

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE HOSPITAL PROVIDER  
COMPLIANCE AUDIT: FORBES  
HOSPITAL**

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## Report in Brief

Date: March 2020

Report No. A-03-18-00005

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



### Why OIG Did This Audit

This report is part of a series of hospital compliance audits. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2017, Medicare paid hospitals \$206 billion, which represents 55 percent of all fee for service payments for the year; accordingly, it is important to ensure that hospital payments comply with requirements.

Our objective was to determine whether Forbes Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims in CYs 2016 and 2017.

### How OIG Did This Audit

Our audit covered \$10.6 million in Medicare payments to the Hospital for 817 claims that were potentially at risk for billing errors.

We selected for review a stratified random sample of 100 claims with payments totaling \$1.7 million. Medicare paid these 100 claims, which consisted of 92 inpatient and 8 outpatient claims, during CYs 2016 and 2017.

We focused our audit on the risk areas that we identified during previous OIG audits at other hospitals. We evaluated compliance with selected billing requirements.

## Medicare Hospital Provider Compliance Audit: Forbes Hospital

### What OIG Found

The Hospital complied with Medicare billing requirements for 51 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 49 claims, all of which were inpatient, resulting in overpayments of \$590,646 for CYs 2016 and 2017.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$3.3 million for CYs 2016 and 2017.

### What OIG Recommends and Hospital Comments

We recommended that the Hospital (1) refund to the Medicare contractor \$3.3 million (\$590,646 in net overpayments identified in our sample) in estimated overpayments for incorrectly billed claims that are within the reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with this recommendation; and (3) strengthen controls to ensure full compliance with Medicare requirements by ensuring that all inpatient rehabilitation facility beneficiaries meet Medicare criteria for acute inpatient rehabilitation, ensuring that all inpatient beneficiaries meet Medicare criteria for inpatient hospital services, ensuring that the procedure and diagnosis codes used are supported by the medical records, and ensuring that the codes used for distinct procedural services are supported by the medical records.

The Hospital disagreed with our findings and recommendations regarding incorrectly billed and incorrectly coded claims. The Hospital also disagreed with our use of extrapolation and our recommendation that it identify, report, and return any additional similar overpayments received outside of the audit period. In addition, the Hospital stated that it has a compliance program, ongoing Hospital monitoring, and system-wide management meetings under physician leadership.

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

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## INTRODUCTION

### WHY WE DID THIS AUDIT

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

### OBJECTIVE

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

### BACKGROUND

#### The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with Medicare administrative contractors to, among other things, process and pay claims submitted by hospitals.

#### Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. In addition to the basic prospective payment, a hospital may be eligible for an additional payment, called an outlier payment, if the hospital's costs exceed certain thresholds.

#### Hospital Inpatient Rehabilitation Facility Prospective Payment System

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for IRFs. CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the payment system, CMS established a Federal prospective payment rate for

each of the 92 distinct case-mix groups (CMGs). The assignment to a CMG is based on the beneficiary's clinical characteristics and expected resource needs.

### **Hospital Outpatient Prospective Payment System**

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

### **Hospital Claims at Risk for Incorrect Billing**

Previous Office of Inspector General (OIG) audits at other hospitals identified types of claims at risk for noncompliance. Out of the areas identified as being at risk, we focused our audit on the following:<sup>2</sup>

- IRF claims,
- inpatient claims billed with Comprehensive Error Rate Testing (CERT) high-error-rate DRG codes,
- inpatient mechanical ventilation claims,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims paid in excess of charges,
- inpatient elective procedure claims,
- outpatient skilled nursing facility consolidated billing,
- outpatient claims paid in excess of \$25,000, and
- inpatient claims paid in excess of \$150,000.

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

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

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 the provider (§§ 1815(a) and 1833(e)).

Federal regulations state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that the Medicare contractor may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23 § 20.3).<sup>3</sup>

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.<sup>4</sup>

The 6-year lookback period is not limited by OIG’s audit period or restrictions on the Government’s ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.<sup>5</sup>

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<sup>3</sup> “Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS)” (42 CFR § 419.2(a)). Moreover, claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)).

<sup>4</sup> The Act § 1128J(d); 42 CFR §§ 401.301-401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

<sup>5</sup> 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, Provider Reimbursement Manual, Pub. No. 15-1, part 1, § 2931.2; 81 Fed. Reg. 7670.

