Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE HOSPITAL PROVIDER COMPLIANCE AUDIT: EDWARD W. SPARROW HOSPITAL

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November 2020
A-05-18-00045

Office of Inspector General

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Report in Brief
Date: November 2020
Report No. A-05-18-00045

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Hospital Provider Compliance Audit: Edward W. Sparrow Hospital

Why OIG 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.

Our objective was to determine whether Edward W. Sparrow Hospital (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 100 claims with payments totaling $1.4 million for our audit period (January 1, 2016, through December 31, 2017).

We focused our audit on the risk areas identified because of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements.

What OIG Found

The Hospital complied with Medicare billing requirements for 91 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining nine claims, resulting in overpayments of $47,317 for the audit period. Specifically, five inpatient claims had billing errors, resulting in overpayments of $46,464, and four outpatient claims had billing errors, resulting in overpayments of $853. 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 $550,917 for the audit period.

What OIG Recommends and Hospital Comments

We recommend that the Hospital, based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation and strengthen its controls to ensure full compliance with Medicare requirements. See the report for additional details regarding the last recommendation.

In written comments on our draft report, the Hospital stated that it disagreed with our findings and partially concurred with one of our recommendations. The Hospital disagreed with our findings that the nine claims were incorrectly billed. Because the Hospital disagreed with these findings and intends to appeal, it does not concur with our recommendations to refund our estimated overpayment amount and to identify, report, and return any overpayments in accordance with the 60-day rule. Although the Hospital disagreed with our finding that it did not have adequate controls to prevent the errors noted in our draft report, it stated that it has and will continue to improve its controls.

After review and consideration of the Hospital's comments, we maintain that our findings, along with our second and third recommendations are valid. We have removed our first recommendation from this report because most of the incorrectly billed claims that we identified are now outside of the 4-year Medicare reopening period. We maintain that our findings remain valid errors and that the Hospital remains responsible for compliance with the 60-day rule and should strengthen its controls to ensure Medicare compliance.

TABLE OF CONTENTS

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 Edward W. Sparrow Hospital (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 (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. 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 inpatient 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] The HCPCS includes the American Medical Association's Current Procedural Terminology (CPT) codes for physician services and CMS-developed codes for certain nonphysician services.[2] 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. Of the areas identified as being at risk, we focused our audit on the following:

- inpatient adverse events,
- inpatient claims billed with comprehensive error rate testing (CERT) DRG codes,[3]
- inpatient elective procedures,
- IRF claims,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient mechanical ventilation claims,

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

[2] 45 CFR § 162.1002(c)(1); The *Medicare Claims Processing Manual,* Publication No. 100-04 (the Manual), chapter 4, § 20.1.

[3] CMS calculates the Medicare Fee-for-Service improper payment rate through the CERT program. Each year, CERT evaluates a statistically valid stratified random sample of claims to determine whether they were paid properly under Medicare coverage, coding, and billing rules. Based on our analysis of CERT data, we have identified 10 DRGs that are most at risk for billing errors: 149, 312, 313, 518, 519, 520, 742, 743, 947, and 948.

- inpatient claims with same-day discharge/readmission,
- outpatient claims with bypass modifiers,
- outpatient claims paid in excess of $25,000, and
- outpatient claims paid in excess of charges.

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.[4]

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items or services "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)).

Claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)). The Manual (chapter 1, § 80.3.2.2) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[5]

[4] 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*, chapter 6, § 6.5.2). We are not constrained by the two-midnight presumption in selecting claims for medical review.

[5] The Act § 1128J(d); 42 CFR §§ 401.301–401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.[6]

Edward W. Sparrow Hospital

The Hospital is a 525-bed, acute-care, nonprofit hospital located in Lansing, Michigan. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately $221 million for 13,845 inpatient and 79,659 outpatient claims from January 1, 2016, through December 31, 2017 (audit period).

HOW WE CONDUCTED THIS AUDIT

Our audit covered $40,009,769 in Medicare payments to the Hospital for 3,329 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (80 inpatient and 20 outpatient) with payments totaling $1,358,928. Medicare paid these 100 claims during our audit period.

We focused our audit on the risk areas identified because 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 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 audit scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 91 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining nine claims, resulting in overpayments of $47,317 for the audit period. Specifically, five inpatient claims had billing errors, resulting in overpayments of $46,464, and four outpatient claims had billing errors, resulting in overpayments of $853.

[6] 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); The *Provider Reimbursement Manual*, – *Part 1* Pub. No. 15-1, § 2931.2; 81 Fed. Reg. 7670.

