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November 2026 | A-07-21-05134

Wellstar Cobb Hospital Received At Least $1 Million in Medicare Overpayments

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Why OIG Did This Audit

- For calendar year 2021, Medicare paid hospitals $182 billion, which represents 46 percent of all fee-for-service payments; accordingly, it is important that hospital payments comply with requirements.
- This audit is part of a series of audits examining hospitals with a high volume of claims previously identified as high-risk for noncompliance.
- Wellstar Cobb Hospital (the Hospital) was selected because it submitted a substantial number of potentially high-risk claims to Medicare.

What OIG Found

- Of the 104 inpatient claims we reviewed totaling $2.4 million, the Hospital complied with Medicare billing requirements for 89 claims. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 15 claims, resulting in overpayments of $404,074 from January 1, 2020, through December 31, 2021 (audit period).
- We estimated that, of the $11.8 million Medicare paid the Hospital, the Hospital received overpayments of at least $1 million for selected types of inpatient services that did not comply with Medicare requirements during the audit period.
- The errors occurred primarily because the Hospital did not always follow its written policies and procedures to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

What OIG Recommends

We recommend that the Hospital refund to the Federal Government the $1 million in estimated overpayments, consider conducting internal audits for claims after our audit period based on the risks identified by this audit, and provide additional training regarding Medicare billing requirements. The full recommendations are in the report.

The Hospital did not concur with any of our findings or recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

For calendar year 2021, Medicare paid hospitals $182 billion, which represented 46 percent of all fee-for-service payments. This audit is part of a series of hospital compliance audits. Previous Office of Inspector General (OIG) audits at other hospitals identified certain types of inpatient and outpatient hospital claims as being at risk for noncompliance.[1] Using computer matching, data mining, and other data analysis techniques, we identified hospitals with a disproportionate number of these claims. We selected Wellstar Cobb Hospital (the Hospital) for this audit because it was one of those hospitals that had a substantial number of claims submitted to Medicare in areas OIG designated as high-risk.[2]

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims from January 1, 2020, through December 31, 2021 (audit period).[3]

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for enrollees 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 Administrative Contractors (MACs) to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

Under the inpatient prospective payment system (PPS), CMS pays hospital costs at predetermined rates for enrollee discharges.[4] The rates vary according to the diagnosis-related

[1] Hospital compliance audit reports issued by OIG are published on the OIG Website.

[2] Submitting claims that are at risk for noncompliance does not by itself mean the claims were noncompliant. Determinations of noncompliance are completed by independent medical review.

[3] These were the most recent data available at the time we started this audit.

[4] The inpatient PPS pays the costs of inpatient stays at acute care hospitals, also known as "subsection (d) hospitals" because they are defined at section 1886(d)(1)(B) of the Social Security Act (the Act). Inpatient Rehabilitation Facilities (IRFs) are excluded from this definition and are not paid under the inpatient PPS. We discuss and treat IRF claims separately.

group (DRG) to which an enrollee's stay is assigned and the severity level of the enrollee'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 enrollee'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 enrollees who require a hospital level of care, including an 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 PPS for IRFs. Under the payment system, CMS established Federal prospective payment rates for distinct case-mix groups (CMGs). The assignment to a CMG is based on the enrollee's clinical characteristics and expected resource needs.

Hospital Claims at Risk for Incorrect Billing

We reviewed the following OIG-designated high-risk areas as part of this audit:

- IRF claims
- Inpatient claims with the following:
    - Comprehensive error rate testing (CERT) error-prone DRG codes[5]
    - High-severity level DRG codes
    - Short stays[6]
    - Claims paid in excess of charges
    - DRGs for severe malnutrition

[5] 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. As a result of our analysis of CERT data, we identified seven DRGs that are most at risk for billing errors: 069, 074, 313, 470, 515, 516, and 563.

[6] Under Medicare requirements, "an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights" (42 CFR § 412.3(d)(1)). A "short stay" is an inpatient admission of less than 2 midnights. Medicare covers short stays in limited circumstances, including "[w]here the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights . . . based on the clinical judgment of the admitting physician and medical record support for that determination" (42 CFR § 412.3(d)(3)).

- Mechanical ventilation
- Same-day discharge and readmission

For the purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas."

