

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW  
OF ORLANDO HEALTH  
FOR THE PERIOD JANUARY 1, 2011,  
THROUGH JUNE 30, 2012**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
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September 2014  
A-04-13-07042

# *Office of Inspector General*

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## EXECUTIVE SUMMARY

***Orlando Health did not fully comply with Medicare requirements for billing inpatient services, resulting in overpayments of at least \$1,453,243 over 1½ years.***

### WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. 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 (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Orlando Health (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

### BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

The Hospital is a 1,788-bed network of hospitals based in Orlando, Florida. According to CMS's National Claims History data, Medicare paid the Hospital approximately \$332 million for 34,676 inpatient and 166,694 outpatient claims for services provided to beneficiaries during January 1, 2011, through June 30, 2012 (audit period).

Our audit covered \$11,799,937 in Medicare payments to the Hospital for 1,260 inpatient claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 218 inpatient claims with payments totaling \$2,075,152. These 218 claims had dates of service in our audit period. We did not review any outpatient claims.

### WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 143 of the 218 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 75 claims, resulting in net overpayments of \$462,142 for the audit period. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,453,243 for the audit period.

## **WHAT WE RECOMMEND**

We recommend that the Hospital:

- refund to the Medicare contractor \$1,453,243 in estimated overpayments for the audit period for claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare requirements.

## **ORLANDO HEALTH COMMENTS**

In written comments on our draft report, the Hospital agreed with our findings. However, regarding our recommendation to refund to the Medicare contractor \$1,453,243 in estimated overpayments, the Hospital expressed concerns about the methodology and the statistical validity of the amount extrapolated. The Hospital also stated that our methodology substantially overestimates the overpayment amount because it does not reflect the potential Medicare Part B reimbursement that could result from rebilling the claims that the Hospital should have billed as outpatient or outpatient with observation services. Regarding our second recommendation, the Hospital provided information on corrective actions that it had taken.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

In response to the Hospital's concerns regarding our extrapolation methodology and statistical validity, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare. Additionally, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology. We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

We acknowledge that the Hospital may rebill Medicare for the incorrectly billed inpatient claims; however, the rebilling issue is beyond the scope of our audit. CMS has issued the final regulations on payment policies (78 Fed. Reg. 160 (Aug. 19, 2013)), and the Hospital should contact its Medicare contractor for rebilling instructions. As stated in the report, we were unable to determine the effect that billing Medicare Part B would have had on the overpayment amount because the Hospital had not billed, and the Medicare contractor had not adjudicated, these services prior to the issuance of our report.

Therefore, we continue to recommend that the Hospital refund to the Medicare contractor \$1,453,243 in estimated overpayments.

## TABLE OF CONTENTS

INTRODUCTION .....	1
Why We Did This Review .....	1
Objective .....	1
Background .....	1
The Medicare Program .....	1
Hospital Inpatient Prospective Payment System .....	1
Hospital Outpatient Prospective Payment System.....	1
Hospital Claims at Risk for Incorrect Billing .....	2
Medicare Requirements for Hospital Claims and Payments .....	2
Orlando Health.....	3
How We Conducted This Review.....	3
FINDINGS .....	3
Billing Errors .....	4
Incorrectly Billed as Inpatient.....	4
Incorrectly Billed as Separate Inpatient Stays .....	4
Incorrectly Billed Diagnosis-Related-Group Codes .....	4
Incorrect Discharge Status .....	5
Overall Estimate of Overpayments.....	5
RECOMMENDATIONS .....	5
ORLANDO HEALTH COMMENTS AND OFFICE OF THE INSPECTOR GENERAL RESPONSE .....	6
Orlando Health Comments .....	6
Office of Inspector General Response .....	6
APPENDIXES	
A: Audit Scope and Methodology .....	7
B: Sample Design and Methodology .....	9
C: Sample Results and Estimates.....	11
D: Results of Review by Risk Area .....	12
E: Orlando Health Comments.....	13

## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

This review is part of a series of hospital compliance reviews. 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 (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

### **OBJECTIVE**

Our objective was to determine whether Orlando Health (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

### **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 contractors to, among other things, process and pay claims submitted by hospitals.