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 $550,917 for the audit period.[7] As of the publication of this report, this amount included claims outside of the 4-year claim reopening period.

See Appendix B for our statistical sampling methodology, Appendix C for our sample results and estimates, and Appendix D for the results of our audit by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS – 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) through (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)). The regulations further state that the "expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event" (42 CFR § 412.3(d)(1)(i)). Moreover, "[t]he factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration" (42 CFR § 412.3(d)(1)(i)).

For 5 of the 80 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient claims. The medical records did not support the necessity for inpatient hospital services. The Hospital did not provide a cause for these errors because officials believed that these claims met Medicare requirements for inpatient claims.

[7] To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

As a result of these five errors, the Hospital received overpayments totaling $46,464.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS – INCORRECTLY BILLED CURRENT PROCEDURAL TERMINOLOGY CODES WITH MODIFIERS

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)). Claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)). Acute care hospitals are required to report HCPCS codes, of which CPT codes are a subset, on outpatient claims (the Manual, chapter 4, § 20.1).[8] 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 Hospital incorrectly billed Medicare for 4 of the 20 outpatient claims that we reviewed. For these four outpatient claims, review of the medical records showed that the Hospital incorrectly billed Medicare for evaluation and management services that were not substantiated by the medical records. Three of these patients were presented to the emergency room for dialysis treatment, and no other conditions were treated or discussed, but the hospital incorrectly billed for evaluation and management that were not provided according to the medical records. One patient was presented to the emergency room for dialysis treatment and hand pain, and the hospital incorrectly billed two evaluation and management services although only one evaluation and management service was provided according to the medical records.

As a result of these errors, the Hospital received overpayments totaling $853.

OVERALL ESTIMATE OF OVERPAYMENTS

The combined overpayments on our sampled claims totaled $47,317. On the basis of our sample results, we estimated that the Hospital received overpayments of at least $550,917 for the audit period.

RECOMMENDATIONS

We recommend that Edward W. Sparrow Hospital:

- based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those

[8] "Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Centers for Medicare & Medicaid Services 'Healthcare Common Procedure Coding System' (HCPCS)" (42 CFR § 419.2(a)).

returned overpayments as having been made in accordance with this recommendation, and

- strengthen controls to ensure full compliance with Medicare requirements; specifically, ensure that:

  - all inpatient beneficiaries meet Medicare requirements for inpatient hospital services and

  - evaluation and management services are supported in the medical records.

OTHER MATTERS

Of the 80 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. The medical records did not support the necessity for inpatient hospital services. These errors caused the Hospital to receive overpayments totaling $80,069.

However, none of the claims in this audit were targeted because they were inpatient short-stay claims but rather because they fell into one of the risk areas discussed in the background section of this report. OIG voluntarily suspended reviews of inpatient short-stay claims after October 1, 2013. As such, we are not including the number and estimated dollar amount of these errors in our overall estimate of overpayments or our repayment recommendation.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

HOSPITAL COMMENTS

In written comments on our draft report, the Hospital stated that it disagreed with our findings and recommendations, except for our recommendation to strengthen internal controls, with which it "concurs . . . in principle, but not as it relates to these audit findings specifically." The Hospital disagreed with our findings that the nine claims, five inpatient and four outpatient, were incorrectly billed. Because the Hospital disagreed with these findings and intends to appeal, it does not concur with our recommendation to refund our estimated overpayment amount and exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule. Although the Hospital disagreed with our findings that it did not have adequate controls to prevent the errors noted in our draft report, it stated that it has and will continue to implement control enhancements.

For the five inpatient errors classified as "incorrectly billed as inpatient," the Hospital explained that inpatient admission decisions are complex evaluations performed by physicians at the time of presentation to the Hospital. The Hospital stated that, after being notified of these errors, it

performed a thorough review of these claims and believes that the cases included complexity and risks that warranted an inpatient admission. For the four outpatient errors classified as "incorrectly billed current procedure terminology codes with modifiers," the Hospital disagreed because these errors relate to one patient under unique circumstances.

The Hospital contends that our findings of $47,317 in actual overpayments should not be extrapolated to the entire sampling frame. The Hospital contends that an error in one case does not infer errors in other inpatient admissions that involve different patients, risks, and requirements for admissions. The Hospital also stated that because the outpatient errors were unique to one individual, those errors do not apply to all outpatient claims in our sampling frame. Furthermore, the hospital stated that it considers the extrapolated amount of $550,917 to be overstated because several of the claims in our findings are beyond the 4-year reopening period as of the draft report date.