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

Limitation on Recovery of Overpayments

MACs may reopen a claim for good cause within 4 years from the date of the initial determination or redetermination.[7] Palmetto GBA, Inc., the Hospital's MAC, reopened all claims in our audit sampling frame within 4 years from the date of the initial determination of each of those claims.

Section 1870 of the Act prohibits the recovery of Medicare fee-for-service overpayments if the provider was without fault with respect to the overpayment.[8] A provider is presumed to be without fault for Medicare fee-for-service overpayments if the overpayment determination is made by the Medicare program after the fifth year following the year in which notice of such payment was sent to the provider.[9] MACs typically waive recovery in accordance with this

[7] 42 CFR § 405.980(b)(2).

[8] Section 1870; 78 Fed. Reg. 74230, 74445 (Dec. 10, 2013); *Medicare Financial Management Manual*, chapter 3, §§ 70.3 and 80.

[9] Section 1870; 78 Fed. Reg. 74230, 74445 (Dec. 10, 2013); *Medicare Financial Management Manual*, chapter 3, §§ 70.3 and 80.

presumption, but have the authority to determine whether there is sufficient evidence to rebut the presumption.

Wellstar Cobb Hospital

The Hospital is a 387-bed, short-term, acute-care hospital located in Austell, Georgia. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately $169 million for 10,606 inpatient claims during the audit period.

HOW WE CONDUCTED THIS AUDIT

Our audit covered roughly $12 million in Medicare payments made to the Hospital for 645 claims in the risk areas identified above.[10] We selected for review a stratified random sample of 104 claims (25 IRF and 79 inpatient) with Medicare payments totaling about $2.4 million made during our audit period.[11]

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.

Appendix A contains the details of our audit scope and methodology.

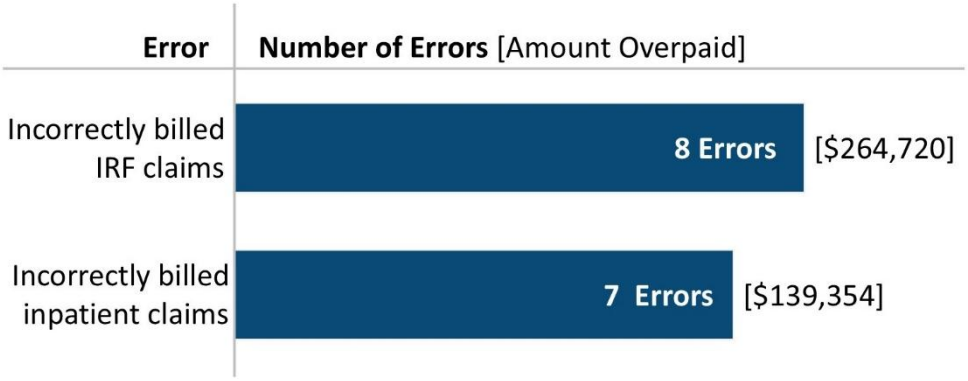
FINDINGS

The Hospital complied with Medicare billing requirements for 89 of the 104 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 15 claims, resulting in overpayments of $404,074 for the audit period. Figure 1 on the following page provides a breakdown of the error types, the number of claims in error, and the associated overpayments.

[10] The total Medicare payments were $11,820,542.

[11] The total Medicare payments were $2,417,414.

Figure 1: Billing Errors



The errors occurred primarily because the Hospital did not always follow its policies and procedures to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