#### **Hospital Inpatient Prospective Payment System**

Under the inpatient prospective payment system (IPPS), CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

#### **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**

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- inpatient short stays,
- inpatient claims paid in excess of charges,
- inpatient claims with cancelled surgical procedures,
- inpatient same day discharges and readmissions,
- inpatient claims billed with high-severity-level DRG codes, and
- inpatient claims billed for kyphoplasty services.<sup>2</sup>

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.” We reviewed these risk areas as part of this review.

### **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 Social Security Act (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 (§ 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), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

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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> Also called “balloon kyphoplasty,” medical professionals use this procedure to treat compression fractures of the spine. See National Institutes of Health’s “Medicine Plus” Web site. Available online at <http://www.nlm.nih.gov/medlineplus/ency/article/007511.htm>. Accessed on June 19, 2014.

## **Orlando Health**

The Hospital is a 1,788-bed network of hospitals based in Orlando, Florida. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately \$332 million for 34,676 inpatient and 166,694 outpatient claims for services provided to beneficiaries during January 1, 2011, through June 30, 2012 (audit period).

### **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$11,799,937<sup>3</sup> in Medicare payments to the Hospital for 1,260 inpatient claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 218 claims with payments totaling \$2,075,152. These 218 claims had dates of service in our audit period. We did not review any outpatient claims.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 50 inpatient claims to medical and coding reviews to determine whether the services were medically necessary and properly coded. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

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

See Appendix A for the details of our audit scope and methodology.

### **FINDINGS**

The Hospital complied with Medicare billing requirements for 143 of the 218 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 75 claims, resulting in net overpayments of \$462,142 for the audit period. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,453,243 for the audit period.

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<sup>3</sup> This was the dollar value of our sample frame at the time of the initial data extraction from the NCH. However, during the course of our review, the Medicare contractor adjusted some of the claims in our sample frame, including sampled claims, due to mass wage-index adjustments. Therefore, we reviewed the 218 sample items and determined which ones were adjusted. The sample results include the adjusted claims' paid amounts.

See Appendix B for our sample design and methodology, Appendix C for our sample results and estimates, and Appendix D for the results of our review by risk area.

## **BILLING ERRORS**

### **Incorrectly Billed as Inpatient**

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

For 52 of the 218 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that it should have billed as outpatient or outpatient with observation services. The Hospital said that the errors occurred because of various factors such as limited staffing resources, admission and order complexity, and its use of multiple Electronic Medical Record (EMR) systems.

As a result of these errors, the Hospital received overpayments of \$433,969.<sup>4</sup>

### **Incorrectly Billed as Separate Inpatient Stays**

The Manual (chapter 3, § 40.2.5) states that, when a patient is discharged or transferred from an acute care hospital and is readmitted to the same hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition, hospitals should adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 4 of the 218 selected claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that the errors occurred because it did not match the billed diagnosis codes to the patients’ subsequent admissions.

As a result of these errors, the Hospital received overpayments of \$17,213.

### **Incorrectly Billed Diagnosis-Related-Group Codes**

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 Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

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<sup>4</sup> The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have had on the overpayment amount because the Medicare administrative contractor had not adjudicated these services prior to the issuance of our report.

For 18 of the 218 selected claims, the Hospital submitted claims to Medicare with incorrectly coded claims that resulted in the higher DRG payments to the Hospital. For example, the Hospital submitted a claim with a secondary diagnosis of pleural effusion. However, the medical records did not support the coding of this diagnosis. By including this secondary diagnosis, the Hospital increased the weight of the DRG, which resulted in an overpayment. The Hospital attributed these errors to several factors such as limited staffing resources, use of multiple EMR systems, and not updating medical documentation in the system after the coding cycles were completed.

As a result of these errors, the Hospital received net overpayments of \$12,992.