The Hospital disagreed with our finding that it did not have adequate controls to prevent the inpatient hospital services errors and the evaluation and management coding errors noted in our audit. The Hospital stated that it continually strives to improve its compliance efforts and implement control enhancements it deems to be warranted.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After review and consideration of the Hospital's comments, we maintain that our findings, along with our second and third recommendations, are valid. We removed our first recommendation from this report because most of the incorrectly billed claims that we identified are now outside of the 4-year Medicare reopening period.[9] Regarding our findings, these claims remain valid errors. Therefore, we maintain that the Hospital remains responsible for compliance with the 60-day rule and should strengthen its internal controls to ensure compliance with Medicare requirements.

Regarding the Hospital's comments on our extrapolation, we note that the use of statistical sampling to determine overpayment amounts in Medicare is well established and has

[9] The first recommendation in the draft report was to refund to the Medicare contractor the portion of the estimated $550,917 overpayment for claims incorrectly billed that are within the reopening period. We removed this recommendation because we expect both the estimated overpayment and the observed overpayment within the reopening period to be $268 on the earliest anticipated date of reopening by CMS. In our judgment, this amount is more reasonably handled as part of our recommendation that the Hospital return any overpayments in accordance with the 60-day rule.

repeatedly been upheld on appeal in Federal courts.[10] 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.[11] We properly executed our statistical sampling methodology in that we defined our sampling frame, sampling unit, and strata; selected a stratified random sample; applied relevant criteria in evaluating the sample items; and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

The statistical lower limit that we use for our recommended recovery represents a conservative estimate of the overpayment that we would have identified if we had reviewed every claim in the sampling frame. The conservative nature of this approach is not affected by the type of errors identified in this audit.

[10] 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, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), adopted by 2014 U.S. Dist. LEXIS 4474 (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).

[11] 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, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), aff'd, 860 F.3d 335 (5th Cir. 2017); Anghel v. Sebelius, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); Transyd Enters., LLC v. Sebelius, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $40,009,769 in Medicare payments to the Hospital for 3,329 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (80 inpatient and 20 outpatient) with payments totaling $1,358,928. 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 record.

We limited our audit 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.

We conducted our fieldwork from February 2018 through September 2020.

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 data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 80 inpatient claims and 20 outpatient claims totaling $1,358,928 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;

- 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

SAMPLING FRAME

We obtained paid claims data from CMS's NCH database totaling $221 million for 13,845 inpatient and 79,659 outpatient claims in 31 risk areas. From these 31 areas, we selected 10, consisting of 66,009 claims totaling $140,660,745, for further review.

We performed data filtering and analysis of the claims within each of the 10 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 revenue codes,
- paid claims equal to or less than $0, and
- claims under review by the Recovery Audit Contractor as of June 19, 2018.

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: Inpatient Adverse Events, Inpatient Claims Billed with Comprehensive Error Rate Testing (CERT) DRG Codes, Inpatient Elective Procedures, Inpatient Rehabilitation Facility Claims, Inpatient Claims Billed with High Severity Level DRG Codes, Inpatient Mechanical Ventilation Claims, Inpatient Claims with Same Day Discharge/Readmission, Outpatient Claims with Bypass Modifiers, Outpatient Claims Paid in Excess of $25,000, and Outpatient Claims Paid in Excess of Charges. This resulted in a sample frame of 3,329 Medicare paid claims in 10 risk areas, totaling $40,009,769, from which we drew our sample (Table 1, next page).

Table 1: Risk Areas

Medicare Risk Area	Frame Size	Value of Frame
Inpatient Adverse Events	740	$9,123,212
Inpatient Claims Billed with Comprehensive Error Rate Testing (CERT) DRG Codes	1,241	14,846,260
Inpatient Elective Procedures	456	6,692,534
Inpatient Rehabilitation Facility Claims	70	1,910,583
Inpatient Claims Billed with High Severity Level DRG Codes	377	4,086,546
Inpatient Mechanical Ventilation Claims	6	219,215
Inpatient Claims with Same Day Discharge/Readmission	1	6,490
Outpatient Claims with Bypass Modifiers	381	872,656
Outpatient Claims Paid in Excess of $25,000	54	2,236,051
Outpatient Claims Paid in Excess of Charges	3	16,222
Total	**3,329**	**$40,009,769**

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 four strata on the basis of claim dollar value. Stratum 1 includes high dollar inpatient claims (payment amounts greater than or equal to $16,740), stratum 2 includes moderate dollar inpatient claims (payment amounts less than $16,740 but greater than $11,720), stratum 3 includes low dollar inpatient claims (payment amounts less than or equal to $11,720), and stratum 4 includes all outpatient claims. 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.