## **Forbes Hospital**

The Hospital, which is part of the Allegheny Health Network, is a 315-bed hospital located in Monroeville, Pennsylvania. Medicare paid the Hospital approximately \$105 million for 22,948 inpatient and 15,438 outpatient claims for services provided between January 1, 2016, and December 31, 2017 (audit period).

### **HOW WE CONDUCTED THIS AUDIT**

Our audit covered \$10.6 million in Medicare payments to the Hospital for 817 claims that were potentially at risk for billing errors. These claims consisted of inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during our audit period. We selected for review a stratified random sample of 100 claims with payments totaling \$1.7 million. Medicare paid these 100 claims, which consisted of 92 inpatient and 8 outpatient claims, during our audit period.

We focused our audit on the risk areas we had identified during previous OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted 100 claims to an independent medical review contractor to determine whether the services met medical necessity and coding requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

### **FINDINGS**

The Hospital complied with Medicare billing requirements for 51 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 49 claims, all of which were inpatient, resulting in overpayments of \$590,646 for the audit period.<sup>6</sup> These billing errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

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<sup>6</sup> For 12 of these claims, the errors resulted in no change to the DRG or payment. Therefore, the overpayments of \$590,646 were for the remaining 37 claims.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$3.3 million<sup>7</sup> for the audit period.<sup>8</sup>

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 49 of the 92 inpatient claims that we reviewed. For 12 of these claims, the errors resulted in no change to the DRG or payment. For the remaining 37 claims, the billing errors resulted in overpayments of \$590,646.

### **Incorrectly Billed Inpatient Rehabilitation Facility Claims**

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

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

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

For IRF care to be considered reasonable and necessary, Federal regulations require that there be a reasonable expectation that, at the time of admission to the IRF, the patient (1) required the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally required and could reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) was sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program; and (4) required physician supervision by a rehabilitation physician (42 CFR § 412.622(a)(3)(i-iv)).

Federal regulations require that the patient’s medical record must contain certain documentation to ensure that the IRF coverage requirements are met. The record must include (1) a comprehensive preadmission screening that is completed within the 48 hours preceding the admission; (2) a post-admission physician evaluation that is completed within 24 hours of

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<sup>7</sup> We estimated that the overpayments totaled at least \$3,343,748.

<sup>8</sup> 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.

admission, documents the patient's status on admission to the IRF, and includes a comparison with the information in the preadmission screening; and (3) an individualized overall plan of care that is completed within 4 days of admission to the IRF (42 CFR § 412.622(a)(4)(i-iii)).

Federal regulations state that when each Medicare Part A fee-for-service patient is admitted to an IRF, a physician must generate admission orders for the patient's care. These admission orders must be retained in the patient's medical record at the IRF (42 CFR § 412.606(a); 42 CFR § 424.5(a)(6); Pub. No. 100-02, chapter 1, § 110.1.4).<sup>9</sup>

CMGs are classes of Medicare patient discharges organized according to functionally related groups based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functionally related groups to estimate variations in resource use (42 CFR § 412.620). Comorbidities are arrayed in three tiers based on whether the costs are considered high, medium, or low. If a case has more than one comorbidity, the CMG payment rate will be based on the comorbidity that results in the highest payment (the Manual, chapter 3, § 140.2.3). Payment is based on the CMGs and possible adjustments specific to the case and facility characteristics (the Manual, chapter 3, § 140.2.4).<sup>10</sup>

For 33 of the 44 IRF claims included in our sample of 92 inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation.

For 28 of these 33 claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria stating that acute inpatient rehabilitation must be reasonable and necessary. IRF services for these beneficiaries were not considered reasonable and necessary because these beneficiaries (1) did not require the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally did not require and could not reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) were not sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; or (4) did not require supervision by a rehabilitation physician. In addition, for 9 of these 28 incorrectly billed claims, the Hospital billed IRF claims that did not comply with Medicare documentation

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<sup>9</sup> Effective October 1, 2018, after our audit period, CMS removed 42 CFR section 412.606(a), stating that it was duplicative and IRFs are required under sections 482.12(c), 482.24(c), and 412.3 to obtain a physician order to be paid by Medicare for inpatient admissions (83 Fed. Reg. 38514, 38553 (Aug. 6, 2018)).

