

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HOSPITAL PROVIDER
COMPLIANCE AUDIT: TEXAS HEALTH
PRESBYTERIAN HOSPITAL DALLAS**

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Office of Inspector General

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Report in Brief

Date: December 2019

Report No. A-04-18-08068



Why OIG Did This Audit

This audit is part of a series of hospital compliance audits. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2017, Medicare paid hospitals \$206 billion, which represents 55 percent of all fee-for-service payments for the year.

Our objective was to determine whether Texas Health Presbyterian Dallas (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

How OIG Did This Audit

We selected for review a stratified random sample of 85 inpatient and 15 outpatient claims with payments totaling \$1.5 million for our 2-year audit period (January 1, 2016, through December 31, 2017).

We focused our audit on the risk areas that we identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements.

Medicare Hospital Provider Compliance Audit: Texas Health Presbyterian Hospital Dallas

What OIG Found

The Hospital complied with Medicare billing requirements for 59 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 41 claims, resulting in net overpayments of \$500,323 for the audit period. The 40 inpatient claims had billing errors, resulting in net overpayments of \$500,232 and 1 outpatient claim had a billing error, resulting in an overpayment of \$91. Specifically, the Hospital incorrectly billed:

- 27 inpatient rehabilitation claims that either did not meet coverage or documentation requirements,
- 8 inpatient Medicare Part A claims that should have been billed as outpatient or outpatient with observation, and
- 1 outpatient and 5 inpatient claims that were incorrectly coded.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$10.7 million for the audit period. During the course of our audit, the Hospital submitted 13 of these claims for reprocessing, and we verified those claims as correctly reprocessed. Accordingly, we have reduced the recommended refund by \$114,415.

What OIG Recommends and Hospital Comments

We recommend that the Hospital refund to the Medicare contractor \$10.6 million (\$10.7 million less \$114,415 that the Hospital has already repaid) 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 strengthen controls to ensure full compliance with Medicare requirements.

The Hospital disagreed with the majority of the inpatient rehabilitation claims that we identified as incorrectly billed and with some of the beneficiary stays that should have been billed as outpatient. In addition, the Hospital disagreed with our use of extrapolation and our recommendation that it refund the extrapolated overpayment.

We obtained independent medical review for all inpatient claims in our sample. We provided the independent medical reviewers with all documentation necessary to sufficiently determine medical necessity for all inpatient claims, and our report reflects the results of that review. Our statistical methods have been fully explained and repeatedly validated. Therefore, we maintain that all of our findings and recommendations are correct.

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INTRODUCTION

WHY WE DID THIS AUDIT

This audit is part of a series of hospital compliance audits. 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 2017, Medicare paid hospitals \$206 billion, which represents 55 percent of all fee-for-service payments; accordingly, it is important to ensure that hospital payments comply with requirements.

OBJECTIVE

Our objective was to determine whether Texas Health Presbyterian Hospital Dallas (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims from January 1, 2016, through December 31, 2017.

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 uses Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

Under the inpatient prospective payment system, 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. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Inpatient Rehabilitation Facility Prospective Payment System

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for rehabilitation facilities. CMS implemented the payment system for cost-reporting periods beginning on or

after January 1, 2002. Under the payment system, CMS established a Federal prospective payment rate for each of the distinct case-mix groups (CMGs). The assignment to a CMG is based on the beneficiary's clinical characteristics and expected resource needs.

Hospital Outpatient Prospective Payment System

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

Hospital Claims at Risk for Incorrect Billing

Previous Office of Inspector General (OIG) audits at other hospitals identified types of claims at risk for noncompliance. Out of the areas identified as being at risk, we focused our audit on the following:

- inpatient mechanical ventilation,
- inpatient claims paid in excess of charges,
- inpatient elective procedures,
- inpatient high-severity level DRG codes,
- inpatient comprehensive error rate testing (CERT) DRG codes,
- inpatient rehabilitation facility (IRF) claims,
- outpatient bypass modifiers,
- outpatient skilled nursing facility (SNF) consolidated billing,
- outpatient operating room units greater than 1,
- outpatient claims paid in excess of \$25,000, and
- outpatient claims paid in excess of charges.