Table 2: Claims by Stratum

Stratum	Claims Type	Frame Size (Claims)	Value of Frame	Sample Size
1	Inpatient High Dollar Claims	399	$10,624,378	24
2	Inpatient Moderate Dollar Claims	986	13,496,838	28
3	Inpatient Low Dollar Claims	1,506	12,763,624	28
4	Outpatient Claims	438	3,124,929	20
	Total	**3,329**	**$40,009,769**	**100**

Notice: The table includes rounded totals.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata 1 through 4. 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	399	$10,624,378	24	$632,248	0	$0
2	986	13,496,838	28	390,532	2	28,781
3	1,506	12,763,624	28	218,383	3	17,683
4	438	3,124,929	20	117,765	4	853
Total	**3,329**	**$40,009,769**	**100**	**$1,358,928**	**9**	**$47,317**

Notice: The table includes rounded totals.

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

Point estimate	$1,983,289
Lower limit	550,917
Upper limit	3,415,660

APPENDIX D: RESULTS OF AUDIT BY RISK AREA

Table 5: Sample Results by Risk Area

Risk Area	Selected Claims	Value of Selected Claims	Claims With Overpayments	Value of Overpayments
Adverse Events	24	$360,861	3	26,743
Claims Billed with Comprehensive Error Rate Testing (CERT) DRG Codes	31	382,680	2	19,721
Elective Procedures	13	229,604	-	-
Rehabilitation Facility Claims	5	146,295	-	-
Claims Billed with High Severity Level DRG Codes	7	121,724	-	-
Inpatient Total	**80**	**$1,241,164**	**5**	**$46,464**
Claims with Bypass Modifiers	17	$15,129	4	$853
Claims Paid in Excess of $25,000	3	102,635	-	-
Outpatient Total	**20**	**$117,764**	**4**	**$853**
Inpatient and Outpatient Total	**100**	**$1,358,928**	**9**	**$47,317**

Notice: The table above includes rounded totals and illustrates the results of our review 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.

Sparrow

Improving the health of the people in our communities by
providing quality, compassionate care to everyone, every time

August 24, 2020

Ms. Sheri L. Fulcher
Regional Inspector General
Office of Audit Services Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

RE: A-05-18-00045 Medicare Hospital Provider Compliance Audit: Edward W. Sparrow Hospital

Dear Ms. Fulcher:

This letter is written in response to your June 23, 2020 communication transmitting the Office of Inspector General ("OIG") report entitled *Medicare Hospital Provider Compliance Audit: Edward W. Sparrow Hospital* ("Draft Audit Report"). Edward W. Sparrow Hospital ("Sparrow") is a 525-bed, acute-care, non-profit hospital located in Lansing, Michigan. Sparrow is a community-based hospital dedicated to providing quality and compassionate care to all patients. Sparrow has a robust compliance program and is committed to continuously improving to meet the requirements of the complex healthcare environment. Sparrow appreciates the opportunity to work with the OIG, and to review and provide written comments in response to the overall audit findings and recommendations contained within the Draft Audit Report.

Overall Audit Findings

OIG Finding #1 from Draft Audit Report - *The Hospital complied with Medicare billing requirements for 91 of the 100 inpatient and outpatient claims reviewed. Specifically, five inpatient claims had billing errors, resulting in overpayments of $46,464 and four outpatient claims had billing errors, resulting in overpayments of $853.*

Sparrow Response – Sparrow would like to emphasize that the OIG audit population for the audit of Sparrow included claims in 10 risk areas as noted in table 1 of Appendix B of the Draft Audit Report. The OIG's audit findings fell in one error category for the five inpatient case denials (inpatient admission), and one area for the four outpatient case denials (incorrect CPT codes with modifiers). There were no denials or concerns raised related to the medical appropriateness of the care, inpatient rehabilitation admissions, the coding of cases for diagnostic related group or adverse events, or the high-payment outpatient cases.

Sparrow disagrees with the findings of the OIG on the five inpatient denials and four outpatient denials noted in the Draft Audit Report.