### **Incorrect Discharge Status**

Federal regulations state that a discharge of a hospital inpatient is considered to be a transfer when the patient's discharge is assigned to one of the qualifying DRGs and the discharge is to a skilled nursing facility (SNF) (42 CFR § 412.4(c)). A hospital that transfers an inpatient under the above circumstance is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For 1 of the 218 selected claims, the Hospital incorrectly billed Medicare for a patient discharge to a SNF instead of to a hospice medical facility. Thus, the Hospital received the graduated per diem payment instead of the full DRG payment it would have received if it had correctly coded the patient's discharge status. The Hospital stated that this error occurred because it acquired the pertinent medical documentation after it had completed its coding cycles.

As a result of this error, the Hospital was underpaid \$2,032.

### **OVERALL ESTIMATE OF OVERPAYMENTS**

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,453,243 for the audit period.

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$1,453,243 in estimated overpayments for the audit period for claims that it incorrectly billed and
- strengthen controls to ensure full compliance with Medicare requirements.

## **ORLANDO HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

### **Orlando Health Comments**

In written comments on our draft report, the Hospital agreed with our findings. However, regarding our recommendation to refund to the Medicare contractor \$1,453,243 in estimated overpayments, the Hospital expressed concerns about the methodology and the statistical validity of the amount extrapolated. The Hospital also stated that our methodology substantially overestimates the overpayment amount because it does not reflect the potential Medicare Part B reimbursement that could result from rebilling the claims that the Hospital should have billed as outpatient or outpatient with observation services. Regarding our second recommendation, the Hospital provided information on corrective actions that it had taken. The Hospital's comments are included in their entirety as Appendix E.

### **Office of Inspector General Response**

In response to the Hospital's concerns regarding our extrapolation methodology and statistical validity, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare.<sup>5</sup> Additionally, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.<sup>6</sup> We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

We acknowledge that the Hospital may rebill Medicare for the incorrectly billed inpatient claims; however, the rebilling issue is beyond the scope of our review. CMS issued the final regulations on payment policies (78 Fed. Reg. 160 (Aug. 19, 2013)), and the Hospital should contact its Medicare contractor for rebilling instructions. As stated in the report, we were unable to determine the effect that billing Medicare Part B would have had on the overpayment amount because the Hospital had not billed, and the Medicare contractor had not adjudicated, these services prior to the issuance of our report.

Therefore, we continue to recommend that the Hospital refund to the Medicare contractor \$1,453,243 in estimated overpayments.

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<sup>5</sup> See *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).

<sup>6</sup> See *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at \*13 (S.D. Tex. 2012).

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

### **SCOPE**

Our audit covered \$11,799,937 in Medicare payments to the Hospital for 1,260 inpatient claims that were potentially at risk for billing errors. (See footnote 3.) We selected for review a stratified random sample of 218 claims with payments totaling \$2,075,152. These 218 claims had dates of service in the period January 1, 2011, through June 30, 2012 (audit period). We did not select any outpatient claims for review.

We focused our review on the risk areas identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 50 claims to medical and coding reviews to determine whether the services were medically necessary and properly coded.

We limited our review of the Hospital's internal controls to those applicable to the inpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the NCH 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 fieldwork at the Hospital during July of 2013.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's NCH 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 218 inpatient claims totaling \$2,075,152 for detailed review (Appendix B);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;

- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning DRG, HCPCS, and admission status codes for Medicare claims;
- used an independent contractor to determine whether 50 claims met medical necessity requirements and were properly coded;
- 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 overpayments to the Hospital (Appendix C); and
- discussed the results of our review 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: SAMPLE DESIGN AND METHDOLOGY

### POPULATION

The population contained inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during the audit period.

### SAMPLING FRAME

We obtained a database of claims from CMS's NCH data totaling \$210,625,406 for 12,006 inpatient and 50,771 outpatient claims in 29 risk areas.

From these 29 areas, we selected 6 inpatient areas consisting of 7,004 inpatient claims totaling \$55,953,123 for further review.

We performed data analyses of the claims within each of the six risk areas. For strata one, two, and four, we removed claims with payment amounts less than \$3,000. For stratum three, we removed claims where the payment amount was less than \$5,000 over the charged amount.