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

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 audit.²

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

OIG believes that this audit report constitutes credible information of potential overpayments. Providers who receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).³

Texas Health Presbyterian Hospital Dallas

The Hospital is a 634-bed short-term acute care nonprofit hospital, located in Dallas, TX. According to CMS’s National Claims History (NCH) data, Medicare paid the Hospital approximately \$249 million for 13,574 inpatient and 52,075 outpatient claims between January 1, 2016, and December 31, 2017 (audit period).

² For purposes of selecting claims for medical review, CMS instructs its Medicare contractors to follow the “two-midnight presumption” in order not to focus their medical review efforts on stays spanning two or more midnights after formal inpatient admission in the absence of evidence of systemic gaming, abuse, or delays in the provision of care (*Medicare Program Integrity Manual*, ch. 6, § 6.5.2). We are not constrained by the two-midnight presumption in selecting claims for medical review.

³ The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$33,554,149 in Medicare payments to the Hospital for 2,768 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (85 inpatient and 15 outpatient) with payments totaling \$1,468,151. Medicare paid these 100 claims during our audit period.

We focused our audit on the risk areas identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted all claims to an independent medical review contractor to determine whether the claim was supported by the medical record. 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

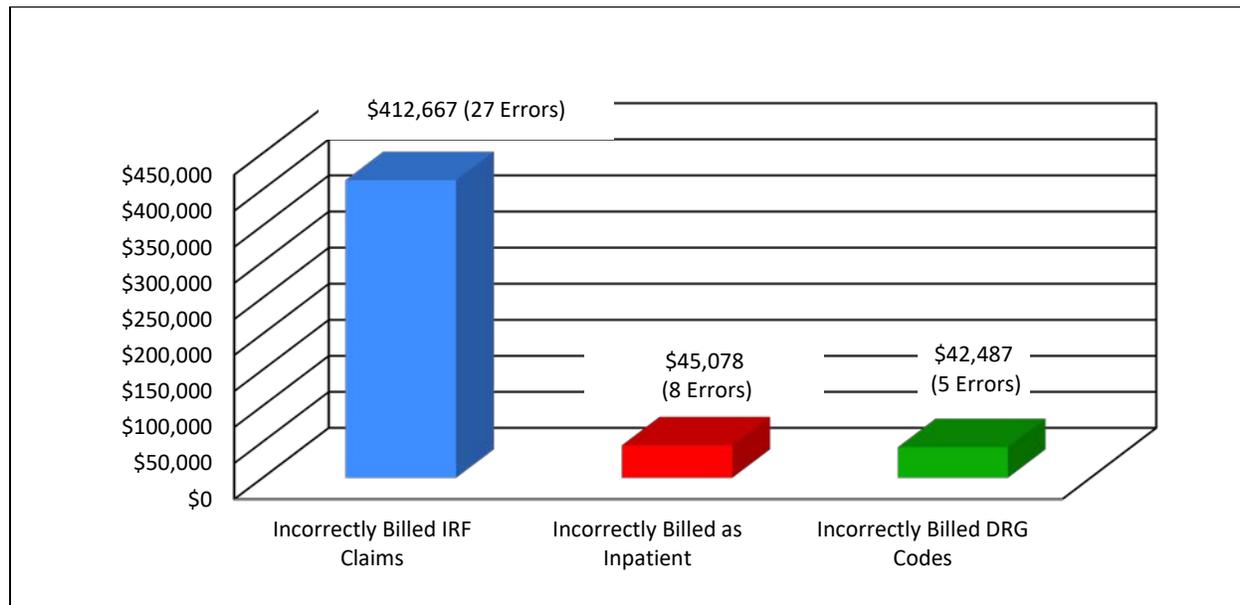
The Hospital complied with Medicare billing requirements for 59 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 41 claims, resulting in net overpayments of \$500,323 for the audit period. Specifically, 40 inpatient claims had billing errors, resulting in net overpayments of \$500,232 and 1 outpatient claim had a billing error, resulting in an overpayment of \$91. 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 \$10,711,548 for the audit period. See Appendix B for statistical sampling methodology, Appendix C for sample results and estimates, and Appendix D for results of audit by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 40 of the 85 inpatient claims that we reviewed. These errors resulted in net overpayments of \$500,232 as shown in the Figure on the next page.

Figure: Inpatient Billing Errors



Incorrectly Billed Inpatient Rehabilitation Facility Claims

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, § 1862(a)(1)(A)).

