



JUL - 2 2003

TO: Neil Donovan  
Director, Audit Liaison Staff  
Centers for Medicare and Medicaid Services

FROM: Dennis J. Duquette *Donald E. Dille for*  
Deputy Inspector General for Audit Services

SUBJECT: Review of Payments Made by Associated Hospital Service for Home Health Services Preceded by a Hospital Discharge (A-01-03-00500)

As part of the Office of Inspector General's self-initiated work, we are alerting you to the issuance within 5 business days of our final audit report entitled, "Review of Payments Made by Associated Hospital Service for Home Health Services Preceded by a Hospital Discharge." The objective of our review was to determine whether home health agencies (HHA) were billing for services that were preceded by an inpatient hospital discharge in compliance with Medicare regulations. This review is part of a nationwide effort being performed at the four regional home health intermediaries (RHHI). We have completed our review at the first RHHI, Associated Hospital Service (AHS). A copy of the report is attached. We suggest you share this report with the Centers for Medicare and Medicaid Services' components involved in program integrity and Medicare payment policy and operations, specifically the Center for Medicare Management. We will share with you our reports to the other three RHHIs as they are finalized.

The prospective payment system (PPS) for Medicare home health services became effective on October 1, 2000. The implementing Medicare PPS regulations provide for a higher payment to HHAs for home health services for which the beneficiary was not discharged from an inpatient hospital within 14 days of the HHA episode.

We identified 6,388 claims in fiscal year (FY) 2001 for which it appears HHAs received a higher payment from AHS even though the beneficiary was discharged from an inpatient hospital within 14 days preceding the home health services. A stratified random sample of 200 of these claims identified overpayments to HHAs totaling \$77,461. Based on our sample results, we estimate that AHS made about \$1.9 million in overpayments to HHAs for the 6,388 claims in question during FY 2001.

In our opinion, these overpayments occurred and recovery was not initiated because:

- HHAs incorrectly billed services due to their clinicians not adequately completing the patient assessment instrument that requires the HHA to

identify all facilities that discharged the beneficiary within 14 days prior to the home health episode; and

- AHS had not established post-payment controls to detect these types of HHA claims that were billed incorrectly.

We recommend that AHS:

- initiate recovery of the \$77,461 in overpayments for the claims in our sample and utilize our file containing the universe of claims with probable billing errors in FY 2001 to identify the additional overpayments estimated at \$1.8 million.
- direct HHAs to strengthen billing controls, including procedures to ensure their clinicians adequately complete the patient assessment instrument.
- subsequent to the period of our review, conduct periodic post-payment data analysis to detect improperly billed HHA claims and use the results of that data analysis to recover overpayments and take additional corrective actions, as necessary.

In its response to our draft report, AHS generally concurred with our findings and recommendations. We commend AHS for assisting us in our review and validation of the 200 sampled claims.

Any questions or comments on any aspect of this memorandum are welcome. Please call me or have your staff contact George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits at (410) 786-7104 or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I at (617) 565-2689.

Attachment



JUL - 8 2003

Office of Audit Services  
Region I  
John F. Kennedy Federal Building  
Boston, MA 02203  
(617) 565-2684

Report Number: A-01-03-00500

Mr. David Crowley  
Executive Director  
Associated Hospital Service  
2 Gannett Drive  
South Portland, Maine 04106

Dear Mr. Crowley:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Payments Made by Associated Hospital Service for Home Health Services Preceded by a Hospital Discharge." A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

Final determination as to actions taken on all matters will be made by the HHS action official named below. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise (see 45 CFR part 5).

To facilitate identification, please refer to report number A-01-03-00500 in all correspondence relating to this report. If you have any questions, please contact either myself or David Lamir at (617) 565-2684.

Sincerely yours,

A handwritten signature in black ink that reads "Michael J. Armstrong".

