk areas were outpatient claims with payments greater than \$25,000 and outpatient billing for dental services.

We performed data filtering and analysis of the claims within each of the two risk areas. The specific filtering and analysis steps performed varied depending on the risk area, but included

such procedures as removing claims that were \$0 paid and under RAC review as of June 12, 2015.

This data filtering resulted in a sampling frame of 29 unique Medicare claims totaling \$777,002.

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into five strata on the basis of risk area and split one risk area on the basis of dollar value. The split risk area was Inpatient Claims Billed with High-Severity-Level DRG Codes (low and high).

SAMPLE SIZE

We selected 199 claims for review as shown in Table 1.

Table 1: Strata, Risk Areas, Frame Sizes and Values, and Sample Details

Stratum	Risk Area	Frame Size	Value of Frame	Sample Size
1	Inpatient Claims Billed With High-Severity-Level DRG Codes (low dollars)	728	\$4,948,976	55
2	Inpatient Claims Billed With High-Severity-Level DRG Codes (high dollars)	296	4,792,860	55
3	Inpatient Hospital-Acquired Conditions and Present on Admission Indicator Reporting	62	853,737	30
4	Inpatient Claims Paid in Excess of Charges	30	423,874	30
5	Outpatient Claims With Payments Greater than \$25,000	27	770,954	27
6	Outpatient Billing for Dental Services	2	6,048	2
	Total	1,145	\$11,796,449	199

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata 1 through 3. After generating the random numbers for these strata, we selected the corresponding claims in each stratum. We selected all claims in strata 4 through 6.

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.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	728	\$4,948,976	55	\$371,231	4	\$8,073
2	296	4,792,860	55	861,525	2	6,879
3	62	853,737	30	451,796	1	1,378
4	30	423,874	30	423,874	7	55,066
5	27	770,954	27	770,954	0	0
6	2	6,048	2	6,048	0	0
Total	1,145	\$11,796,449	199	\$2,885,429	14	\$71,396

ESTIMATES

Table 3: Estimated Value of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	\$201,790
Lower Limit	\$108,749 ³
Upper Limit	\$294,832

³ The Hospital voluntarily self-reported potential overpayments that pertained to claims both inside and outside of our sample frame. The Hospital repaid the Medicare administrative contractor (MAC) for these self-reported overpayments. Of the amount repaid to the MAC, we calculated that \$5,658 pertained to 248 claims in our sample frame. Therefore, we subtracted \$5,658 from the lower limit of the estimated value of the overpayments we identified for the audit period. The resulting overpayment was \$103,091.

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Table 4: Sample Results by Risk Area

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Claims Billed With High-Severity-Level DRG Codes (low)	55	\$371,231	4	\$8,073
Claims Billed With High-Severity-Level DRG Codes (high)	55	861,525	2	6,879
Hospital-Acquired Conditions and Present on Admission Indicator Reporting	30	451,796	1	1,378
Claims Paid in Excess of Charges	30	423,875	7	55,066
Inpatient Totals	170	\$2,108,427	14	\$71,396
Outpatient				
Claims with Payments Greater than \$25,000	27	\$770,954	0	0
Billing for Dental Services	2	6,048	0	0
Outpatient Totals	29	\$777,002	0	\$0
Totals	199	\$2,885,429	14	\$71,396

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: MAYO CLINIC FLORIDA COMMENTS



December 6, 2016

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

Re: Draft Report on *Medicare Compliance Review of Mayo Clinic Florida for 2013 and 2014* (A-04-15-07058, November 2016).

Dear Ms. Pilcher:

Mayo Clinic appreciates the opportunity to respond to the U.S. Department of Health and Human Services Office of Inspector General (OIG) draft report titled "*Medicare Compliance Review of Mayo Clinic Florida for 2013 and 2014*" dated November 2016.

Mayo Clinic's leadership and staff are steadfast in their commitment to comply with applicable laws, regulations, billing requirements, and coding guidelines. Mayo Clinic has a longstanding and robust compliance program in support of all compliance program activities, including accurate billing and coding, with a proactive process to keep up-to-date on the complex regulations and policies. Mayo Clinic takes compliance very seriously and strives for continued process and performance improvements. These processes contributed to our very low error rate.

Mayo Clinic is a nonprofit worldwide leader in medical care, research and education. Mayo Clinic in Florida is a destination medical center that draws patients from near and far who seek highly specialized services for complex problems. Teams of physicians and caregivers from more than 40 specialties provide quality, integrated medical and surgical care to patients with complex conditions or difficult medical problems. Mayo Clinic in Florida's research and education programs support and strengthen the outpatient and hospital care it provides. Mayo Clinic's patient-centered, comprehensive, integrated care has consistently earned high marks in a variety of patient satisfaction and hospital ranking surveys including being named the #1 hospital in Florida in *U.S. News & World Report's* 2016 annual survey of top hospitals in America.