<sup>10</sup> For additional information, see the fiscal year (FY) 2016 IRF prospective payment system (PPS) Final Rule, 80 Fed. Reg. 47036, 47037-47046 (Aug. 6, 2015); FY 2017 IRF PPS Final Rule, 81 Fed. Reg. 52056, 52057-52071 (Aug. 5, 2016); and FY 2018 IRF PPS Final Rule, 82 Fed. Reg. 36238, 36240-36247 (Aug. 3, 2017).

requirements because the Hospital's medical records did not include sufficient documentation. Specifically:

- for eight errors, the admission orders were missing from the documentation, and
- for one error, an interdisciplinary plan of care was missing from the documentation.

For 5 of the 33 incorrectly billed claims, the Hospital submitted to Medicare IRF claims that were incorrectly coded, resulting in incorrect CMG payments to the Hospital. Specifically, the CMG was not applied correctly based on the patient's clinical characteristics and expected resource needs. The Hospital did not provide a cause for these errors because its officials contended that these claims met Medicare requirements. However, Hospital officials did not provide any additional information that would impact our finding.

As a result of these errors, the Hospital received net overpayments of \$533,671.

#### **Incorrectly Billed Inpatient Comprehensive Error Rate Testing High-Error-Rate Diagnosis-Related Group Code Claims**

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(a)). 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. Consequently, the Manual states that "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

For 13 of the 16 inpatient CERT high-error-rate DRG code claims included in our sample of 92 inpatient claims, the Hospital submitted CERT high-error-rate DRG code claims to Medicare that were not coded correctly, resulting in incorrect DRG payments to the Hospital. For 10 of the 13 claims, correcting the error still generated the same DRG and resulted in no under- or over-payment. However, for the remaining 3 claims, correcting the error changed the DRG and resulted in an overpayment to the Hospital. The Hospital did not provide a cause for these errors because its officials contended that these claims met Medicare requirements. However, Hospital officials did not provide any additional information that would impact our finding.

As a result of these errors, the Hospital received net overpayments of \$40,524.

#### **Incorrectly Billed Inpatient High-Severity-Level Diagnosis-Related Group Code Claims**

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(a)). 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. Consequently, the Manual states that "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

Under IPPS, fiscal intermediaries reimburse hospitals a predetermined amount for inpatient services furnished to program beneficiaries depending on the illness and its classification under

DRG. As of October 1, 2007, the DRG payment system changed into a three-tiered design. Diagnosis codes classified as Major Complication/Comorbidity reflect the highest level of severity and therefore generate the highest payment amounts. The next level of severity consists of diagnosis codes classified as Complication/Comorbidity. The lowest level is for Non-Complication/Comorbidity, which are diagnosis codes that do not significantly affect severity of illness and resource use and which generate the lowest payment amounts. Each year, CMS publishes a list of diagnosis codes that, when used as a secondary diagnosis code, will allow a hospital to receive a higher-coded DRG. It takes only one of these codes to move the DRG into a higher payment category.

For 3 of the 5 inpatient high-severity-level DRG code claims included in our sample of 92 inpatient claims, the Hospital submitted high-severity-level DRG code claims to Medicare that were not coded correctly, resulting in incorrect DRG payments to the Hospital. For two of these three claims, correcting the error still generated the same DRG and resulted in no under- or over-payment. However, for the remaining claim, correcting the error changed the DRG and resulted in an overpayment to the Hospital. The Hospital did not provide a cause for these errors because its officials contended that these claims met Medicare requirements. However, Hospital officials did not provide any additional information that would impact our finding.

As a result of the error for one claim, the Hospital received a net overpayment of \$16,451.

#### **CORRECTLY BILLED INPATIENT CLAIMS**

The Hospital correctly billed Medicare for the remaining 27 inpatient claims that we reviewed. We reviewed 7 inpatient claims paid in excess of charges, 18 inpatient elective procedure billing claims, and 2 inpatient claims paid in excess of \$150,000.

#### **CORRECTLY BILLED OUTPATIENT CLAIMS**

The Hospital correctly billed Medicare for all eight outpatient claims that we reviewed. We reviewed seven outpatient claims paid in excess of \$25,000 and one outpatient skilled nursing facility consolidated billing claim.

#### **OVERALL ESTIMATE OF OVERPAYMENTS**

The combined overpayments for the sampled claims totaled \$590,646. On the basis of these sample results, we estimated that the Hospital received overpayments of at least \$3.3 million for the audit period.