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

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

For an IRF claim to be considered reasonable and necessary, Federal regulations require that there be a reasonable expectation that, at the time of admission, the patient (1) requires the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) is sufficiently stable at the time of admission to

the IRF to be able to actively participate in the intensive rehabilitation program; and (4) requires physician supervision by a rehabilitation physician (42 CFR § 412.622 (a)(3)(i-iv)).

Federal regulations require that the patient's medical record must contain certain documentation to ensure that the IRF coverage requirements are met. The record must include (1) a comprehensive preadmission screening, (2) a post-admission physician evaluation, and (3) an individualized overall plan of care (42 CFR § 412.622 (a)(4)(i-iii)).

For 27 of the 85 selected inpatient claims, the Hospital incorrectly billed IRF services. Specifically, for 26 of the 27 claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation. IRF services for these beneficiaries were not considered reasonable and necessary because these beneficiaries did not require the active and ongoing therapeutic intervention of multiple therapy disciplines; generally did not require and could not reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; were not sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; or did not require supervision by a rehabilitation physician. In addition, for 1 of the 27 claims, the Hospital incorrectly billed an IRF claim that did not meet Medicare documentation requirements. For this claim, the medical record did not include the individualized overall plan of care. The Hospital did not provide a cause for these errors because its officials contended that these claims met Medicare requirements. However, Hospital officials did not provide any additional information that would impact our finding.

As a result of these errors, the Hospital received overpayments of \$412,667. For 2 of these claims, the Hospital refunded \$42,229 of the overpayments after the start of our review.

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)). 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)).

A payment for services furnished to an individual may be made only to providers of services that are eligible and only if, "with respect to inpatient hospital services . . . , which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment . . ." (the Act, § 1814(a)(3)). Federal regulations require an order for inpatient admission by a physician or other qualified provider at or before the time of the inpatient admission (42 CFR § 412.3(a)-(c)).

In addition, the regulations provide that an inpatient admission, and subsequent payment under Medicare Part A, is generally appropriate if the ordering physician expects the patient to require care for a period of time that crosses two midnights (42 CFR § 412.3(d)(1)).

Furthermore, the *Medicare Benefit Policy Manual* states that physicians “should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation” (Pub. No. 100-02, chapter 1 § 10). The *Medicare Benefit Policy Manual* further states that:

the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;
- the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- the availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered on the basis of the length of time the patient actually spends in the hospital (Pub. No. 100-02, chapter 1 § 10).

For 8 of the 85 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have billed as outpatient or outpatient with observation. Because the medical records did not support the necessity for inpatient hospital services, the services should have been provided at a lower level of care. The Hospital did not provide a cause for these errors because its officials contended that these claims met Medicare requirements. However, Hospital officials did not provide any additional information that would impact our finding.

As a result of these errors, the Hospital received overpayments of \$45,078. For 6 of these claims, the Hospital refunded \$26,352 of the overpayments after the start of our review.

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 5 of the 85 selected inpatient claims, the Hospital submitted claims to Medicare that were incorrectly coded, resulting in incorrect DRG payments to the Hospital. Specifically, certain procedure or diagnosis codes were not supported by the medical records. The Hospital did not provide a cause for these errors because its officials contended that these claims met Medicare requirements. However, Hospital officials did not provide any additional information that would impact our finding.

As a result of these errors, the Hospital received net overpayments of \$42,487. For 4 of these claims, the Hospital refunded \$45,743 of the overpayments after the start of our review.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 1 of the 15 outpatient claims that we reviewed. This error resulted in an overpayment of \$91.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1833(e)). 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 1 of the 15 selected outpatient claims, the Hospital submitted a claim to Medicare with an incorrect HCPCS code that was not supported by the medical record. The Hospital did not provide a cause for these errors because its officials contended that these claims met Medicare requirements. However, Hospital officials did not provide any additional information that would impact our finding.

As a result of this error, the Hospital received an overpayment totaling \$91. For this claim, the Hospital refunded \$91 of the overpayment after the start of our review.

OVERALL ESTIMATE OF OVERPAYMENTS

The combined overpayments on the 41 sampled claims that did not fully comply with Medicare billing requirements totaled \$500,323. On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$10,711,548 for the audit period. During the course of our audit, the Hospital submitted 13 of these 41 claims for reprocessing, and we

verified those claims as correctly reprocessed. Accordingly, we have reduced the recommended refund by \$114,415.