Michael J. Armstrong  
Regional Inspector General  
for Audit Services

Enclosures – as stated

Page 2 – Mr. David Crowley

**Direct Reply to HHS Action Official:**

Dr. Charlotte S. Yeh

Regional Administrator

Centers for Medicare and Medicaid Services – Region I

Department of Health and Human Services

John F. Kennedy Federal Building, Room 2325

Boston, MA 02203-0003

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF PAYMENTS MADE BY  
ASSOCIATED HOSPITAL SERVICE  
FOR HOME HEALTH SERVICES  
PRECEDED BY A HOSPITAL  
DISCHARGE**



**JULY 2003  
A-01-03-00500**

# **Notices**

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

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

## **OAS FINDINGS AND OPINIONS**

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



## **EXECUTIVE SUMMARY**

### **OBJECTIVE**

The objective of our audit was to determine whether home health agencies (HHA) were billing for services that were preceded by an inpatient hospital discharge in compliance with Medicare prospective payment system regulations.

### **FINDINGS**

The HHAs are eligible for a higher payment for services provided to beneficiaries that are not discharged from an inpatient hospital within 14 days of the HHA episode. However, we identified 6,388 claims in fiscal year (FY) 2001 for which it appears HHAs received a higher payment from Associated Hospital Service (AHS) even though the beneficiary was discharged from an inpatient hospital within 14 days preceding the home health services. A stratified random sample of 200 of these claims identified overpayments to HHAs totaling \$77,461. Based on our sample results, we estimate that AHS made about \$1.9 million in overpayments to HHAs for the 6,388 claims in question during FY 2001.

In our opinion, these overpayments occurred and recovery was not initiated because:

- HHAs incorrectly billed services due to their clinicians not adequately completing the patient assessment instrument that requires the HHA to identify all facilities that discharged the beneficiary within 14 days prior to the home health episode; and
- AHS had not established post-payment controls to detect these types of HHA claims that were billed incorrectly.

### **RECOMMENDATIONS**

We recommend that AHS:

- initiate recovery of the \$77,461 in overpayments for our sample claims and utilize our file containing the universe of claims with probable billing errors in FY 2001 to identify the additional overpayments estimated at \$1.8 million.
- direct HHAs to strengthen billing controls, including procedures to ensure their clinicians adequately complete the patient assessment instrument.
- subsequent to the period of our review, conduct periodic post-payment data analysis to detect improperly billed HHA claims and use the results of that data analysis to recover overpayments and take additional corrective actions, as necessary.

### **AHS COMMENTS**

In its response to our draft report, AHS generally agreed with our findings and recommendations.

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## INTRODUCTION

### BACKGROUND

#### *Home Health Services*

Home health services allow people with limited mobility to live independently while still receiving professional health care services. A home health agency (HHA) is a public or private organization that is primarily engaged in providing skilled nursing care and other therapeutic services in the home on a visiting basis. In 2002 Medicare paid \$13.2 billion for home health services nationwide. According to the Centers for Medicare and Medicaid Services (CMS), Medicare payments to HHAs are expected to grow by another 13 percent in 2003, to a total of \$14.9 billion.

#### *Medicare Payment Regulations*

The Balanced Budget Act of 1997 (Act), as amended by the Balanced Budget Refinement Act of 1999 and the Benefits Improvement Protection Act of 2000, mandated CMS to implement a prospective payment system (PPS) for Medicare home health services. The CMS implemented the home health PPS on October 1, 2000. The HHA PPS utilizes a classification system that groups home health services into 80 mutually exclusive groups called Home Health Resources Groups (HHRG). Each HHRG corresponds to a 5-character Health Insurance Prospective Payment System (HIPPS) code that is entered on the UB-92 HCFA-1450 claim and represents the beneficiary's needs over a 60-day service period called an episode.

The HHA registered nurse or therapist utilizes the Outcome and Assessment Information Set (OASIS), which is a measure of the care a patient needs, to determine the appropriate HHRG. The HHRG is determined by point values from three dimensions. The clinical severity dimension includes items pertaining to the beneficiary's condition and risk factors. The functional status dimension is comprised of six daily living activities. The service utilization dimension includes two types of data elements: (1) the patient's use of inpatient services in the 14 days preceding admission to home care and (2) the receipt of at least 10 therapy visits during the home health episode.