## RECOMMENDATIONS

We recommend that Forbes Hospital:

- refund to the Medicare contractor \$3,343,748 (\$590,646 in net overpayments identified in our sample) in estimated overpayments for incorrectly billed claims that are within the reopening period;<sup>11</sup>
- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule<sup>12</sup> and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements by:
  - ensuring that all IRF beneficiaries meet Medicare criteria for acute inpatient rehabilitation,
  - ensuring that all inpatient beneficiaries meet Medicare criteria for inpatient hospital services,
  - ensuring that the procedure and diagnosis codes used are supported by the medical records, and
  - ensuring that the codes used for distinct procedural services are supported by the medical records.

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<sup>11</sup> OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a Medicare administrative contractor 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 Part A and Part B appeals process has 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.

<sup>12</sup> This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

## HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

### HOSPITAL COMMENTS

In written comments on our draft report, the Hospital disagreed with our findings and recommendations. Specifically, the Hospital:

- did not agree that it incorrectly billed Medicare for the 28 IRF claims that we identified as not meeting Medicare requirements for acute inpatient rehabilitation;
- did not agree that it incorrectly coded the 5 IRF claims we identified as having an incorrect CMG; and
- did not agree that it incorrectly coded the 16 inpatient claims for CERT high-error-rate DRGs and high-severity-level DRGs that we identified as being coded incorrectly, including 4 inpatient claims that we determined resulted in an overpayment to the Hospital.

For the 28 IRF claims for stays that we found did not meet Medicare criteria requiring that rehabilitation must be reasonable and necessary, the Hospital stated that its review concluded that the prescribed level of service met CMS inpatient rehabilitation medical necessity criteria and that the medical record documentation supported that conclusion. In addition, the Hospital stated that 16 of the 28 patients we identified as not requiring acute inpatient rehabilitation had a primary diagnosis of debility and that 9 of the 28 had a primary diagnosis of repaired hip fracture, for a total of 25 patients with primary diagnoses outside of the 13 approved diagnoses that qualify under the “60-percent rule.”<sup>13</sup> The Hospital stated that the medical reviewer expressed that a primary diagnosis of debility does not support the medical necessity of IRF care, which is not consistent with Medicare regulations. The Hospital also commented that, for each calendar year, Medicare allows for 40 percent of an IRF’s patients to have a diagnosis other than the 13 diagnoses included in the rule. Furthermore, the Hospital believes that all 28 IRF claims had evidence of medical necessity.

For the nine IRF claims that we found were missing either admission orders or an interdisciplinary plan of care, the Hospital stated that the lack of orders or plan of care was due to a newly-installed system that caused the orders and plan of care to not transfer from the patients’ acute care records to their rehabilitation records. The Hospital stated that the orders and plan of care can be found in the patients’ acute care records.

For the five IRF claims that we found were incorrectly coded, the Hospital stated that its review concluded that the independent medical reviewer’s determination was incorrect. The Hospital

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<sup>13</sup> During our audit period, the “60-percent rule” stated that, for a facility to be paid under the Medicare prospective payment system for IRFs, the IRF must meet certain requirements including that the IRF must serve an inpatient population of whom at least 60 percent required IRF services for treatment of 1 or more of 13 specified diagnoses (42 CFR § 412.29).

stated that it takes all of the diagnoses and functional scoring documented in the medical record and enters it into a software system that utilizes CMS's database to calculate the CMG. Therefore, the Hospital disagreed with our finding that the claims were incorrectly coded.

For the 16 inpatient claims for CERT high-error-rate DRGs and high-severity level DRGs that we found were incorrectly coded, including the 4 claims that we determined resulted in an overpayment to the Hospital, the Hospital stated that the claims in the finding did not contain details about which codes were incorrect. The Hospital stated that it believed that its coding and billing were correct as submitted.

The Hospital stated that it has a compliance program in place to evaluate the appropriateness of both acute inpatient stays and inpatient rehabilitation admissions. It also stated that it has ongoing monitoring within the Hospital and has system-wide utilization management services meetings under physician leadership.

The Hospital commented that it did not agree with our findings being extrapolated across its population of inpatient rehabilitation patients. The Hospital stated that it intends to pursue appeals of the claims for which it disagrees with our findings. Finally, the Hospital also stated that its opinion is that repayment, if required, should occur after the baseline error rate is established and all appeal mechanisms are exhausted.

