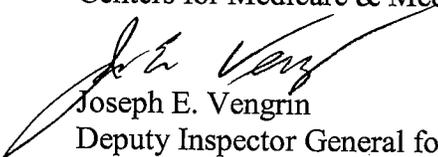




**FEB -3** 2009

**TO:** Charlene Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid Services

**FROM:**   
Joseph E. Vengrin  
Deputy Inspector General for Audit Services

**SUBJECT:** Review of Emergency Health Services at Orlando Regional Healthcare Furnished to Undocumented Aliens Covered by Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (A-04-07-07030)

Attached is an advance copy of our final report on emergency health services at Orlando Regional Healthcare System, Inc. (ORH), furnished to undocumented aliens covered by section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). We will issue this report to ORH within 5 business days.

Section 1011 of the MMA, "Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens" (section 1011), provided \$250 million per year for fiscal years 2005 through 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens pursuant to Emergency Medical Treatment and Labor Act (EMTALA) requirements. Under EMTALA, a Medicare-participating hospital is to provide an appropriate medical screening examination to any person, regardless of ability to pay, who comes to the hospital emergency department to determine whether an emergency medical condition (EMC) exists. If the examination reveals an EMC, the hospital must also provide either treatment necessary to stabilize the EMC or an appropriate transfer to another medical facility.

We selected for review a judgmental sample of 30 claims totaling \$27,395 that ORH submitted for payment for the period May 10 through September 30, 2005. In total, ORH received \$89,114 for 87 claims for that period.

Our objective was to determine whether claims submitted by ORH for services provided under section 1011 for the period May 10 through September 30, 2005, were submitted on behalf of individuals who met eligibility requirements, were for eligible services, and were adequately supported and not reimbursed from other sources as required by Federal regulations.

Of the 30 sampled claims, 13 claims totaling \$8,556 met section 1011 requirements and were eligible for section 1011 program reimbursement. The 17 remaining claims totaling \$18,839 were either partially or completely unallowable for section 1011 program reimbursement. As a result, ORH received \$16,568 in unallowable payments. The unallowable payments occurred because ORH did not always follow its own policies and procedures for ensuring that services were provided up to the point of patient stabilization, medical records contained sufficient documentation to support eligibility determinations and the services provided, and treatments were for EMCs. Furthermore, ORH written policies and procedures did not address section 1011 requirements regarding reimbursements from third-party payers.

We recommend that ORH:

- refund to TrailBlazer \$16,568 received for services that did not meet section 1011 reimbursement requirements;
- review the 57 remaining claims for our audit period, totaling \$61,719, and claims for subsequent periods and submit adjustments for any claims that did not meet section 1011 reimbursement requirements;
- follow its existing policies and procedures to ensure that future section 1011 program claims meet section 1011 reimbursement requirements; and
- develop and implement procedures to ensure that reimbursements for services are made to the extent that a third-party payer did not otherwise reimburse care.

In written comments on our draft report, ORH agreed with our recommendations and described its plan of action.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at [George.Reeb@oig.hhs.gov](mailto:George.Reeb@oig.hhs.gov) or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through e-mail at [Peter.Barbera@oig.hhs.gov](mailto:Peter.Barbera@oig.hhs.gov). Please refer to report number A-04-07-07030.

Attachment



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General  
Office of Audit Services

REGION IV  
61 Forsyth Street, S.W., Suite 3T41  
Atlanta, Georgia 30303

FEB -9 2009

Report Number: A-04-07-07030

Ms. Bridget B. Walters  
Corporate Billing/Governmental Manager  
Orlando Regional Healthcare System, Inc.  
dba Orlando Regional Healthcare  
3090 Caruso Court  
Orlando, Florida 32806

Dear Ms. Walters:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Emergency Health Services at Orlando Regional Healthcare Furnished to Undocumented Aliens Covered by Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Andrew A. Funtal, Audit Manager, at (404) 562-7762 or through e-mail at [Andrew.Funtal@oig.hhs.gov](mailto:Andrew.Funtal@oig.hhs.gov). Please refer to report number A-04-07-07030 in all correspondence.