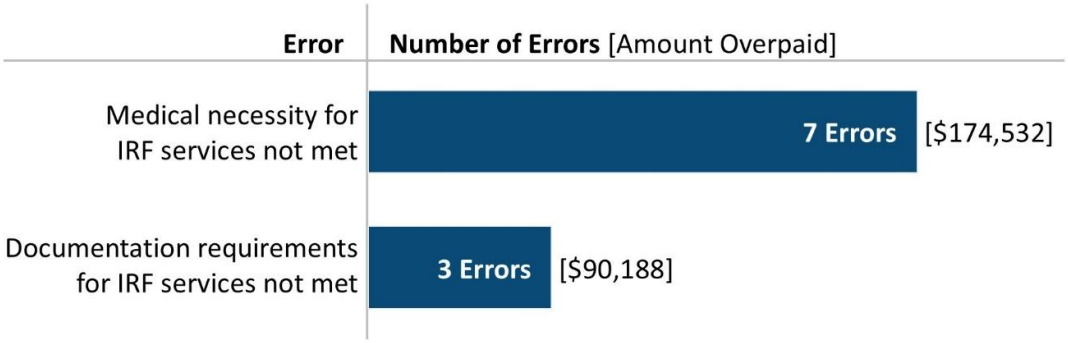
On the basis of our sample results, we estimated that the Hospital received overpayments of at least $1 million for the audit period.[12] See Appendix B for statistical sampling methodology, Appendix C for sample results and estimates, and Appendix D for the results of our audit by risk area.

INCORRECTLY BILLED INPATIENT REHABILITATION FACILITY CLAIMS

For 8 of the 25 selected IRF claims, our independent medical review contractor determined that the Hospital incorrectly billed Medicare Part A for enrollee stays that did not meet Medicare criteria for inpatient rehabilitation services. Overpayments associated with these eight claims that did not meet Medicare requirements totaled $264,720, as shown in Figure 2 on the following page.

[12] Our actual estimate is $1,020,828. 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.

Figure 2: Inpatient Rehabilitation Facility Billing Errors*



*The number of errors associated with each error category will not match the total number of claims in error (eight) because some claims had multiple error types.

Medical Necessity for Inpatient Rehabilitation Facility Services Not Met

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 enrollee: (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 supervision by a rehabilitation physician (42 CFR § 412.622(a)(3)(i—iv)). During the COVID-19 Public Health Emergency, the second requirement and the "intensive" nature of rehabilitation therapy in the third requirement were waived (42 CFR § 412.622(a)(3)(ii-iii)).

For 7 of the 25 selected IRF claims, the Hospital incorrectly billed Medicare Part A for enrollee stays that did not meet Medicare criteria for acute inpatient rehabilitation because the enrollees did not reasonably require supervision by a rehabilitation physician. Overpayments associated with these seven claims totaled $174,532.

Documentation Requirements for Inpatient Rehabilitation Facility Services Not Met

Federal regulations mandate that an IRF enrollee must require an interdisciplinary team (IDT) approach to care, as evidenced by documentation in the enrollee's medical record of weekly IDT meetings that are led by the rehabilitation physician. The documentation must support that the IDT reviewed the enrollee's progress toward stated rehabilitation goals at each meeting and identified any problems that could impede progress toward those goals. Furthermore, the results and findings of weekly IDT meetings—and the concurrence by the rehabilitation physician with the results and findings—should be retained in the enrollee's medical record (42 CFR § 412.622(a)(5)(i-iii)).

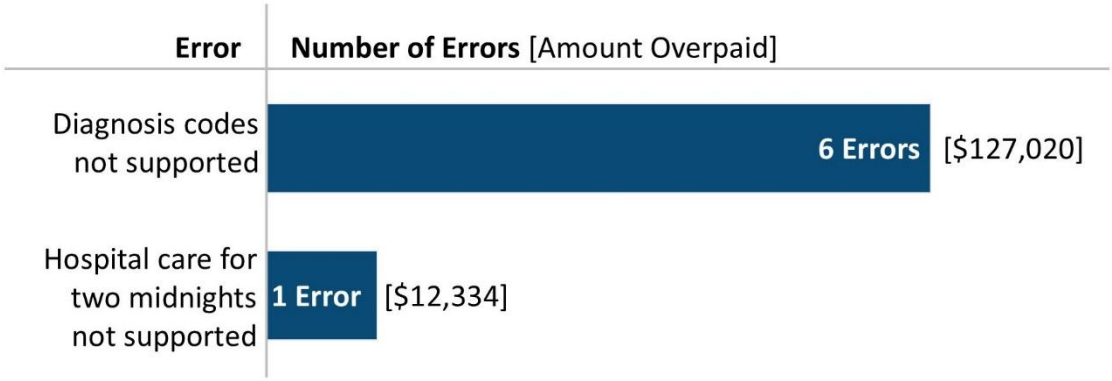
For 3 of the 25 selected IRF claims, the Hospital billed Medicare Part A for enrollee stays that did not meet IRF Medicare documentation requirements because the rehabilitation physician did

not lead the IDT meeting or document concurrence with the IDT's progress notes and goals. Overpayments associated with these three claims totaled $90,188.