See Appendix E for the Hospital's comments on our draft report.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

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

For the 28 IRF claims for stays that we found did not meet Medicare criteria stating that rehabilitation must be reasonable and necessary, the independent medical reviewer did not deny claims solely based on the patient's primary diagnosis, whether it was debility, repaired hip fracture, or something else.<sup>14</sup> The medical reviewer considered the patient's entire clinical picture, including other medical needs and co-morbid conditions, and found that these beneficiaries (1) did not require the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally did not require and could not reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) were not sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; or (4) did not require supervision by a rehabilitation physician.

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<sup>14</sup> It is unclear why the Hospital mentioned in its comments that 25 of the 28 IRF admissions that we found did not meet Medicare medical necessity requirements had diagnoses that are not among those listed for the "60-percent rule". Our medical reviewer did not deny claims on this basis, and IRF admissions for patients with diagnoses not listed in 42 CFR § 412.29(b)(2) are not exempt from Medicare medical necessity requirements.

For the nine IRF claims that we found were missing either admission orders or an interdisciplinary plan of care, the Hospital did not provide any evidence documenting that the acute care records contained the missing admission orders or interdisciplinary plan of care. Therefore, we have not changed our finding regarding these nine IRF claims.

For the 5 IRF claims and the 16 inpatient claims that we found were incorrectly coded, the independent medical reviewer who reviewed the claims is a certified coding specialist and a registered health information technician skilled in classifying clinical data from medical records and assigning number codes for each diagnosis and procedure. The reviewer has expertise in ICD-9, ICD-10, and CPT coding systems and is knowledgeable in medical terminology, disease processes, and pharmacology. The reviewer used this expertise and knowledge to analyze the claims and determine whether they were incorrectly coded.

The independent medical reviewers examined all of the medical records and documentation submitted by the Hospital and carefully considered the information to determine whether the Hospital billed the inpatient claims in compliance with Medicare requirements. On the basis of the medical reviewer's conclusions, we maintain that our findings and recommendations are correct.

Finally, with regard to the Hospital's disagreement with us extrapolating these findings across its inpatient rehabilitation population, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.<sup>15</sup> And, as we note in footnote 11, potential overpayments that are based on extrapolation and identified in OIG reports may be re-estimated depending on CMS determinations and the outcome of appeals.

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<sup>15</sup> 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 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered \$10,550,098 in Medicare payments to the Hospital for 817 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (92 inpatient and 8 outpatient) with payments totaling \$1,740,659. Medicare paid these 100 claims during our audit period.

We focused our audit on the risk areas we identified as a result of previous OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted all 100 sampled claims to an independent medical review contractor to determine whether the services met medical necessity and coding requirements.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

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

We conducted our fieldwork from April 2018 through November 2019.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's National Claims History file for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 92 inpatient claims and 8 outpatient claims for a total of \$1,740,659 for detailed review (Appendix B);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been canceled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;

- reviewed the Hospital's procedures for assigning DRG, CMG, and admission status codes for Medicare claims;
- used an independent medical review contractor to determine whether all sampled claims met medical necessity and coding requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample review to calculate the estimated Medicare overpayment to the Hospital (Appendix C); and
- discussed the results of our audit with Hospital officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

Medicare paid the Hospital approximately \$105 million for 22,948 inpatient and 15,438 outpatient claims during the audit period.

We obtained a database of inpatient and outpatient claims in 29 risk areas from CMS's National Claims History database. The database contained claims paid to the Hospital during the audit period. Claims paid during this period may include services provided before 2016.

From this data, we selected claims from 9 risk areas consisting of 1,254 inpatient and outpatient claims totaling \$14,232,379 for further refinement. These nine risk areas are (1) IRF claims, (2) inpatient claims billed with CERT high-error-rate DRG codes, (3) inpatient mechanical ventilation claims, (4) inpatient claims billed with high-severity-level DRG codes, (5) inpatient claims paid in excess of charges, (6) inpatient elective procedure claims, (7) outpatient skilled nursing facility consolidated billing, (8) outpatient claims paid in excess of \$25,000, and (9) inpatient claims paid greater than \$150,000.