RECOMMENDATIONS

We recommend that the Texas Health Presbyterian Hospital Dallas:

- refund to the Medicare contractor \$10,597,133 (\$10,711,548 less \$114,415 that the Hospital has already repaid) in estimated overpayments for the audit period for claims that it incorrectly billed;⁴
- exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day repayment rule; and
- strengthen controls to ensure full compliance with Medicare requirements, specifically:
 - ensure all IRF beneficiaries meet Medicare criteria for acute inpatient rehabilitation and all required documentation is included in the medical record;
 - ensure all inpatient beneficiaries meet Medicare criteria for inpatient hospital services;
 - ensure procedure and diagnosis codes are supported in the medical records and staff are properly trained; and
 - ensure HCPCS codes are supported in the medical records and staff are properly trained.

OTHER MATTERS

Of the 85 inpatient claims in our sample, the Hospital incorrectly billed Medicare Part A for 5 beneficiary stays of less than two midnights (known as “inpatient short stays”), which it should have billed as outpatient or outpatient with observation. Because the medical records did not support the necessity for inpatient hospital services, the services should have been provided at a lower level of care. As a result of these errors, the Hospital received overpayments totaling \$33,951.

⁴ OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to HHS action officials. Action officials at CMS, acting through a Medicare Administrative Contractor (MAC) or other contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Parts A and B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a decision by the Office of Hearings and Appeals. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

We did not review any of the claims in our sample because they were inpatient short stays; instead, we reviewed them because they fell into one of the high-risk categories discussed in the background section of this report. We voluntarily suspended audits of inpatient short stay claims after October 1, 2013. Therefore, we are not including the number and estimated dollar amount of these errors in our overall estimate of overpayments or in our repayment recommendation.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital agreed with our findings that 5 of 85 selected inpatient claims were incorrectly coded, resulting in incorrect DRG payments, and 1 of 15 selected outpatient claims contained an incorrect HCPCS code that was not supported by the medical records. Otherwise, the Hospital generally disagreed with our findings and recommendations. The Hospital disagreed that it incorrectly billed IRF services for 27 claims and concluded that 25 of the 27 IRF claims contained adequate documentation to meet Medicare requirements.

The Hospital objected to the conclusion that the errors identified in our draft report were the result of a lack of adequate internal controls to prevent the incorrect billing of Medicare claims. In addition, the Hospital asserted that the findings in the report raised factual disputes related to documentation in multiple individual claims, as opposed to findings that the Hospital delivered medically unnecessary services or otherwise acted fraudulently. Furthermore, the Hospital stated that OIG's medical reviewer acts as the Hospital's Qualified Independent Contractor and has a history of significant error rates in its claim denials. Should OIG's medical reviewer be used as the medical reviewer during subsequent appeals, the Hospital will deem this a conflict of interest. Finally, the Hospital asserted that the number of IRF claims in the sample was disproportionately high and represented approximately 40 percent of the sample frame.

The Hospital disagreed with our recommendation to refund to the Medicare contractor \$10,597,133 in estimated overpayments because the amount of the proposed refund represents the extrapolation of many payments that are in dispute, and the recommendations set forth in the report are not final determinations by the Medicare Program. In addition, the Hospital stated that accepting this recommendation would deny the Hospital its right to appeal any of the extrapolated claims. Furthermore, the Hospital stated that the use of extrapolation requires a persistent high error rate before a provider is subject to such a review (Program Integrity Manual, chapter 8 § 8.4—Use of Statistical Sampling for Overpayment Estimation).

The Hospital did not state whether it agreed or disagreed with our last two recommendations but stated that it maintains a robust compliance program, refunding overpayments as appropriate, and continuously trains and monitors staff with respect to medical record documentation and coding.

OFFICE OF INSPECTOR GENERAL RESPONSE

After review and consideration of the Hospital's comments, we maintain that our findings and recommendations are correct.