Sincerely,

A handwritten signature in cursive script that reads "Peter J. Barbera".

Peter J. Barbera  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 East 12th Street, Room 235  
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF EMERGENCY  
HEALTH SERVICES AT ORLANDO  
REGIONAL HEALTHCARE  
FURNISHED TO UNDOCUMENTED  
ALIENS COVERED BY  
SECTION 1011 OF THE  
MEDICARE PRESCRIPTION DRUG,  
IMPROVEMENT, AND  
MODERNIZATION ACT OF 2003**



Daniel R. Levinson  
Inspector General

February 2009  
A-04-07-07030

# ***Office of Inspector General***

<http://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## ***Office of Audit Services***

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## ***Office of Evaluation and Inspections***

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## ***Office of Investigations***

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## ***Office of Counsel to the Inspector General***

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <http://oig.hhs.gov>

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Social Security Act impose specific obligations on Medicare-participating hospitals that offer emergency services. Section 1867 is frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA). Congress enacted EMTALA in 1986 because of its concerns with an increasing number of reports that hospital emergency rooms were refusing to accept or treat individuals with emergency conditions if the individuals did not have insurance. Under EMTALA, a Medicare-participating hospital is to provide an appropriate medical screening examination to any person, regardless of ability to pay, who comes to the hospital emergency department “to determine whether or not an emergency medical condition [(EMC)] . . . exists” (section 1867(a)). If the examination reveals an EMC, the hospital must also provide either treatment necessary to stabilize the EMC or an appropriate transfer to another medical facility.

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 (MMA). Section 1011 of the MMA, “Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens” (section 1011), provided \$250 million per year for fiscal years 2005 through 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens pursuant to EMTALA requirements.

Orlando Regional Healthcare System, Inc. (ORH), is a Medicare-participating network of health care facilities that also participates in the section 1011 program. With the assistance of the designated section 1011 program contractor, TrailBlazer Health Enterprises, LLC (TrailBlazer), we reviewed 30 judgmentally selected claims totaling \$27,395 that ORH submitted for payment for the period May 10 through September 30, 2005. In total, ORH received \$89,114 for 87 claims for that period.

### **OBJECTIVE**

Our objective was to determine whether claims submitted by ORH for services provided under section 1011 for the period May 10 through September 30, 2005, were submitted on behalf of individuals who met eligibility requirements, were for eligible services, and were adequately supported and not reimbursed from other sources as required by Federal regulations.

### **SUMMARY OF FINDINGS**

From a sample of 30 ORH claims totaling \$27,395, we found that 17 claims totaling \$18,839 were either partially or completely unallowable for section 1011 program reimbursement. As a result, ORH received \$16,568 in unallowable payments. The 17 claims did not meet section 1011 reimbursement requirements because:

- Four claims totaling \$5,581 were for services provided beyond the point of patient stabilization.

- Three claims totaling \$5,014 did not have sufficient documentation to support the patient's eligibility determination.
- Seven claims totaling \$3,962 did not contain sufficient documentation in the medical records to support the services provided.
- One claim totaling \$1,922 was reimbursed by the section 1011 program after a third-party payment.
- Two claims totaling \$89 were for non-EMCs beyond initial screening by the hospital or for services that should have been excluded as having been for nonemergent conditions.

The 13 remaining claims totaling \$8,556 met section 1011 requirements and were eligible for section 1011 program reimbursement.

Although ORH had written policies and procedures that, if followed, might have precluded some of the errors identified, ORH did not always follow its own policies and procedures for ensuring that services were provided pursuant to section 1011 reimbursement requirements. Furthermore, ORH written policies and procedures did not address section 1011 requirements regarding reimbursements from third-party payers.