A CMS study of costs concluded that an HHA episode associated with an acute care discharge within 14 days of the HHA episode resulted in the least use of HHA resources as compared to no hospital discharge or a post-acute care facility discharge, or a combination of discharges within 14 days of the HHA episode. As a result, HHAs may receive higher payments for billing services that were not preceded by an inpatient hospital discharge within 14 days of the HHA episode. The HHAs submit these claims with an additional one point in the services utilization dimension resulting in the assignment of a "K" or "M" in the fourth position of the HIPPS code ("K" and "M" claims).

#### *Intermediary Responsibility*

The CMS contracts with regional home health intermediaries (RHHI) to assist it in administering the home health benefits program. The Associated Hospital Service (AHS) is one of the four

RHHIs nationwide. The AHS processes Medicare claims and conducts audits of cost reports submitted by 272 HHAs in the 6 New England states.

### ***Office of Inspector General Risk Assessment***

After the implementation of the new payment system, we conducted a risk assessment designed to identify vulnerable areas of the PPS for HHAs in terms of potential loss of Medicare program funds. Although our assessment utilized limited HHA payment data, we found that HHAs may be incorrectly billing “K” and “M” claims for which there was an inpatient hospital discharge in the most recent 14 days preceding home health services. This type of billing error results in excessive PPS reimbursement to HHAs.

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

### ***Objective***

The objective of our audit was to determine whether HHAs were billing for services that were preceded by an inpatient hospital discharge in compliance with PPS regulations.

### ***Scope***

Our review included AHS payments for HHA claims with a date of service during fiscal year (FY) 2001. During this period, we identified 6,388 “K” and “M” claims that had total payments of \$18,006,797 for which there was an inpatient hospital discharge within 14 days of the start of the HHA episode (4,645 “K” claims valued at \$9,571,212 and 1,743 “M” claims valued at \$8,435,585).

Our internal control review at AHS was limited to obtaining an understanding of its claims processing system edits and procedures to detect improperly billed HHA claims and to identify and recover overpayments. We also limited our consideration of the internal control structure at selected HHAs to those controls concerning the creation and submission of Medicare HHA claims because the objective of our review did not require an understanding or assessment of the complete internal control structure at HHAs.

### ***Methodology***

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- extracted the HHA PPS claims data for AHS paid claims from the National Claims History (NCH) file for services rendered during FY 2001;
- performed a computer match of this data to the beneficiaries’ inpatient hospital data in NCH in order to obtain a data file of “K” and “M” claims with a hospital discharge within 14 days of the HHA episode;

- selected a stratified random sample of 100 “K” paid claims and 100 “M” paid claims (see APPENDIX A for sampling methodology);
- obtained the common working file (CWF) data for the sample HHA claims and the corresponding inpatient hospital claims and recalculated the correct payment for the sample claims to determine overpayment amounts;
- met with representatives of judgmentally selected HHAs to validate billing errors and determine the underlying cause of noncompliance with Medicare billing requirements;
- utilized a stratified variable appraisal program to estimate the overpayments to HHAs under the payment jurisdiction of AHS (see APPENDIX B for sample results and projections); and
- discussed the results of our review with AHS officials and provided AHS a file containing the population of claims with payment errors for recovery.

We performed our field work at the Office of the Inspector General (OIG) regional office in Boston, Massachusetts; AHS in South Portland, Maine; and at selected HHAs in Massachusetts, Connecticut, and New Hampshire. Our field work was conducted from October 2002 to February 2003. The AHS’s written comments to our draft report are appended in their entirety to this report (see APPENDIX C) and are summarized and addressed on page 7.

Our audit was conducted in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

Medicare PPS regulations provide for a higher payment to HHAs for home health services for which the beneficiary was not discharged from an inpatient hospital within 14 days of the HHA episode. To determine compliance with the regulations, we developed a computer match that identified 6,388 claims for FY 2001 for which HHAs received a higher payment from AHS even though the beneficiary was discharged from an inpatient hospital within 14 days prior to home health services. A stratified random sample of 200 of these claims identified overpayments to HHAs for all 200 claims totaling \$77,461. Based on our sample results, we estimate that AHS made \$1.9 million in overpayments to HHAs for the 6,388 claims in question during FY 2001.