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

- \$0 paid claims,
- claims with certain patient discharge status codes,
- claims with specific diagnosis and HCPCS codes, and
- claims under review by the Recovery Audit Contractor as of December 31, 2017.

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: (1) inpatient claims paid greater than \$150,000, (2) IRF claims, (3) inpatient claims billed with CERT high-error-rate DRG codes, (4) inpatient claims paid in excess of charges, (5) elective procedure claims, (6) inpatient mechanical ventilation claims, (7) inpatient claims billed with high-severity-level DRG codes, (8) outpatient skilled nursing facility consolidated billing, and (9) outpatient claims paid in excess of \$25,000. This assignment hierarchy resulted in a sample frame of 817 unique Medicare paid claims in 9 risk areas totaling \$10,560,469. (See Table 1 on the following page.)

**Table 1: Risk Areas Sampled**

<b>Risk Area</b>	<b>Number of Claims</b>	<b>Amount of Payments</b>
IRF Claims Under \$17,000	193	\$2,631,036
IRF Claims Over \$17,000	171	3,791,930
Inpatient CERT High-Error-Rate DRG Code Claims Under \$17,000	149	626,925
Inpatient CERT High-Error-Rate DRG Code Claims Over \$17,000	5	96,535
Inpatient Mechanical Ventilation Claims	3	57,031
Inpatient High-Severity-Level DRG Code Claims	27	143,023
Inpatient Claims Paid in Excess of Charges	62	511,006
Inpatient Elective Procedure Claims	152	1,412,037
Outpatient Skilled Nursing Facility Consolidated Billing	26	197,191
Outpatient Claims Paid in Excess of \$25,000	27	702,992
Inpatient Claims Paid Greater Than \$150,000	2	380,393
<b>Total</b>	<b>817</b>	<b>\$10,550,098</b>

**SAMPLE UNIT**

The sample unit was a Medicare paid claim.

**SAMPLE DESIGN**

We used a stratified random sample. We stratified the sampling frame into five strata based on claim type, risk area, and claim paid amount.

**SAMPLE SIZE**

We selected 100 claims for review as shown in Table 2 on the following page.

**Table 2: Claims by Stratum**

<b>Stratum</b>	<b>Risk Area</b>	<b>Claims in Sample</b>	<b>Claims in Sampling Frame</b>	<b>Payments in Sampling Frame</b>
1	IRF Claims and Inpatient CERT High-Error-Rate DRG Code Claims Under \$17,000	30	342	\$3,257,961
2	IRF Claims and Inpatient CERT High-Error-Rate DRG Code Claims Over \$17,000	30	176	3,888,465
3	Inpatient Mechanical Ventilation Claims, Inpatient High-Severity-Level DRG Code Claims, Inpatient Claims Paid in Excess of Charges, and Inpatient Elective Procedure Claims	30	244	2,123,097
4	Outpatient Skilled Nursing Facility Consolidated Billing and Outpatient Claims Paid in Excess of \$25,000	8	53	900,183
5	Inpatient Claims Paid Greater Than \$150,000	2	2	380,393
	<b>Total</b>	<b>100</b>	<b>817</b>	<b>\$10,550,098</b>

**SOURCE OF RANDOM NUMBERS**

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG, OAS), statistical software Random Number Generator.

**METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the claims within strata one through four. After generating the random numbers for these strata, we selected the corresponding frame items. We selected for review all claims in stratum five.

**ESTIMATION METHODOLOGY**

We used the OIG, OAS statistical software to estimate the total amount of overpayments paid to the Hospital during the audit period. To be conservative, we recommend recovery of any 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.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 3: Sample Results**

<b>Stratum</b>	<b>Frame Size (Claims)</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Incorrectly Billed Claims in Sample</b>	<b>Value of Overpayments in Sample</b>
1	342	\$3,257,961	30	\$256,292	19	\$99,686
2	176	3,888,465	30	661,798	27	474,510
3	244	2,123,097	30	249,996	3	16,451
4	53	900,183	8	192,181	0	0
5	2	380,393	2	380,392	0	0
<b>Total</b>	<b>817</b>	<b>\$10,550,098</b>	<b>100</b>	<b>\$1,740,659</b>	<b>49</b>	<b>\$590,647*</b>

\* The total does not match the actual value of overpayments in the report due to rounding.