## **RECOMMENDATIONS**

We recommend that ORH:

- refund to TrailBlazer \$16,568 received for services that did not meet section 1011 reimbursement requirements;
- review the 57 remaining claims for our audit period, totaling \$61,719, and claims for subsequent periods and submit adjustments for any claims that did not meet section 1011 reimbursement requirements;
- follow its existing policies and procedures to ensure that future section 1011 program claims meet section 1011 reimbursement requirements; and
- develop and implement procedures to ensure that reimbursements for services are made to the extent that a third-party payer did not otherwise reimburse care.

## **ORLANDO REGIONAL HEALTHCARE COMMENTS**

In written comments on our draft report, ORH agreed with our recommendations and described its plan of action. ORH's comments appear in their entirety as the Appendix.

**TABLE OF CONTENTS**

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Emergency Medical Treatment and Labor Act.....	1
Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 .....	1
TrailBlazer Health Enterprises.....	2
Orlando Regional Healthcare.....	2
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	2
Objective.....	2
Scope.....	2
Methodology.....	2
<b>FINDINGS AND RECOMMENDATIONS</b> .....	3
<b>FEDERAL REQUIREMENTS</b> .....	4
<b>UNMET FEDERAL REQUIREMENTS</b> .....	5
<b>ORLANDO REGIONAL HEALTHCARE POLICIES AND PROCEDURES</b> .....	6
<b>RECOMMENDATIONS</b> .....	7
<b>ORLANDO REGIONAL HEALTHCARE COMMENTS</b> .....	7
<b>APPENDIX</b>	
<b>ORLANDO REGIONAL HEALTHCARE COMMENTS</b>	

## INTRODUCTION

### BACKGROUND

#### **Emergency Medical Treatment and Labor Act**

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Social Security Act<sup>1</sup> (the Act) impose specific obligations on Medicare-participating hospitals that offer emergency services. Section 1867 is frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA). Congress enacted EMTALA in 1986 because of its concerns with an increasing number of reports that hospital emergency rooms were refusing to accept or treat individuals with emergency conditions if the individuals did not have insurance. Under EMTALA, a Medicare-participating hospital is to provide an appropriate medical screening examination to any person, regardless of ability to pay, who comes to the hospital emergency department “to determine whether or not an emergency medical condition [(EMC)] . . . exists” (section 1867(a)). If the examination reveals an EMC, the hospital must also provide either treatment necessary to stabilize the medical condition or an appropriate transfer to another medical facility.

#### **Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003**

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. No. 108-173)<sup>2</sup> (MMA). Section 1011 of the MMA, “Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens” (section 1011), provided \$250 million per year for fiscal years (FY) 2005 through 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens. Two-thirds of the funds was divided among all 50 States and the District of Columbia based on their relative percentages of undocumented aliens. One-third was divided among the six States with the largest number of undocumented alien apprehensions for each FY.<sup>3</sup> From the respective State allotments, payments were made directly to hospitals, certain physicians, and ambulance providers using Medicare payment rules to calculate the payment amount for some or all of the costs of providing eligible individuals with emergency health care required under section 1867 of the Act and related hospital inpatient, outpatient, and ambulance services.

Payments could be made for services furnished to certain individuals described in the MMA as (1) undocumented aliens, (2) aliens who have been paroled into the United States at a U.S. port of entry for the purpose of receiving eligible services, and (3) Mexican citizens permitted to enter

---

<sup>1</sup>42 U.S.C. §§ 1866(a)(1)(I), 1866(a)(1)(N), and 1867.

<sup>2</sup>The Act, § 1860D-1(a), 42 U.S.C. § 1395w-101(a).

<sup>3</sup>The numbers of undocumented alien apprehensions were determined using the four consecutive quarters ending before the beginning of the FY for which information is available. For FY 2005, the numbers from the period April 1, 2003, to March 31, 2004, were used. During that period, data from the Department of Homeland Security indicated that the six States with the largest number of undocumented alien apprehensions were Arizona, California, Florida, New Mexico, New York, and Texas.

the United States for not more than 72 hours under the authority of a biometric, machine-readable, border-crossing identification card (also referred to as a “laser visa”).