Except for one IRF finding, our IRF and inpatient admission findings were not documentation errors as asserted by the Hospital. Rather, we found that, for 26 claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation. Moreover, we found that, for 8 claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status. These are medical necessity errors. Pursuant to section 1815(a) of the Act and Federal regulations (42 CFR § 424.5(a)(6)), the Hospital is required to have sufficient information (i.e., documentation) for CMS and its contractors to determine whether payments were due and the amount of the payments. OIG-contracted medical reviewers assessed the medical documentation and, based on those documents, determined that the Hospital's Medicare claims did not comply with Medicare requirements (i.e., were not medically necessary). We also did not assert that the Hospital acted fraudulently.

Based on the results of our review, we determined that these errors were a result of a lack of adequate internal controls over these claim areas. We acknowledge and appreciate the Hospital's response that it maintains a robust compliance program; as the Hospital noted, we identified opportunities for improvement in the Hospital's current compliance program.

We disagree with the Hospital's assertion that our Medical review contractor's conclusions in this audit are unreliable based on its "error rates" when acting as a Qualified Independent Contractor (QIC). The CMS QIC contract is entirely separate from the OIG medical review contract. Each of these contracts makes use of a separate team of contractor employees who are responsible for meeting the requirements of separate and distinct statements of work. OIG does not oversee the CMS QIC contract and cannot opine on the favorable or unfavorable decision rate under that contract. Further, given the differences in the two statements of work, OIG cannot draw any conclusion based on an attempted comparison of the favorable and unfavorable rates between the two contracts. The claims the QIC reviewed were originally denied by a MAC as having indications of noncompliance with Medicare regulations. Conversely, our hospital sample cases in this audit passed MAC coverage edits and were paid. Our sample was a stratified random sample drawn from a population of these paid claims. Thus, there would be no common rate of denial between the two samples, and any comparison of rates from the two groups is meaningless.

Our extrapolation applied to only 11 selected high-risk areas, one of which was IRF claims. Given this focus, it is not unexpected that the proportion of IRF claims within the frame did not match the proportion of IRF claims across the Hospital as a whole. Our audit was not designed to, and did not provide, an overall error rate for all of the Hospital's Medicare claims.

The requirement that, a determination of a sustained or high level of payment error or documented failed educational intervention must be made before extrapolation, applies only to Medicare contractors. See Social Security Act § 1893(f)(3) and CMS Medicare Program Integrity Manual, Pub. No. 100-08, ch. 8.4, § (effective January 2, 2019).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$33,554,149 in Medicare payments to the Hospital for 2,768 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (85 inpatient and 15 outpatient) with payments totaling \$1,468,151. Medicare paid these 100 claims from January 1, 2016, through December 31, 2017 (audit period).

We focused our audit on the risk areas identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted all claims to an independent medical review contractor to determine whether the claims were supported by the medical records.

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 NCH data, 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.

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 database 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 85 inpatient claims and 15 outpatient claims totaling \$1,468,151 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 all claims complied with selected billing 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 audit 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: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

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

SAMPLING FRAME

According to CMS's NCH database, Medicare paid the Hospital \$249 million for 13,574 inpatient and 52,075 outpatient claims during the audit period.

We obtained a database of claims from the NCH data totaling \$152 million for 9,945 inpatient and 43,159 outpatient claims in 31 risk areas. From these 31 areas, we selected 11 consisting of 29,104 claims totaling \$55,070,026 for further review.

We performed data filtering and analysis of the claims within each of the 11 high-risk areas. The specific filtering and analysis steps performed varied depending on the Medicare issue but included such procedures as removing:

- claims with certain discharge status and diagnosis codes,
- paid claims less than \$0, and
- claims under review by the Recovery Audit Contractor as of June 27, 2018.

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: Inpatient Mechanical Ventilation Claims, Inpatient Claims Paid in Excess of Charges, Inpatient Elective Procedures Claims, Inpatient Claims Billed with High Severity Level DRGs, Inpatient Claims Billed with CERT DRG Codes, IRF Claims, Outpatient Claims with Bypass Modifiers, Outpatient SNF Consolidated Billing Claims, Outpatient Claims with Operating Units Greater than 1, Outpatient Claims Paid in Excess of \$25,000, and Outpatient Claims Paid in Excess of Charges. This resulted in a sample frame of 2,768 Medicare paid claims in 11 high-risk areas totaling \$33,554,149 from which we drew our sample (Table 1).