**Table 4: Estimated Overpayments for the Audit Period**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

Point Estimate	\$4,054,009
Lower limit	\$3,343,748
Upper limit	\$4,764,270

**APPENDIX D: RESULTS OF AUDIT BY RISK AREA**

<b>Risk Area</b>	<b>Sampled Claims</b>	<b>Value of Sampled Claims</b>	<b>Claims With Overpayments</b>	<b>Value of Overpayments</b>
<b>Inpatient</b>				
IRF Claims Under \$17,000	15	\$190,891	7	\$76,466
IRF Claims Over \$17,000	29	644,495	26	457,206
Inpatient CERT High-Error-Rate DRG Code Claims Under \$17,000	15	65,401	12	23,220
Inpatient CERT High-Error-Rate DRG Code Claims Over \$17,000	1	17,304	1	17,304
Inpatient Mechanical Ventilation Claims	0	0	0	0
Inpatient High-Severity-Level DRG Code Claims	5	35,436	3	16,451
Inpatient Claims Paid in Excess of Charges	7	62,465	0	0
Inpatient Elective Procedure Claims	18	152,096	0	0
Inpatient Claims Greater Than \$150,000	2	380,392	0	0
<b>Inpatient Totals</b>	<b>92</b>	<b>\$1,548,480</b>	<b>49</b>	<b>\$590,647*</b>
<b>Outpatient</b>				
Outpatient Skilled Nursing Facility Consolidated Billing	1	\$10,053	0	\$0
Outpatient Claims Paid in Excess of \$25,000	7	182,128	0	0
<b>Outpatient Totals</b>	<b>8</b>	<b>\$192,181</b>	<b>0</b>	<b>\$0</b>
<b>Inpatient and Outpatient Totals</b>	<b>100</b>	<b>\$1,740,661†</b>	<b>49</b>	<b>\$590,647*</b>

\* The total does not match the actual value of overpayments in the report due to rounding.

† The total does not match the actual value of sample claims in the report due to rounding.

## APPENDIX E: HOSPITAL COMMENTS



December 20, 2019

Re: Report Number: A03-18-00005 (Forbes Hospital)

Ms. Nicole Freda  
Regional Inspector General for Audit Services  
Office of Audit Services, Region III  
801 Market Street  
Suite 8500  
Philadelphia, PA 19107

Dear Ms. Freda,

This letter is in response to the U.S. Department of Health and Human Services, Office of Inspector General's (OIG) audit report A03-18-00005 of one hundred (100) claims billed to Medicare during calendar years 2016 through 2017 for services provided at Forbes Hospital.

We appreciate the professionalism and candor of the auditors who visited our institution back in April, 2018 and throughout communications thereafter. Forbes Hospital is committed to compliance with applicable regulations and payor requirements, and it is our mission to keep patients at the center of everything we do. This includes providing care in the right setting at the right time. Upon receipt of the final audit report, Forbes Hospital initiated a comprehensive claims and medical record review.

The OIG recommendations are addressed below:

1. *Refund to the Medicare contractor \$3,343,748 (\$590,646 in net overpayments identified in our sample) in estimated overpayments for incorrectly billed claims reported.*

A summary of cases with financial errors identified by the OIG is summarized below:

- 28 IRF claims denied for medical necessary
- 5 IRF claims incorrectly coded
- 3 High error rate DRGs and 1 High severity DRG incorrectly coded

The cases that are attributed to the OIG's financial error rate were related to either admission to the inpatient rehab unit or to the coding of the inpatient rehab case. 100% of this requested repayment amount is related to inpatient rehabilitation reimbursement. Specifically, in twenty-eight (28) of the cases reviewed, the OIG reported that the level of care prescribed by the physician was not medically necessary or ordered as required by CMS, and five (5) of the cases were allegedly coded incorrectly. When Forbes Hospital received documentation on the review performed by the OIG, we compared the OIG's findings to Medicare regulations and billing requirements for acute inpatient rehab.

Medicare Benefit Manual Pub. # 100-02, Chapter 1 110.2 - Inpatient Rehabilitation Facility Medical Necessity Criteria states that:

"In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF:

1. The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines.
2. The patient must generally require an intensive rehabilitation therapy program, generally consisting of at least 3 hours of therapy per day at least 5 days per week.
3. The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program.
4. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.
5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

Forbes Hospital disagrees with the OIG's findings. In the 28 cases where medical necessity was called into question, our review concluded that the level of service prescribed by the clinician for admission to an acute rehabilitation unit met CMS inpatient rehabilitation medical necessity criteria and the medical record documentation supported such conclusion. We agree that there were 9 cases where an order was missing for inpatient rehab within the inpatient rehab case; however, the missing orders were due to a newly installed system where the order did not transfer from the acute care record to the rehab record. The order for inpatient rehab can be found at the end of the acute stay record. In only one of these cases did the OIG deny services solely related to the lack of physician order.