### **TrailBlazer Health Enterprises**

The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, designated TrailBlazer Health Enterprises, LLC (TrailBlazer), as the national processing and compliance contractor for the section 1011 program. TrailBlazer enrolls eligible providers, assists with enrollment and billing questions, and calculates provider payment amounts. In addition, TrailBlazer conducts prepayment or postpayment claim reviews, identifies and assesses overpayments if necessary, and ensures compliance with section 1011.

### **Orlando Regional Healthcare**

Orlando Regional Healthcare System, Inc. (ORH), is a Medicare-participating network of health care facilities that also participates in the section 1011 program.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether claims submitted by ORH for services provided under section 1011 for the period May 10 through September 30, 2005, were submitted on behalf of individuals who met eligibility requirements, were for eligible services, and were adequately supported and not reimbursed from other sources as required by Federal regulations.

### **Scope**

Our review covered services provided during the period May 10 through September 30, 2005. For this period, ORH received section 1011 program payments of \$89,114 for 87 claims.

We limited our review of internal controls to obtaining an understanding of the procedures for implementing the section 1011 program.

We conducted fieldwork at TrailBlazer in Dallas, Texas, and at ORH in Orlando, Florida.

### **Methodology**

To accomplish our objective, we:

- met with and maintained ongoing communications with TrailBlazer officials;
- reviewed applicable laws, regulations, and CMS guidelines regarding the section 1011 program;

- obtained and reviewed a listing of all emergency health claims submitted, approved, and paid under the section 1011 program during the audit period;
- obtained and reviewed a listing of all approved section 1011 program providers;
- selected for review a judgmental sample of 30 section 1011 program claims submitted by ORH;
- interviewed ORH officials to obtain an understanding of the policies, procedures, and controls relating to the section 1011 program;
- obtained and reviewed the medical records and other documentation associated with the selected claims;
- requested TrailBlazer to perform a review of the medical and nonmedical documentation associated with the selected claims to determine whether:
  - claims were made on behalf of individuals who met eligibility criteria,
  - claims were for services that met the definition of emergency health services,
  - claims were for services provided during the patient’s stabilization period,
  - claims were made for properly supported services, and
  - providers exercised due diligence in ensuring that section 1011 program payments were the payments of last resort; and
- requested that TrailBlazer quantify any overpayments.

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 objective.

### **FINDINGS AND RECOMMENDATIONS**

From a sample of 30 ORH claims totaling \$27,395, we found that 17 claims totaling \$18,839 were either partially or completely unallowable for section 1011 program reimbursement. As a result, ORH received \$16,568 in unallowable payments. The 17 claims did not meet section 1011 program reimbursement requirements because:

- Four claims totaling \$5,581 were for services provided beyond the point of patient stabilization.

- Three claims totaling \$5,014 did not have sufficient documentation to support the patient’s eligibility determination.
- Seven claims totaling \$3,962 did not contain sufficient documentation in the medical records to support the services provided.
- One claim totaling \$1,922 was reimbursed by the section 1011 program after a third-party payment.
- Two claims totaling \$89 were for non-EMCs beyond initial screening by the hospital or for services that should have been excluded as having been for nonemergent conditions.

The 13 remaining claims totaling \$8,556 met section 1011 requirements and were eligible for section 1011 program reimbursement.

Although ORH had written policies and procedures that, if followed, might have precluded some of the errors identified, ORH did not always follow its own policies and procedures for ensuring that emergency medical services were provided pursuant to section 1011 reimbursement requirements. Furthermore, ORH written policies and procedures did not address section 1011 requirements regarding reimbursements from third-party payers.