INCORRECTLY BILLED INPATIENT CLAIMS

For 7 of the 79 selected inpatient claims, our independent medical review contractor determined that the Hospital incorrectly billed Medicare Part A for enrollee stays that did not meet Medicare criteria for inpatient services at acute care hospitals. These errors resulted in overpayments totaling $139,354. Figure 3 provides a breakdown of the error types, number of claims in error, and the associated overpayments.

Figure 3: Inpatient Billing Errors



Diagnosis Codes Not Supported

DRG codes are assigned to specific hospital discharges based on claims data submitted by hospitals (42 CFR § 412.60(c)), so claims data must be accurate.

For 6 of the 79 selected inpatient claims, the Hospital submitted claims to Medicare that had principal diagnosis codes that were not supported by the medical records. The incorrectly coded claims resulted in payments for incorrect DRGs to the Hospital. Overpayments associated with these six claims totaled $127,020.

Hospital Care for Two Midnights Not Supported

No payment may be made under Medicare Part A for any expenses incurred 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)).

Federal regulations provide that an inpatient admission, and subsequent payment under Medicare Part A, is appropriate if the ordering physician expects the enrollee to require care for a period that crosses two midnights (42 CFR § 412.3(d)(1)).[13]

For 1 of the 79 selected inpatient claims, the medical records did not support that it was reasonable for the admitting physician, at the time the inpatient order was written, to have expected that hospital care was required for a period that crosses two or more midnights.[14] Overpayments associated with this one claim totaled $12,334.

Two-Midnight Stay Was Not Supported

One enrollee was admitted to an observation bed for short-term treatment and assessment to determine whether inpatient admission was necessary. Laboratory and diagnostic testing were unremarkable, and no documented orders for additional laboratory testing or imaging existed. All the ordered consultations, apart from physical therapy, had been completed, and the hospital medicine note indicated an expected discharge within 24 hours. Therefore, documentation did not support that it was reasonable for the admitting physician to expect that the enrollee would require care across two or more midnights.

HOSPITAL STAFF DID NOT ALWAYS FOLLOW PROCEDURES TO PROPERLY BILL HOSPITAL SERVICES

The 15 incorrectly billed claims did not comply with Medicare requirements because staff did not consistently follow the Hospital's written policies related to IRF medical necessity and documentation requirements, inpatient coding, and the Two-Midnight Rule. Although Hospital officials contended that the claims met Medicare requirements, they did not provide any additional information that would affect our findings.

[13] We refer to this regulation as the "Two-Midnight Rule" throughout the report.

[14] Our medical review contractor also determined that 13 of the 79 selected claims did not meet InterQual® Level of Care criteria for inpatient hospital admission. These criteria are evidence-based clinical decision support tools that many hospitals use to help assess clinical appropriateness and strengthen patient outcomes. Failure to meet InterQual Level of Care criteria does not equate with failure to meet Medicare requirements, but we believe this is useful information for the Hospital for its quality assurance efforts. See the "Other Matters" section for additional information.

RECOMMENDATIONS

- We recommend that the Hospital refund to the Federal Government the estimated $1,020,828 in overpayments for incorrectly billed claims, excluding amounts presumed to be unrecoverable under the section 1870 waiver of liability provision.[15, 16]

- We recommend that the Hospital consider conducting one or more internal audits or investigations for claims after our audit period, based on the risks identified by this audit, to identify any similar overpayments the Hospital might have received and return any identified overpayments to the Medicare program.

- We recommend that the Hospital provide additional training to clinical and billing personnel on its policies and procedures related to IRF medical necessity and documentation requirements, inpatient coding, and the Two-Midnight Rule.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital disagreed with our findings that it received at least $1,020,828 in Medicare overpayments during the audit period, and it did not concur with any of our recommendations. The Hospital stated that the claims at issue were supported by clinical documentation, coding, billing, and payment requirements, as well as the applicable Medicare coverage. The Hospital further stated that our audit relied on a limited review of select high-risk areas rather than an overall assessment of the Hospital's Medicare billing compliance. Additionally, the Hospital disagreed with our overpayment amount because the amount was extrapolated from a sample rather than determined through final Medicare overpayment determinations. The Hospital also provided additional comments regarding the characterization of certain findings and the use of commercial screening tools. Finally, the Hospital requested that we revise our draft report to remove the overpayment finding and withdraw our recommendations. We summarize the Hospital's comments below.