We believe medical necessity for those cases is clearly documented within each patient's medical record. The population of patients deemed by the OIG to be suitable for a different level of care (ex. skilled nursing) was at home or in a personal care setting prior to the hospitalization. At discharge, those patients reached sufficient improvement in mobility and activities of daily living, enough in fact, to go back to the prior level of functioning; many of which were able to be alone at home.

Forbes Hospital would also like to note that the 16 of the 28 patients identified by the OIG as not requiring inpatient rehab had the primary diagnosis of debility and 9 of the 28 with post fractured hip repair and therefore, were outside of the 13 approved diagnoses for the 60% Rule. The OIG's medical reviewer(s) cited that a primary diagnosis of debility does not support the medical necessity of acute inpatient rehab. The reason identified by the OIG's medical reviewer(s) for denial of inpatient rehab is not reflected within the Medicare regulations. Medicare allows for 40% of the unit's patients (during a calendar year) to have a diagnosis other than the 13 diagnoses cited in the Rule. Medical necessity is of course required for any diagnosis, and we believe medical necessity is evidenced in all 28 cases selected for review.

Five (5) cases contributing to the OIG's financial error rate calculation were identified by the OIG as having an incorrect Case Mix Group (CMG). Our review of these cases concluded that the OIG's reviewer applied "tiering comorbidity" exclusions incorrectly, and failed to use the comprehensive list of Codes which are approved for CMG Tiering assignment. Additionally, the OIG reviewer used Raw FIM scores to calculate CMG assignment, and failed to apply the appropriate weighting to the respective functional elements, thus incorrectly calculating the appropriate CMG. All of the diagnoses and functional scoring documented in the medical record is entered into a software system which utilizes CMS's Database to calculate the CMG subsequently populating the IRF-PAI to submit to CMS. We disagree with all five (5) of the OIG's coding of inpatient rehab case findings.

The OIG identified a total of 16 incorrect DRG assignments for inpatient stays (CERT high error rate and high severity DRGs) which resulted in a change of DRG for 3 cases. The cases provided by the OIG for this finding were inpatient rehab cases without details as to what coding was incorrect. Forbes Hospital disagrees with these inpatient rehab coding findings provided to the hospital and believes the coding and resultant billing was correct as submitted.

Forbes Hospital plans to appeal almost all of the cases referenced above through the proper channels within Medicare.

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

We are of the opinion that repayment, if required, should occur after the baseline error rate is established and all appeal mechanisms are exhausted. Furthermore, we disagree that any of these initial findings should be extrapolated across our population of inpatient rehab patients.

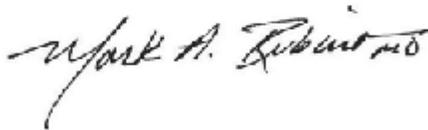
*3. Strengthen controls to ensure full compliance with Medicare requirements by:*

- *ensuring that all IRF beneficiaries meet Medicare criteria for acute inpatient rehabilitation,*
- *ensuring that all inpatient beneficiaries meet Medicare criteria for inpatient hospital services,*
- *ensuring that the medical records support the procedure and the diagnosis codes used, and ensuring that medical records accurately document distinct procedural services.*

Forbes Hospital has processes in place to evaluate the appropriateness of both acute inpatient stays and inpatient rehabilitation admissions. Ongoing monitoring occurs within the hospital and there are system-wide Utilization Management services meetings under physician leadership. Objective compliance audits occur one to two times per year for medical necessity of inpatient stays, inpatient rehab stays and DRG/coding assignments. Results of ongoing monitoring, auditing and outcomes of internal and external audits are used to develop recommendations to improve documentation to support medical necessity and coding.

We appreciate the opportunity afforded us to respond to this report.

Sincerely,



Mark A. Rubino, MD  
President, Forbes Hospital



Sandra Sessoms, RN, CHC  
Compliance Officer, FH  
Director, AHN Corporate Compliance