## **FEDERAL REQUIREMENTS**

Section 1011 sets forth the requirements governing Federal reimbursement of emergency health services furnished to undocumented aliens. CMS issued as additional guidance a final implementation notice delineating CMS’s section 1011 program implementation approach, general framework, procedural rules, and general statements of policy. In addition, 42 CFR § 482.24(b) and (c) establishes medical record requirements for hospitals. The requirements for each finding follow:

- **Point of Stabilization**—Section VI of CMS’s final implementation notice (70 Fed. Reg. 25,583 (May 13, 2005)) states that section 1011 program payments will be made for eligible services that begin when an individual arrives at the hospital emergency department and requests examination or treatment for a medical condition. If the hospital determines that the individual has an EMC, the hospital must either provide stabilizing treatment or transfer the individual. To be considered stable, a patient’s EMC must be resolved, even though the underlying medical condition may persist.
- **Adequate Eligibility Documentation**—Section IX of CMS’s final implementation notice (70 Fed. Reg. 25,587 (May 13, 2005)) states that because section 1011 program payments are authorized only for the three categories of noncitizens specified in section 1011(c)(5), providers are required to request, collect, and maintain information about the patient’s eligibility. Although providers are not required to use the information collection instrument designed by CMS, they must collect and maintain all of the information contained in the approved information collection instrument. If a patient

refuses to or is unable to provide proof of eligibility, the provider should not submit an individual claim for the services delivered to that patient.

- **Content of Medical Records**—Hospitals must maintain a medical record for each inpatient and outpatient (42 CFR § 482.24(b)) to “. . . justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services” (42 CFR § 482.24(c)). Records must document evidence of a physical examination, admitting diagnosis, results of all consultative evaluations of the patient, practitioners’ orders, nursing notes, discharge summary, and final diagnosis, among other information (42 CFR § 482.24(c)(2)).
- **Third-Party Payer**—Section 1011(c)(1) states that payments to providers will be made to the extent that care was not otherwise reimbursed for the services during that FY. In its final implementation notice, CMS states that allowing providers to seek reimbursement from all available funding sources is consistent with the statutory intent of section 1011 and limits section 1011 program reimbursement to those instances for which no other reimbursement is likely to be received.
- **Eligible Services**—Section 1011(c)(4) states that “[p]ayments made to eligible providers . . . may only be used for costs incurred in providing eligible services to aliens.” Paragraph (e)(2) of section 1011 defines eligible services as “health care services required by the application of section 1867 of the . . . Act . . . , and related hospital inpatient and outpatient services and ambulance services.” Eligible healthcare services are described in section 1867 as those provided to treat emergency medical conditions, which are defined as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child [section 1867(e)(1)].

## **UNMET FEDERAL REQUIREMENTS**

ORH submitted 17 claims totaling \$18,839 that were either partially or completely unallowable for section 1011 program reimbursement. As a result, ORH received \$16,568 in payments that did not meet section 1011 program reimbursement requirements during our audit period:

- For four claims, ORH received section 1011 program funds for services provided after the patient was stabilized. For these four claims, we reviewed the patient's entire medical record and found that ORH provided treatment and stabilized the patient's EMC. However, ORH did not follow section VI of CMS's final implementation notice because it submitted claims for the patient's entire stay instead of submitting claims for only the services provided through stabilization. ORH staff stated that they did not have enough personnel to go over the medical record, determine the point of stabilization, and submit a claim for charges up to the point of stabilization. ORH received \$5,581 in unallowable payments for these four claims.
- For three claims, the documentation provided did not support the patient's eligibility determination. ORH contracted with vendors to screen individuals and collect supporting documentation as required by section 1011. However, for these three claims, ORH did not collect and maintain in the medical records all of the information required by the CMS-approved information collection instrument to support the patients' eligibility determination. ORH received \$5,014 in unallowable payments for these three claims.
- For seven claims, ORH submitted claims for services that did not have adequate supporting documentation, such as progress notes, doctor's orders, emergency records, nursing notes, and discharge summaries, as required by 42 CFR § 482.24(b) and (c). ORH received \$3,962 in unallowable payments for these seven claims.
- For one claim, ORH failed to inform TrailBlazer that ORH had received a \$10,000 payment from a third-party payer. ORH submitted a claim and received a section 1011 program payment of \$1,922 for the same claim. Because the third-party payer amount exceeded the section 1011 approved amount, we considered the third-party payer amount as payment in full. ORH received a \$1,922 unallowable payment for this claim.
- For two claims, the treatments provided were not for an EMC. We determined that the treatments provided were nonemergency and therefore did not meet the definition of an EMC as required by section 1011. ORH submitted claims to the section 1011 program for two follow-up visits related to a previous EMC. The EMC was treated and the patient was sent home on June 3, 2005, with doctor's instructions to come back for follow-up treatment. The patient came back to the emergency department on June 5 and 8, 2005, and received follow-up treatments. ORH received \$89 in unallowable payments for these two claims.