In our opinion, these overpayments occurred and recovery was not initiated because:

- HHAs incorrectly billed services due to its clinicians not adequately completing the OASIS that requires the HHA to identify all facilities that discharged the patient within 14 days prior to the home health episode; and
- AHS had not established post-payment controls to detect these types of HHA claims that were billed incorrectly.

## **HHA PPS REGULATIONS**

Medicare payments to HHAs under the PPS are based on a home health case-mix system that uses selected data elements from the OASIS. The data elements are organized into three dimensions to capture clinical severity factors, functional severity factors, and services utilization factors influencing case mix. There are four clinical severity levels, five functional severity levels, and four services utilization severity levels. Therefore, each combination of severity levels across the 3 dimensions defines 1 of the 80 groups in the case-mix system.

The services utilization dimension includes the patient's use of inpatient services in the 14 days preceding admission to home care. In the Federal Register dated July 3, 2000, CMS states that "...not only are pre-admission inpatient stays a traditional indication of need in clinical practice, but also such variables were useful correlates of resource cost in our analysis of the case-mix data." Further, CMS data indicate that an acute care hospital discharge (without follow-up post-acute inpatient stay) within the 14 days preceding admission to home care is associated with the lowest costs during the 60-day episode. Accordingly, HHAs are entitled to higher payments for providing services that were not preceded by an inpatient hospital discharge within 14 days of the HHA episode.

## **HHA BILLING ERRORS**

To determine compliance with the PPS regulations, we extracted AHS paid claims data from the NCH file for HHAs that received higher payments for billing services that were not preceded by an inpatient hospital discharge within 14 days of the HHA episode. The HHAs bill these claims using a "K" or "M" in the fourth position of the HIPPS code. We matched this data to inpatient hospital records in NCH to obtain a universe of 6,388 "K" and "M" claims for which 232 HHAs received a higher payment from AHS even though the beneficiary was discharged from a hospital within 14 days preceding home health services (see Exhibit for examples of incorrectly billed "K" and "M" claims).

To validate the results of our computer match, we performed a detailed review of a stratified random sample of 100 "K" claims and 100 "M" claims. We found that AHS made overpayments totaling \$17,633 for all 100 "K" claims valued at \$197,300, which is about 9 percent; and \$59,828 for all 100 "M" claims valued at \$490,897, which is about 12 percent. Based on the results of our computer match and subsequent data validation procedures, we believe the risk is high that AHS made overpayments for the remaining 6,188 claims that are vulnerable to this billing error during FY 2001.

### **Billing Errors in Scoring Services Utilization Dimension**

Each of the 80 HHRG payments for HHA services corresponds to the 5-character HIPPS code as determined by the point values from 3 dimensions - clinical severity, functional status, and services utilization. Under the services utilization dimension, as shown below, HHAs are entitled to a higher score and, therefore, a higher payment for providing services that were not

preceded by an inpatient hospital discharge within 14 days of the HHA episode. We found the services utilization dimension was vulnerable to billing errors because HHAs incorrectly billed “K” and “M” claims for which there was an inpatient hospital discharge within the 14 days prior to the start of the HHA episode.

Service Utilization Dimension Scoring Combinations	Points without 10 Therapy visits	HIPPS Code	Points with 10 Therapy visits	HIPPS Code
Hospital discharge only	0 points	J	4 points	L
No institutional discharge	1 point	J	5 points	L
Hospital and SNF/rehab discharge	2 points	J	6 points	L
SNF/rehab discharge only	3 points	K	7 points	M

As shown above, the HHA is entitled to an additional point for providing services that were preceded by a skilled nursing facility (SNF) or rehabilitation discharge only within 14 days of the HHA episode. This additional point changes the fourth position of the HIPPS code from “J” to “K”(minimum to low service utilization) or from “L” to “M”(moderate to high service utilization), resulting in higher HHRG reimbursement.

### **BILLING AND PAYMENT CONTROLS NOT ESTABLISHED**

During the scope of our review, HHAs incorrectly billed services because their clinicians were not adequately completing the OASIS that requires the HHA to identify all facilities that discharged the beneficiary within 14 days prior to the home health episode. Furthermore, AHS had not established post-payment controls to detect these types of HHA claims that were billed incorrectly and recover the overpayments.