As the OIG draft report concluded, Mayo Clinic Florida (referred to in the report as "the Hospital") complied with Medicare billing requirements in almost all claims reviewed (185 of the 199 inpatient and outpatient claims). The OIG draft report alleged that Mayo Clinic did not fully comply with Medicare billing requirements in only 14 claims, which the report alleged resulted in overpayments of \$71,396 for the audit period.

Incorrectly Billed Diagnosis-Related Group Codes

Mayo Clinic concurs with nine of the diagnosis-related group coding errors alleged. Coding subjectivity and human error contributed to several of the coding discrepancies identified. It is well known that coding professionals often disagree on the interpretation and application of the *ICD-9-CM Official Guidelines*. Coding subjectivity is further evidenced by the difference in coding errors identified by the OIG and those identified by the independent contractor engaged by the OIG.

Of the ten principal or secondary coding errors alleged in the OIG report, there is no pattern of error that indicates any systemic errors or a sustained or high error rate. Despite the lack of any pattern in the alleged coding errors, Mayo Clinic implemented a plan of correction:

1. Provided individual coding feedback to each coder involved in the cases.
2. Provided education to inpatient coders on official coding guidelines.
3. Reviewed and revised the inpatient coding policy and procedure.
4. Increased the frequency of coding quality reviews.
5. Provided education to inpatient coders on coding for sepsis.
6. Implemented a pre-billing control to monitor cases coded with acute blood loss anemia.
7. Provided physician education on the acute blood loss anemia criteria.

Incorrectly Billed as Inpatient

Mayo Clinic concurs with the OIG findings in this category. During Mayo Clinic's self-audit in preparation for the OIG review, Mayo Clinic identified the canceled surgery billing errors and disclosed the errors to the OIG during their onsite review. The OIG stated this type of error was outside of the scope of the OIG review and these claims would not be identified as errors for purposes of the OIG review. Therefore, Mayo Clinic proceeded with a voluntary refund to the Medicare Administrative Contractor on December 18, 2015. It was not until April, 2016, that the OIG notified Mayo these errors would be included in the error rate. As Mayo Clinic had already voluntarily refunded the overpayments for the look back period, further extrapolation is not appropriate. Mayo Clinic's plan of correction was previously implemented and included adding case managers for coverage of the post-anesthesia care unit and a revised process to incorporate a pre-billing review of inpatient short stays, which includes patients with canceled surgeries.

Extrapolation

Mayo Clinic respectfully requests the OIG not use extrapolation for this audit and reserves the right to dispute the extrapolation and methodology. The OIG report incorrectly states OIG used a stratified random sample of 199 claims. Rather, for Mayo Clinic's audit, two strata, the strata identified as strata 5 and 6 (with frame sizes of 27 and 2 respectively) were judgmental samples, not random samples. In addition, during Mayo Clinic's audit the OIG Region IV Office of Audit Services changed the extrapolation methodology from extrapolation on strata with six or more errors to extrapolation on all strata regardless of the number of errors. This extrapolation methodology change impacts all organizations, but particularly organizations with very low error rates like Mayo Clinic. With the exception of stratum 4, the OIG report did not identify any stratum with six or more errors, and only seven errors were alleged in that stratum. In this case, the extrapolation methodology was changed during an ongoing audit and this creates significant concerns about the integrity and fairness of the process.

Mayo Clinic takes exception to the statement in the OIG's draft report "Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims." Many factors contributed to the alleged errors including complex, confusing, and inconsistent regulations, and human judgment. On multiple occasions, the OIG auditors complimented Mayo Clinic on the quality of the coding. We are pleased to

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hear the positive comments from the OIG auditors regarding Mayo Clinic's excellent coding. As evidenced by the very low error rate, Mayo Clinic has a well-established and strong compliance program and culture. For these reasons, we disagree Mayo Clinic did not have adequate controls in place.

Mayo Clinic strives to submit accurate claims. When an error is discovered, Mayo Clinic refunds the overpayment based on established policies and procedures. Mayo Clinic continuously assesses and reviews billing and coding processes and implements process improvements including, but not limited to, adding controls, education, and auditing and monitoring.

Mayo Clinic would like to acknowledge the OIG auditors professional and responsive manner throughout the onsite audit. The OIG senior auditor has been excellent about keeping us informed of the current status and next steps. Mayo Clinic is available to respond to any additional inquiries. You may contact Brenda Mickow, Revenue Compliance Officer, or me if you have any questions.

Sincerely,

Kim Otte

Kimberly K. Otte
Chief Compliance Officer
Mayo Clinic

cc: Brenda Mickow, Revenue Compliance Officer