Table 1: Risk Areas

Medicare Risk Area	Frame Size	Value of Frame
1. Inpatient Mechanical Ventilation Claims	5	\$174,847
2. Inpatient Claims Paid in Excess Charges	30	432,576
3. Inpatient Elective Procedure Claims	330	4,924,187
4. Inpatient Claims Billed With High Severity Level DRGs	809	8,034,470
5. Inpatient Claims Billed With CERT DRG Codes	413	2,274,363
6. IRF Claims	924	14,987,784
7. Outpatient Claims with Bypass Modifiers	101	117,535
8. Outpatient SNF Consolidated Billing Claims	42	13,152
9. Outpatient Claims with Operating Units Greater than 1	26	159,752
10. Outpatient Claims Paid in Excess of \$25,000	81	2,394,131
11. Outpatient Claims Paid in Excess of Charges	7	41,352
Total	2,768	\$33,554,149

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We stratified the sampling frame into five strata on the basis of claim type, relative risk of improper payment based on previous OIG audit work and claims paid amount. Strata 1 and 2 include risk areas 1 through 4 from Table 1 separated by paid amount;⁵ strata 3 and 4 include risk areas 5 and 6 from Table 1 separated by paid amount,⁶ and stratum 5 includes all outpatient claims from risk areas 7 through 11 from Table 1. All claims were unduplicated, appearing in only one area and only once in the entire sampling frame.

We selected 100 claims for review as shown in Table 2.

⁵ Paid claims less than \$14,167 are in stratum 1 and paid claims \$14,167 or greater are in stratum 2.

⁶ Paid claims less than \$15,525 are in stratum 3 and paid claims \$15,525 or greater are in stratum 4.

Table 2: Claims by Stratum

Stratum	Claims Type	Frame Size (Claims)	Value of Frame	Sample Size
1	Inpatient Risk Areas 1-4, Low Dollar Claims	892	\$6,974,734	20
2	Inpatient Risk Areas 1-4, High Dollar Claims	282	6,591,346	20
3	Inpatient Risk Areas 5-6, Low Dollar Claims	879	8,053,280	22
4	Inpatient Risk Areas 5-6, High Dollar Claims	458	9,208,867	23
5	All Outpatient Claims	257	2,725,922	15
	Total	2,768	\$33,554,149	100

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 strata 1 through 5. 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. To be conservative, we used the lower-limit of the two-sided 90-percent confidence interval to estimate the amount of improper Medicare payments in our sampling frame during the audit period. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: 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	892	\$6,974,734	20	\$155,830	6	\$29,568
2	282	6,591,346	20	430,903	5	74,876
3	879	8,053,280	22	205,481	16	152,085
4	458	9,208,867	23	453,265	13	243,703
5	257	2,725,922	15	222,672	1	91
Total	2,768	\$33,554,149	100	\$1,468,151	41	\$500,323

ESTIMATES

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

Point estimate	\$13,305,419
Lower limit	\$10,711,548
Upper limit	\$15,899,291

APPENDIX D: RESULTS OF AUDIT BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Overpayments	Value of Overpayments
Inpatient Mechanical Ventilation Claims	1	\$36,671	1	\$26,908
Inpatient Claims in Excess of Charges	2	33,909	1	11,526
Inpatient Elective Procedures Claims	14	218,976	-	-
Inpatient Claims Billed With High Severity Level DRGs	23	297,177	9	66,009
Inpatient Claims Billed With CERT DRG Codes	9	49,658	6	35,177
IRF Claims	36	609,088	23	360,612
Inpatient Totals	85	\$1,245,479	40	\$500,232
Outpatient Claims With Bypass Modifiers	7	\$7,969	1	\$91
Outpatient Claims With Operating Units Greater Than 1	1	3,833	-	-
Outpatient Claims Paid in Excess of \$25,000	7	210,870	-	-
Outpatient Totals	15	\$222,672	1	\$91
Inpatient and Outpatient Totals	100	\$1,468,151	41	\$500,323

Notice: The table above illustrates the results of our audit by risk area. In it, we have organized inpatient and outpatient 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.