After reviewing the Hospital's comments, we maintain that all our findings and recommendations are valid.

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[15] OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Parts A and Part B appeals processes have five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

[16] Palmetto GBA, Inc., retains the authority to determine whether there is sufficient evidence to rebut the Section 1870 "fifth year following" "without fault" presumption that might limit the recovery of any of these overpayments.

The Hospital's comments are included as Appendix E.

RESPONSES TO AUDIT RECOMMENDATIONS

Hospital Comments

The Hospital did not concur with any of our recommendations. Regarding our first recommendation, the Hospital stated that our recommended refund is based on an extrapolated estimate and disputed both the underlying determinations that the sampled claims were improperly billed and the use of an extrapolated estimate derived from a limited sample of claims in selected risk areas. The Hospital further stated that a refund is not warranted based on the findings in our report.

Regarding our second recommendation, the Hospital disagreed with our overpayment finding and recommendation, and added that therefore, it does not believe there is a basis to require additional internal audits or investigations. The Hospital noted, however, that it remains committed to ongoing monitoring and improvement and that it continuously evaluates its billing, coding, clinical documentation, compliance, and utilization review controls as part of its existing compliance program.

Regarding our third recommendation, the Hospital maintained that its personnel followed applicable processes and that the claims at issue were supported by the medical records and applicable Medicare requirements. The Hospital indicated that it would continue to provide education and guidance as appropriate through its established compliance and revenue cycle education programs but did not agree that corrective training is needed based on the alleged noncompliance.

Office of Inspector General Response

For our first recommendation, we disagree with the Hospital's assertion that the claims at issue were billed in compliance with Medicare requirements. We submitted the selected claims to an independent medical review contractor that reviewed the medical records in their entirety to determine whether the services were medically necessary and were provided in accordance with Medicare requirements. We worked with our medical review contractor to ensure that their review was conducted by experienced professionals, including physicians and coders with relevant expertise, and that the appropriate Medicare criteria were applied. In addition, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[17] The Hospital has the right to

[17] See *Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 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 at *17 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

appeal any overpayment determinations and recovery actions taken by CMS or the MAC (footnote 15).

For our second recommendation, we disagree that our calculation of the overpayment is inaccurate and continue to believe that the Hospital should conduct internal audits or investigations for claims after our audit period. Our medical review contractor identified errors in several inpatient risk categories, which indicate that these errors are not isolated and similar issues may exist.

Finally, we do not agree with the Hospital that its personnel followed applicable processes and that the claims at issue were supported by the medical records and applicable Medicare requirements. Notwithstanding the Hospital's existing compliance and training programs, we identified multiple errors in several categories. We continue to believe that additional training should be provided to increase compliance with Medicare requirements.

ADDITIONAL COMMENTS ON DRAFT REPORT FINDINGS

Hospital Comments

The Hospital disagreed with the draft report's characterization of findings related to IRF medical necessity, IRF documentation, inpatient diagnosis coding, and the Two-Midnight Rule. The Hospital objected to any implication that the use of a commercial screening tool, such as InterQual® criteria, establishes noncompliance with Medicare requirements. The Hospital requested that we revise the draft report to remove the overpayment finding and our recommendations.

Office of Inspector General Response

We acknowledge the Hospital's concerns regarding the use of a commercial screening tool. However, our findings are based on a comprehensive review of the medical records and applicable Medicare requirements. As stated in the report, 89 of 104 inpatient claims met Medicare requirements, despite some of the claims not meeting InterQual® criteria, and we did not include those claims as errors in our report. We do not contend that CMS requires a commercial screening tool. We believe, though, that the use of such a tool can increase the strength of the Hospital's internal controls that are part of its compliance program.