We also removed the following:

- \$0 paid claims,
- claims under review by the Recovery Audit Contractor, and
- claims duplicated within individual risk areas.

We assigned each claim that appeared in multiple risk areas to just one area based on the following hierarchy: Inpatient Claims Paid in Excess of Charges, Inpatient Claims Billed With High-Severity-Level DRG Codes, and Inpatient Short Stays. This resulted in a sample frame of 1,260 unique Medicare claims in 6 risk areas totaling \$11,799,937. (See footnote 3.)

<b>Risk Area</b>	<b>Number of Claims</b>	<b>Amount of Payments</b>
1. Inpatient Short Stays	449	\$3,841,802
2. Inpatient Claims Billed With High-Severity-Level DRG Codes	778	7,621,159
3. Inpatient Claims Paid in Excess of Charges	8	193,423
4. Inpatient Claims With Cancelled Surgical Procedures	9	39,532
5. Inpatient Same Day Discharges and Readmissions	15	89,615
6. Inpatient Claims Billed for Kyphoplasty Services	1	14,406
<b>Total</b>	<b>1,260</b>	<b>\$11,799,937</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 six strata based on the risk area. All claims are unduplicated, appearing in only one area and only once in the entire sampling frame.

## **SAMPLE SIZE**

We selected 218 claims for review as follows:

<b>Stratum</b>	<b>Risk Area</b>	<b>Claims in Sampling Frame</b>	<b>Claims in Sample</b>
1	Inpatient Short Stays	449	85
2	Inpatient Claims Billed With High-Severity-Level DRG Codes	778	100
3	Inpatient Claims Paid in Excess of Charges	8	8
4	Inpatient Claims With Cancelled Surgical Procedures	9	9
5	Inpatient Same Day Discharges and Readmissions	15	15
6	Inpatient Claims Billed for Kyphoplasty Services	1	1
	<b>Total Sampled Claims</b>	<b>1,260</b>	<b>218</b>

## **SOURCE OF RANDOM NUMBERS**

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

## **METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the claims within strata one and two. After generating the random numbers for strata one and two, we selected the corresponding claims in each stratum. We selected all claims in strata three through six.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments in our sampling frame for the Hospital during the audit period.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**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 Net Overpayments in Sample</b>
1	449	\$3,841,802	85	\$757,319	40	\$354,087
2	778	7,621,159	100	1,014,531	20	21,025
3	8	193,423	8	159,647	1	15,842
4	9	39,532	9	39,569	9	39,569
5	15	89,615	15	89,680	4	17,213
6	1	14,406	1	14,406	1	14,406
<b>Total</b>	<b>1,260</b>	<b>\$11,799,937</b>	<b>218</b>	<b>\$2,075,152</b>	<b>75</b>	<b>\$462,142</b>

**ESTIMATES**

**Estimated Value of Overpayments for the Audit Period**  
*Limits Calculated for a 90-Percent Confidence Interval*

Point Estimate	\$2,121,020
Lower limit	\$1,453,243
Upper limit	\$2,788,796

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

<b>Risk Area</b>	<b>Selected Claims</b>	<b>Value of Selected Claims</b>	<b>Claims With Underpayments /Overpayments</b>	<b>Value of Net Overpayments</b>
<b>Inpatient</b>				
Short Stays	85	\$757,319	40	\$354,087
Claims With Cancelled Surgical Procedures	9	39,569	9	39,569
Claims Billed With High-Severity-Level DRG Codes	100	1,014,531	20	21,025
Same Day Discharges and Readmissions	15	89,680	4	17,213
Claims Paid in Excess of Charges	8	159,647	1	15,842
Claims Billed for Kyphoplasty Services	1	14,406	1	14,406
<b>Inpatient Totals</b>	<b>218</b>	<b>\$2,075,152</b>	<b>75</b>	<b>\$462,142</b>

**Notice:** The table above illustrates the results of our review by risk area. In it, we have organized inpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

## APPENDIX E: ORLANDO HEALTH COMMENTS



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OrlandoHealth.com

July 31, 2014

Ms. Lori S. Pilcher  
Regional Inspector General for Audit Services  
Office of Audit Services, Region IV  
61 Forsyth Street SW Suite 3T41  
Atlanta, GA 30303

Re: Report Number: A 04-13-07042

Dear Ms. Pilcher:

We are writing on behalf of Orlando Health to respond to the Office of Inspector General's (OIG) Draft Audit Report No. A-04-13-07042 entitled *Medicare Compliance Review of Orlando Health for the Period January 1, 2011, Through June 30, 2012* received by Orlando Health on Friday June 27, 2014.