#### **Billing Controls Not Established at HHAs**

During the period of our review, HHAs did not establish the necessary controls to prevent the incorrect billing of “K” and “M” claims for which there was an inpatient hospital discharge within the 14 days prior to the HHA episode. Specifically, HHAs did not establish procedures to ensure that their clinicians adequately complete the M0175 question from the OASIS.

As shown below, the M0175 question requires the HHA to identify all facilities that discharged the patient within the 14 days prior to the HHA episode. Correct HHA claims billing for Medicare payment is contingent on the accuracy of OASIS data, including responses to the M0175 question.

**(M0175) From which of the following facilities was  
The patient discharged during the past 14 days?  
(Mark all that apply)**

1 Hospital

2 Rehabilitation facility

3 Skilled nursing facility

4 Other nursing home

5 Other (specify)

NA Patient was not discharged from an inpatient facility

As part of this review, we met with a selected number of HHA providers to validate the payment errors in our sample and identify specific control weaknesses contributing to noncompliance with Medicare payment provisions. We also discussed any recently developed control procedures to facilitate compliance. We found that HHAs did not always adequately respond to the M0175 question because their clinicians:

- mistakenly identified only the most recent post-acute care facility discharge during the 14 days preceding the home health episode, rather than all discharges, including the discharge from the inpatient hospital; or
- did not obtain the necessary hospital discharge information from the beneficiary, family members, or the referral facility to determine whether there was a hospital discharge within 14 days prior to the home health episode.

According to HHAs, clinicians may not always be able to obtain the necessary information to facilitate the accurate completion of the M0175 question. Specifically, the information sources available to HHAs--beneficiaries, family members, and recent caregivers--cannot always be depended upon for accurate hospital discharge information. We contacted several skilled nursing facilities and rehabilitation facilities to determine how these referral providers could facilitate HHA compliance with the M0175 question. Each facility informed us that the inpatient hospital discharge information needed by HHAs to accurately complete the M0175 is not always included in the referral facility's discharge summary. However, this information is ultimately available in the discharge summary provided by the hospital to the referral facility.

### **Payment Controls Not Established at AHS**

The HHA PPS introduced a new payment policy for Medicare home health services effective October 1, 2000. Accordingly, we acknowledge the additional efforts required by Medicare contractors to design and implement effective controls to address new payment systems. However, during the scope of our review, overpayments were made to HHAs and not recovered because AHS had not established payment controls to detect these types of improperly billed

HHA claims. Specifically, AHS had not initiated post-payment data analysis to detect HHA claims vulnerable to this billing error in order to facilitate overpayment identification and recovery.

## **MEDICARE PROGRAM OVERPAYMENTS**

We found that billing errors for all 200 claims in our stratified random sample resulted in overpayments of \$17,633 for the 100 “K” claims and \$59,828 for the 100 “M” claims, or total payment error of \$77,461. Projecting our results to the universe of “K” and “M” claims with an inpatient hospital discharge within 14 days of the HHA episode, we estimate that AHS made \$1.9 million in overpayments to HHAs for services rendered during FY 2001.

## **RECOMMENDATIONS**

We recommend that AHS:

- initiate recovery of the \$77,461 in overpayments related to the claims selected in our sample.
- utilize our file containing the universe of paid claims with probable billing errors to identify and recover the additional overpayments estimated at \$1.8 million.
- direct HHAs to strengthen billing controls, including procedures to ensure their clinicians adequately complete the M0175 question on the OASIS. Specifically, clinicians should make every reasonable attempt to obtain and report accurate data on the type of facilities and the dates of beneficiary discharge within the 14 days preceding the HHA episode.
- subsequent to the period of our review, conduct periodic post-payment data analysis to detect improperly billed “K” and “M” claims and use the results of that data analysis to recover overpayments and take additional corrective actions, as necessary.