OTHER MATTERS

During our audit period, CMS required its medical review contractors to use a screening tool as part of their medical review of acute inpatient PPS claims (*Medicare Program Integrity Manual* (*MPIM*), chapter 6, § 6.5.1). These tools are typically used by hospitals and reviewers to assess

the appropriateness of inpatient and other levels of care. CMS did not require that the contractor use a specific tool, nor does CMS or the OIG endorse any specific tool.[18]

In prior hospital compliance audits, in response to findings that claims did not meet Medicare inpatient admission requirements, several auditees noted that their documentation submitted to support audited claims met the criteria in InterQual® or Milliman Care Guidelines (MCG) (the predecessor to current MCG Care Guidelines) screening tools.[19]

As part of this audit, we asked our independent medical review contractor to apply clinical screening criteria to review the Hospital's inpatient PPS claims. This was done for informational purposes to provide the auditee with additional information that might assist it with its compliance and utilization review programs.

The contractor used InterQual® criteria to evaluate the 79 inpatient claims selected in our sample. For 13 of those claims, our independent medical review contractor found that the admissions did not meet InterQual® criteria.[20] Although those claims do not constitute a failure to meet Medicare requirements, the results of our audit suggest that properly applying a screening tool to the Hospital's compliance or utilization review programs would reduce inappropriately billed claims.

[18] Several commercially available screening tools exist, including InterQual® Level of Care Criteria, Milliman Care Guidelines Inpatient & Surgical Care Guidelines, and other proprietary systems.

[19] For example, see *Medicare Hospital Provider Compliance Audit: Lake Hospital System* (A-05-19-00024), June 30, 2021, and *Medicare Hospital Provider Compliance Audit: St. Vincent Hospital* (A-05-18-00040), Nov. 27, 2019.

[20] One of these inpatient claims was reported as an error for not meeting the Two-Midnight Rule.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $11,820,542 in Medicare payments to the Hospital for 645 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 104 claims (25 IRF and 79 inpatient) with payments totaling $2,417,414.[21] Medicare paid these 104 claims from January 1, 2020, through December 31, 2021 (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.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

During our audit, we did not assess the overall internal control structure of the Hospital. Rather, we limited our review to the Hospital's internal controls for compliance with Medicare billing requirements. To evaluate these internal controls, we:

- Interviewed Hospital officials regarding the Hospital's internal controls for compliance with Medicare billing requirements that related to the risk areas we identified

- Obtained an understanding of the Hospital's policies and procedures related to IRF medical necessity and documentation requirements, inpatient coding, and the Two-Midnight Rule by reviewing an internal control questionnaire

- Reviewed a stratified random sample of 25 IRF claims and 79 inpatient claims to determine if claims were properly billed and reimbursed

- Discussed with Hospital officials the cause of the identified errors

[21] For claim selection, CMS instructs Medicare review contractors to apply the "Two-Midnight Presumption" and avoid reviewing stays spanning two or more midnights, unless there is evidence of systemic abuse, gaming, or care delays (*MPIM*, chapter 6, § 6.5.2). The Two-Midnight Presumption is CMS guidance directing Medicare reviewers to presume that an inpatient admission is appropriate and medically necessary when an enrollee remains in the hospital for at least two midnights after a physician orders inpatient status unless there is evidence of abuse. However, OIG is not constrained by the Two-Midnight Presumption for the purpose of selecting claims for review.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and guidance
- Extracted the Hospital's inpatient 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
- Created a sampling frame of paid Medicare claims from selected risk areas consisting of 645 claims with a total paid amount of $11,820,542
- Selected a stratified random sample of 104 claims (25 IRF and 79 inpatient) with payments totaling $2,417,414
- Reviewed data from the Recovery Audit Contractor Data Warehouse for the claims included in the sample to determine whether the claims had been previously reviewed
- Obtained from the Hospital all supporting documentation for the claims in our sample
- Used an independent medical review contractor to determine whether all claims complied with selected billing requirements
- Calculated the overpayments for those claims requiring adjustments
- Used the results of the sample review to calculate the estimated Medicare overpayment to the Hospital in the sampling frame (Appendix C)
- Discussed the results 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

Our sampling frame contained 654 Medicare paid claims in 8 risk areas totaling $11,820,542 from which we selected our sample (Table 1). The sampling frame included claims:

- With only certain discharge status and diagnosis codes
- With payments greater than $0
- Not under review by the Recovery Audit Contractor as of April 7, 2022

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: IRF Claims, Inpatient Claims Billed with High CERT DRG Codes, Inpatient Claims Billed with High-Severity Level DRG Codes, Inpatient Short-Stay Claims of Less Than 2 Midnights, Inpatient Claims Paid In Excess of Charges, Inpatient Claims Billed with Severe Malnutrition, Inpatient Claims Billed with Mechanical Ventilation, and Inpatient Claims Covering Same Day Readmission.