July 11, 2019

Lori S. Pilcher
Regional Inspector General for Audit Service
U.S. 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 Medicare Compliance Review of Texas Health Presbyterian Hospital Dallas
OIG Report Number A-04-18-08068

Dear Ms. Pilcher:

This letter is in response to your letter of June 11, 2019 to Jim Parobek, Interim President of Texas Health Presbyterian Hospital Dallas (“Texas Health Dallas” or “Hospital”). Texas Health Resources, acting on behalf of Texas Health Dallas, appreciates the opportunity to review and provide written comments on the U.S. Department of Health and Human Services, Office of Inspector General (“OIG”), draft report entitled *Medicare Compliance Review of Texas Health Presbyterian Hospital Dallas* (“the Report”).

Texas Health Dallas is part of Texas Health Resources, a faith-based, nonprofit health system in the United States that cares for more patients in North Texas than any other provider. Texas Health Dallas serves the communities of Dallas County, treating complex cases from across North Texas with advanced medical treatments and an experienced staff that provides compassionate care. Texas Health Dallas is an 875-bed, acute-care hospital with Level II Trauma Center Designation, Cycle IV Chest Pain Accreditation from the Society of Cardiovascular Patient Care and is also accredited for emergency stroke care by the Joint Commission. Additionally, Texas Health Dallas is designated as a Magnet hospital by the American Nurses Credentialing Center, an honor that recognizes hospitals for excellence in nursing.

Response to General Findings

Texas Health Resources generally disagrees with many of the findings and recommendations set forth in the Report. Further, Texas Health Resources stresses that the Introduction and Background sections of the report are generalized statements regarding the OIG’s compliance review efforts and do not specifically describe or refer to activity identified at any Texas Health Resources hospital, including Texas Health Dallas, that specifically suggested non-compliance with Medicare billing requirements.

Texas Health Resources objects to the general finding that potential errors identified in the Report were the result of a lack of adequate controls to prevent the incorrect billing of Medicare claims. Texas Health Resources maintains a robust, highly reliable compliance program. The program provides support to Texas Health Dallas from the corporate level, as well as a compliance officer that is dedicated to Texas Health Dallas. The Texas Health Resources compliance program includes billing policies and procedures, staff training, and monitoring of billing activities. Pursuant to these policies and procedures, identified billing and/or charge entry errors are corrected and rebilled. Overpayments are refunded within sixty (60) days following identification of the overpayment.

Texas Health Resources asserts that the findings in the Report raise specific fact disputes related to documentation in multiple individual claims (specifically whether such documentation supports the medical necessity of services delivered to beneficiaries) as opposed to findings that Texas Health Dallas delivered medically unnecessary services or otherwise fraudulently acted. Each of the individual disputed claims was submitted on a fully completed claim form, and a CMS authorized contractor processed and paid each disputed claim.

With respect to the general reliability of the conclusions about individual claims, it is noteworthy that Maximus Federal Services (“Maximus”), the medical review expert used by OIG to review the sample, has a history of significant error rates in its claims denials when acting as a Qualified Independent Contractor (“QIC”). Maximus acts as the QIC in Texas Health Resources’ region. In 2012, in “Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals OEI-02-10-00340” the OIG recognized that the error rate of QICs exceeded 50% based on the number of denials subsequently overturned by an Administrative Law Judge. In fact, the overturn rate for Part A claims was 72%. That is substantially worse than if the QIC simply flipped a coin. The OIG also noted “One QIC added that it approaches appeals expecting to uphold prior-level decisions unless the evidence to reverse is compelling.” During 2014-2017, Texas Health Resources successfully overturned 43% of Maximus’ denials, with Texas Health Dallas experiencing an overturn rate of 32%. In addition to Texas Health Resources’ concerns regarding the accuracy of Maximus’ reviews, should Maximus be used as a medical reviewer during subsequent appeals of the claims in dispute, Texas Health Resources will deem this a conflict of interest.

Texas Health Resources also asserts that the number of inpatient rehabilitation facility (IRF) claims in the sample was disproportionately high. IRF claims represented approximately 40% of the “sample frame”. Texas Health Dallas’ inpatient rehabilitation department had an average daily census of 30.86 in 2016 and 27.69 in 2017. In comparison, the average daily census for the entire Hospital during the years of 2016 and 2017 was 405 and 398.6 respectively.

At the request of OIG, Texas Health Resources conducted an internal review (the “Internal Review”) of each claim in the sample. Texas Health Resources’ concurrence or nonconcurrence with specific findings related to incorrectly billed claims is based on the results of that Internal Review. Specific responses to each finding and recommendation in the Report are set forth below.