## **AHS Comments**

In response to our draft report, AHS generally concurred with our findings and recommendations. However, AHS asserted that the statement in our draft report, “...AHS had not established adequate post-payment controls to detect HHA claims that were billed incorrectly...” is not entirely accurate. According to AHS, it has established post-payment controls over the therapy utilization dimension. Additionally, AHS stated it would increase post-payment medical review to determine whether providers are appropriately billing for “K” and “M” claims.

## **OIG Response**

We have revised our report to state that AHS had not established post-payment controls specific to question M0175 on the OASIS. Although we commend AHS for increased post-payment

medical review to detect additional errors, we continue to recommend periodic post-payment data analysis to detect errors in question M0175.

**EXHIBIT**

**EXAMPLES OF INCORRECTLY  
BILLED “K” AND “M” CLAIMS**

	<b>HIPPS CODE BILLED BY HHA</b>	<b>HHA SERVICE DATE</b>	<b>ORIGINAL PAYMENT AMOUNT</b>	<b>DATE OF HOSPITAL DISCHARGE</b>	<b>HIPPS CODE REVISED PER OIG</b>	<b>OIG REVISED PAYMENT AMOUNT</b>	<b>OIG DETERMINED OVERPAYMENT</b>
1	HBFK1	7/20/2001	\$2,040.45	7/10/2001	HBFJ1	\$1,833.54	\$206.91
2	HBGM1	3/7/2001	\$4,852.70	2/26/2001	HBGL1	\$4,251.14	\$601.57

Example 1

The HHA billed for HIPPS code HBFK1 on its HCFA-1450 claim. The “K” in the fourth position of the HIPPS code indicates an assessment of “low severity” for the services utilization dimension because, according to the HHA, the beneficiary was only discharged from a skilled nursing facility in the 14 days preceding the home health services. However, our review of inpatient claims history shows the beneficiary was also discharged from an inpatient hospital on 7/10/2001, 10 days prior to the start of the HHA episode. As a result, the HHA was overpaid \$206.91 because it billed for services that did not properly identify an inpatient hospital discharge within 14 days of the HHA episode.

Example 2

The HHA billed for HIPPS code HBGM1 on its HCFA-1450 claim. The “M” in the fourth position of the HIPPS code indicates an assessment of “high severity” for the services utilization dimension because, according to the HHA, the beneficiary was only discharged from a rehabilitation facility in the 14 days preceding the home health services. However, our review of inpatient claims history shows the beneficiary was also discharged from an inpatient hospital on 2/26/2001, 9 days prior to the start of the HHA episode. As a result, the HHA was overpaid \$601.57 because it billed for services that did not properly identify an inpatient hospital discharge within 14 days of the HHA episode.

## SAMPLING METHODOLOGY

### OBJECTIVE

The objective of our audit was to determine whether HHAs were billing for services that were preceded by an inpatient hospital discharge in compliance with Medicare PPS regulations.

### POPULATION

We used the population of HHA claims paid by AHS with a date of service during FY 2001 having a “K” or “M” in the fourth position of the HIPPS code that were preceded by an inpatient hospital discharge within 14 days of the home health episode.

Stratum Number	Type of Claim	Number of Claims	Payment Amount
1	“K”	4,645	\$9,571,212
2	“M”	<u>1,743</u>	<u>8,435,585</u>
	Total	<u>6,388</u>	<u>\$18,006,797</u>

### SAMPLE DESIGN

We used a stratified random sample for this review. We utilized two strata, one for “K” paid claims and one for “M” paid claims with dates of service during FY 2001.

### SAMPLE SIZE

We selected 100 claims for each strata from our identified populations.

## APPENDIX B

### SAMPLE RESULTS AND PROJECTIONS

#### Sample Results

Stratum Number	Number of Claims	Sample Size	Value of Sample	Number of Errors	Value of Errors
1	4,645	100	\$197,300	100	\$17,633
2	<u>1,743</u>	<u>100</u>	<u>490,897</u>	<u>100</u>	<u>59,828</u>
Total	<u>6,388</u>	<u>200</u>	<u>\$688,197</u>	<u>200</u>	<u>\$77,461</u>

#### Variable Projections

The point estimate of the sample was \$1,861,857 with a precision of plus or minus \$38,141 at the 90 percent confidence level.