## **ORLANDO REGIONAL HEALTHCARE POLICIES AND PROCEDURES**

Although ORH had written policies and procedures that, if followed, might have precluded some of the errors that TrailBlazer identified, ORH did not always follow its own policies and procedures for ensuring that services were provided up to the point of stabilization, medical records contained sufficient documentation to support eligibility determinations and the services provided, and treatments were for EMCs.

Furthermore, ORH written policies and procedures did not address section 1011 requirements regarding reimbursements from third-party payers.

## **RECOMMENDATIONS**

We recommend that ORH:

- refund to TrailBlazer \$16,568 received for services that did not meet section 1011 reimbursement requirements;
- review the 57 remaining claims for our audit period, totaling \$61,719, and claims for subsequent periods and submit adjustments for any claims that did not meet section 1011 reimbursement requirements;
- follow its existing policies and procedures to ensure that future section 1011 program claims meet section 1011 reimbursement requirements; and
- develop and implement procedures to ensure that reimbursements for services are made to the extent that a third-party payer did not otherwise reimburse care.

## **ORLANDO REGIONAL HEALTHCARE COMMENTS**

In written comments on our draft report, ORH agreed with our recommendations and described its plan of action. ORH's comments appear in their entirety as the Appendix.

# **APPENDIX**

Oct. 9. 2008 3:45PM

No. 0563 P. 2/2



When it matters most.

1414 Kuhl Ave.  
Orlando, FL 32806  
321.843.7000

orlandohealth.com

October 7, 2008

Peter J. Barbera  
Regional Inspector General for Audit Services  
Region IV  
61 Forsyth Street, S. W. Suite 3T41  
Atlanta, Georgia 30303

Report Number: A-04-07-07030

Dear Mr. Barbera:

This letter is in response to the above report number regarding "Review of Emergency Health Services Furnished to Undocumented Aliens covered by Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 at Orlando Regional Healthcare." We appreciate the opportunity to review and respond to your summary of findings and recommendations. The total charges Orlando Regional Healthcare experienced for the Undocumented Aliens for the period of May 2005 through August 2008 was in excess of twelve million dollars. The reimbursement provided to Orlando Regional Healthcare under the Section 1011 program was less than three percent of the total charge amount.

We agree with the recommendations in the report and have listed our plan of action below:

- ◆ Orlando Regional Healthcare will refund to Trailblazer in the amount of \$16,568 received for services that did not meet section 1011 reimbursement requirements by November 1, 2008;
- ◆ Orlando Regional Healthcare will review the 57 remaining claims within the next six months of the audit period and over the next twelve months all claims that were reimbursed by Trailblazer will be reviewed;
- ◆ Orlando Regional Healthcare will reeducate our financial assistance department and billing team by November 1, 2008 regarding the guidelines of the Federal Reimbursement of emergency Health Services furnished to undocumented aliens;
- ◆ Orlando Regional Healthcare will review internal operational processes ensure all claims be reviewed for the point of stabilization period and ensure patients do not have a third-party payer prior to submitting payment request to Trailblazer starting October 6, 2008.

If you need additional information please contact Bridget B. Walters, Manager, at (407)650-3771.

Sincerely,

Keith Eggert, FHFMA  
Vice President, Revenue Management  
Orlando Health, Inc.

B-140