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a) Inpatient Denials - All five inpatient denials were related to "incorrectly billed as inpatient". The determination as to the appropriateness for inpatient admission is a complex, fact-based determination based on many elements evaluated by a physician at the time that the patient presents to the hospital. Sparrow has performed a thorough review of each of these inpatient determinations, including a review by a physician leader independent of these cases. Each of the five inpatient cases were in the hospital for a period crossing two midnights, and Sparrow believes the cases included appropriate complexity and risks to warrant an inpatient admission. Sparrow intends to appeal these findings.

b) Outpatient Denials – All four outpatient denials were related to "incorrectly billed current procedural terminology codes with modifiers". These four cases relate to one patient who presented to Sparrow's Emergency Department. Sparrow disagrees that the coding of the services provided to this patient was incorrect, given the unique circumstances and fact-based nature of these cases. Sparrow intends to appeal these findings.

OIG Finding #2 from Draft Audit Report – *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.*

Sparrow Response – Sparrow disagrees with the finding that the Hospital did not have adequate controls to prevent the incorrect billing due to the fact that Sparrow does not agree that the denied cases were errors, as noted above.

OIG Finding #3 from Draft Audit Report – *On the basis of our sample results, we estimated that the Hospital received overpayments of at least $550,917 for the audit period. As of the publication of this report, this amount included claims outside of the 4-year claim reopening period.*

Sparrow Response – Sparrow disagrees with the estimated amount due as a result of this audit for the following reasons:

a) Disagree with Extrapolation in Theory – Sparrow disagrees that the suggested denied amount for this audit ($47,317) should be extrapolated to the entire audit population. As noted above, inpatient admission determinations are very complex and involve clinical judgement on a very case-specific basis. An error on one case does not infer an error on other inpatient admissions that involve very different patients, risks, and requirements for hospital admission. Similarly, the outpatient errors noted by the OIG were unique to a particular patient, which would not apply to all outpatient cases noted in the audit population.

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b) Disagree with Extrapolation in Amount – Sparrow disagrees with the suggested extrapolated amount of $550,917 due to the noted four-year reopening period. The four-year reopening period will have elapsed for several of the errors noted by the OIG in Sparrow's sample. In addition, the extrapolated amount does not consider the impact of a case that is inpatient being alternatively paid as an inpatient part B or outpatient level of service, therefore Sparrow believes the extrapolation is overstated.

Response to OIG Recommendations

In the following section, Sparrow provides the requested response of concurrence or non-concurrence with the OIG's three recommendations noted in the Draft Audit Report.

OIG Recommendation #1 - *Refund to the Medicare contractor $550,917 in estimated overpayments for the audit period for claims that it incorrectly billed that are within the 4-year reopening period.*

Sparrow Response – Sparrow does not concur with this recommendation given Sparrow's disagreement with the audit findings and the fact that the errors continue to be in dispute. Sparrow will pursue its appeal rights with the Medicare Administrative Contractor (MAC) for these findings at the appropriate time. Should Sparrow be successful on appeal, the estimated overpayment will no longer be valid.

OIG Recommendation #2 - *Based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.*

Sparrow Response – As it relates to the results of this audit, Sparrow does not concur with this recommendation, given Sparrow's disagreement with the audit findings and the fact that the errors continue to be in dispute. Sparrow will pursue its appeal rights with the Medicare Administrative Contractor (MAC) for these findings at the appropriate time.

OIG Recommendation #3 - *Strengthen controls to ensure full compliance with Medicare requirements; specifically, ensure that:*

- *all inpatient beneficiaries meet Medicare requirements for inpatient hospital services and*
- *evaluation and management services are supported in the medical records*

Sparrow Response – Sparrow concurs with this recommendation in principle, but not as it relates to these audit findings specifically.

- Inpatient Hospital Services – As noted above, Sparrow does not agree with the findings that Sparrow did not have adequate controls to prevent the suggested errors

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noted in the audit. However, as noted in the introduction to this letter, Sparrow strives to continuously improve, and has implemented many enhancements to the control environment related to admissions over the last several years. These enhancements were outlined to the OIG as part of this audit process, and Sparrow will continue to implement additional control enhancements as deemed warranted.

- Evaluation and Management Services – As noted above, Sparrow does not agree with the findings that Sparrow did not have adequate controls to prevent the suggested errors noted in the audit. However, Sparrow will continue to monitor and strive for continuous improvement in the area of coding evaluation and management services as part of its overall compliance efforts.

Sparrow appreciates the opportunity to respond in writing to the Draft Audit Report. Please do not hesitate to contact me if you would like to discuss Sparrow's response at 517-364-2552, or john.hyden@sparrow.org.

Sincerely,

/John Hyden/

John Hyden, Esq.
Vice President, Compliance and Audit Services and
Chief Privacy Officer

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