Table 1: Risk Areas

Medicare Risk Area	Frame Size	Value of Frame
1. IRF Claims	125	$3,776,255
2. Inpatient Claims Billed With High CERT DRG Codes	265	3,105,148
3. Inpatient Claims Billed With High-Severity Level DRG Codes	134	1,683,540
4. Inpatient Short-Stay Claims of Less Than 2 Midnights	67	1,108,582
5. Inpatient Claims Paid In Excess of Charges	13	301,848
6. Inpatient Claims Billed With Severe Malnutrition	28	1,378,377
7. Inpatient Claims Billed With Mechanical Ventilation	9	395,979
8. Inpatient Claims Covering Same Day Readmission	4	70,813
Total	**645**	**$11,820,542**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We grouped the sampling frame into strata based on risk areas in Table 1, resulting in five strata. Stratum 1 includes all claims from risk area 1; stratum 2 includes all claims from risk areas 2, 3, 5, and 7; stratum 3 includes all claims from risk area 4;

stratum 4 includes all claims from risk area 6; and stratum 5 includes all claims from risk area 8. All claims were unduplicated, appearing in only one risk area and only once in the entire sampling frame.

We selected 104 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 Risk Area 1	125	$3,776,255	25
2	Inpatient Risk Areas 2, 3, 5, and 7	421	5,486,515	25
3	Inpatient Risk Area 4	67	1,108,582	25
4	Inpatient Risk Area 6	28	1,378,377	25
5	Inpatient Risk Area 8	4	70,813	4
	Total	**645**	**$11,820,542**	**104**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We sorted the items in each stratum by a unique claim identifier, and then consecutively numbered the items in strata 1, 2, 3, and 4. After generating the random numbers in accordance with our sample design, we selected the corresponding frame items for review. We selected all four claims in stratum 5.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments in the sampling frame made to the Hospital at the lower limit of the two-sided 90-percent confidence interval (Appendix C). 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 Details and 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	125	$3,776,255	25	$724,685	8	$264,720
2	421	5,486,515	25	309,360	2	15,541
3	67	1,108,582	25	414,694	1	12,334
4	28	1,378,377	25	897,862	3	80,500
5	4	70,813	4	70,813	1	30,979
Total	**645**	**$11,820,542**	**104**	**$2,417,414**	**15**	**$404,074**

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

Point estimate	$1,739,505
Lower limit	1,020,828
Upper limit	2,458,182

APPENDIX D: RESULTS OF AUDIT BY RISK AREA

Table 5: Sample Results by Risk Area*

Risk Area	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
IRF Claims	25	$724,685	8	$264,720
IRF Total	**25**	**$724,685**	**8**	**$264,720**
Inpatient Billed With Severe Malnutrition	25	$897,862	3	$80,500
Inpatient Covering Same Day Readmission	4	70,813	1	30,979
Inpatient Short Stays of Less Than 2 Midnights	25	414,694	1	12,334
Inpatient Billed With High-Severity Level DRG Codes	10	110,177	1	8,843
Inpatient Billed With High CERT DRG Codes	15	199,182	1	6,698
Inpatient Totals	**79**	**$1,692,728**	**7**	**$139,354**
IRF and Inpatient Totals	**104**	**$2,417,413†**	**15**	**$404,074**

* The table above illustrates the results of our audit by risk area. We organized inpatient claims by the risk areas we reviewed. However, we organized this report's findings by the types of billing errors we found at the Hospital. Because the information is organized differently, the information in the individual risk areas in this table does not precisely match the information in the Findings section of this report.

† Amounts in the report may differ due to rounding.