Incorrectly Billed Inpatient Rehabilitation Facility Claims

Texas Health Resources disagrees with OIG's finding that the Hospital incorrectly billed IRF services for 27 of the selected inpatient claims. The Internal Review concluded that 25 of the 27 IRF claims included in the sample contained adequate documentation to meet Medicare criteria for IRF services. As stated above, specific fact disputes about these claims exist. Texas Health Resources intends to exercise its right to appeal each of these disputed claims. Payment for the remaining 2 claims for which sufficient documentation was not found was refunded.

Incorrectly Billed as Inpatient

As a result of the Internal Review, Texas Health Resources concurs that a small number of random errors occurred in the claims identified as Incorrectly Billed as Inpatient. Texas Health Resources refunded overpayments of \$26,352 that were attributable to those claims. The remaining claims are in dispute and Texas Health Resources intends to exercise its right to appeal such claims.

Incorrectly Billed Diagnosis-Related Group Codes

Texas Health Resources concurs with this finding. The Internal Review concluded that random coding errors with partial reimbursement impact, including one underpayment, occurred in 5 of the claims identified in the Incorrectly Billed Diagnosis-related Group Codes group. A corrected claim was promptly submitted for each and corrected reimbursement was subsequently received. Human error was the cause of the incorrect coding.

Incorrectly Billed Healthcare Common Procedure Coding System Codes

Texas Health Resources concurs with this finding. The Internal Review identified a secondary diagnosis change on a single account. This was a result of human error. A corrected claim was promptly submitted and corrected reimbursement was subsequently received.

Recommendations

Refund to the Medicare Contractor \$10,597,133 in Estimated Overpayments

Texas Health Resources disagrees with OIG's recommendation to refund to the Medicare contractor \$10,597,133 in estimated overpayments for multiple reasons. The amount of the proposed refund represents the extrapolation of many payments that are still in dispute, as discussed above. Texas Health Resources strongly believes it will prevail in its appeal of these claims. Further, as noted in Footnote 3 of the Report, the recommendations set forth in the report are not final determinations by the Medicare Program. Thus, Texas Health Resources believes it is premature to repay an amount that is extrapolated from claims that likely will be adjudicated in its favor during the appeals process.

Accepting the OIG recommendation to refund \$10,597,133 at this point would deny Texas Health Resources its right to appeal any of the extrapolated claims, which is fundamentally unfair. The Medicare program requires a persistent high error rate before a provider is subject to such a review. (Program Integrity Manual Chapter 3 § 8.4 - Use of Statistical Sampling for

Overpayment Estimation, et seq. Specifically: § 8.4.1.2 - The Purpose of Statistical Sampling- “The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandates that *before using extrapolation (i.e., projection, extension, or expansion of known data) to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, there must be a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error [emphasis added]*.” Neither the OIG audit nor the Internal Review definitively revealed such a persistent high error rate to subject Texas Health Dallas to such a review by a Medicare Contractor.

Exercise Reasonable Diligence to Identify and Return Additional Overpayments Received Outside of the Audit Period

As stated above, Texas Health Resources maintains a robust compliance program. Texas Health Resources actively monitors coding and billing activities and refunds overpayments as appropriate. These activities will continue to be part of our routine, daily operations. Corrective action plans related to utilization management and coding were implemented as a result of the Internal Review. These plans were shared with OIG during the onsite review.

Strengthen Controls to ensure full Compliance with Medicare Requirements

Texas Health Resources continuously trains and monitors its staff with respect to medical record documentation and coding. These activities will continue to be part of our routine, daily operations. Corrective action plans related to utilization management and coding were implemented as a result of the Internal Review. These plans were shared with OIG during the onsite review.

Conclusion

Texas Health Resources acknowledges that the OIG review correctly identified some opportunities for improvement. However, Texas Health Resources was aware of, and actively addressing these opportunities, prior to receiving notice of the review. This is testament to the fact that the compliance program is functioning reliably and continuously improving operations at Texas Health Resources. Texas Health Resources remains committed to delivering high quality, cost-effective care to Medicare program beneficiaries and all patients in the communities which it serves.

Please do not hesitate to contact me at with any questions you may have.

Sincerely,

/Liz Madzik/

Liz Madzik
Chief Compliance Officer
Texas Health Resources