Wellstar
HEALTH SYSTEM

September 18, 2026

Response to OIG Draft Report A-07-21-05134

James I. Korn
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
Office of Inspector General
U.S. Department of Health and Human Services
1201 Walnut Street, Suite 1309
Kansas City, MO 64106

Re: Response to Draft Report A-07-21-05134, *Wellstar Cobb Hospital Received At Least $1 Million in Medicare Overpayments*

Dear Mr. Korn:

Wellstar Cobb Hospital appreciates the opportunity to respond to the Office of Inspector General's draft report. After careful review, the Hospital respectfully disagrees with the draft report's conclusion that it received at least $1,020,828 in Medicare overpayments during the audit period and does not concur with any of the draft report's recommendations.

The Hospital's nonconcurrence is based on the following: the Hospital maintains that the claims at issue were supported by the clinical documentation and applicable Medicare coverage, coding, billing, and payment requirements; the draft report relies on a limited review of selected high-risk areas rather than an overall assessment of the Hospital's Medicare billing compliance; and the overpayment amount is extrapolated from a sample rather than determined through final Medicare overpayment determinations.

Wellstar Health System
Compliance Department
1800 Parkway Place | Marietta, GA 30067

Response to Recommendation 1: Refund the estimated $1,020,828 in overpayments

The Hospital does not concur with this recommendation. The draft report's recommended refund is based on an extrapolated estimate derived from a limited sample of claims in selected risk areas. The Hospital disputes the underlying determinations that the sampled claims were improperly billed and, therefore, disputes the extrapolated overpayment amount. Accordingly, the Hospital does not agree that a refund is warranted based on the draft report.

Response to Recommendation 2: Consider conducting internal audits or investigations for claims after the audit period

The Hospital does not concur with this recommendation. The Hospital disagrees with the draft report's findings of an overpayment, and therefore, the Hospital does not believe there is a basis to require additional internal audits or investigations tied to the alleged errors or premised on the draft's conclusion. Nonetheless, the Hospital remains committed to ongoing monitoring and improvement and continuously evaluates its billing, coding, clinical documentation, compliance, and utilization review controls as part of its existing compliance program.

Response to Recommendation 3: Provide additional training to clinical and billing personnel

The Hospital does not concur with this recommendation. The Hospital disagrees with the draft report's assertion that the alleged errors occurred because staff did not consistently follow written policies and procedures related to IRF medical necessity and documentation requirements, inpatient coding, and the Two-Midnight Rule. The Hospital maintains that its personnel followed applicable processes and that the claims at issue were supported by the medical records and applicable Medicare requirements. As part of its routine and ongoing compliance process, the Hospital will continue to provide education and guidance as appropriate through its established compliance and revenue cycle education programs, but it does not agree that there is a need for corrective training based on alleged noncompliance.

Wellstar Health System
Compliance Department
1800 Parkway Place | Marietta, GA 30067

Additional Comments on the Draft Findings

The Hospital also disagrees with the draft report's characterization of IRF medical necessity, IRF documentation, inpatient diagnosis coding, and Two-Midnight Rule findings. The Hospital believes the relevant records support the admissions, services, coding, and billing decisions. The Hospital further objects to any implication that use of a commercial screening tool, including InterQual® criteria, establishes noncompliance with Medicare requirements. As the draft report acknowledges, failure to meet such screening criteria does not equate to failure to meet Medicare requirements. Therefore, the Hospital requests that OIG revise the draft report to remove the overpayment finding and withdraw the recommendations.

Wellstar remains committed to providing high-quality, medically necessary patient care and to ensuring that its Medicare billing practices are accurate, compliant, and supported by appropriate clinical documentation. Consistent with that commitment, Wellstar maintains compliance controls, monitoring processes, and education efforts designed to promote billing accuracy and adherence to applicable Medicare coverage, coding, billing, and payment requirements. Additional information regarding the basis and foundation of Wellstar's conclusions can be provided upon request. Nothing in this response should be construed as a waiver of Wellstar's rights, remedies, defenses, or appeal rights with respect to any future CMS or Medicare contractor determination.

Sincerely,



Beth Kost
Senior Vice President & Chief Compliance Officer
Wellstar Health System

Wellstar Health System
Compliance Department
1800 Parkway Place | Marietta, GA 30067

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