Orlando Health is one of Florida's comprehensive private, not-for-profit healthcare organizations. Since 1918, Orlando Health has been part of the Greater Orlando community, growing from a single hospital in Orlando into an award-winning family of community and specialty hospitals in Central Florida. From our rigorous training programs for new physicians to our emphasis on medical research, technology, and innovation, we proudly offer a world-renowned cancer center and the region's only Level One Trauma Centers for children and adults. Orlando Health's total Community Benefit in 2013 was \$233 Million; Cost of providing Charity Care was \$76 Million with a Total Value to the Community of \$289 Million. We work hard to support our mission, "To Improve the Health and Quality of Life of the Individuals and the Communities We Serve."

### Background:

The audit covered \$11,799,937 in Medicare payments for 1,260 inpatient accounts in the audit period. The Draft Report identified a total alleged overpayment of \$462,142 based on a universe of 218 Claims that the OIG specifically selected as being at risk for billing error after reviewing the medical record documentation for each claim. We agreed that we complied with the Medicare billing requirements for 143 of the 218 inpatient claims that the OIG auditors reviewed and the remaining 75 claims were medically necessary services for the beneficiaries but were technical errors as the claims were billed as inpatient rather than outpatient.

The Draft Report section "Executive Summary" states that Orlando Health did not comply with Medicare requirements for billing inpatient services, resulting in an extrapolated overpayment amount of \$1,453,243 over an 18 month period. This extrapolated amount resulted from the sampled claims' error rate projected (estimated) to all claims in the sampling frame. The two selected areas at risk from the statistical sampling were the Inpatient Short Stays and the Inpatient Claims billed with High Severity-Level Diagnosis Related Group Codes, of which extrapolation applies. The number of incorrectly billed claims in the sample totaled 40 claims that were technical billing denials and 20 claims were due to insufficient documentation and equate to \$375,112 in net overpayments for this 18 month period. The



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care and services provided by Orlando Health to the Medicare beneficiaries were medically necessary on all claims in the sampling frame but were billed as inpatient vs. outpatient.

The remaining four areas identified in the overall sample frame include 15 inpatient claims with similar patient status technical billing issues. Again, Orlando Health contends that the services and care provided to the Medicare beneficiaries were medically necessary on all claims. As such, Orlando Health agrees with the findings identified in the 75 claims with a value of net overpayments of \$462,142, subject to the requested adjustment as set forth below.

Orlando Health is committed to compliance with regulations applicable to federal health care programs and the quality of not only the clinical care we provide but also the financial and billing aspects of all services rendered within our facilities. We strive to accurately assign patients to the correct billing status based on clinical review which includes current severity of illness, comorbidities, risk of adverse outcome, and intensity of service/treatment. We agree with the recommendation to strengthen controls to ensure full compliance with Medicare requirements, and we have undertaken a number of corrective actions in this regard to date including but not limited to: 1) educating our physicians and case management staff on documentation requirements for inpatient short stays, 2) quarterly audit review, 3) work flow process with our electronic medical record updates, and 4) collaboration with all teams engaging leadership, case management, revenue cycle, and compliance teams in a review of internal controls and consistent monitoring of our processes.

Orlando Health agrees with the findings identified in the 75 individually audited claims. With respect to the extrapolation approach, we have concerns about the methodology and the statistical validity of the extrapolation amount requested of \$1,453,243. While we will accept this amount for the limited purpose of completing this step of the audit process, we reserve the right to further contest the extrapolation methodology as it applies to the non-audited accounts in the audit period.

Further, even if this extrapolation methodology is valid, it substantially overestimates any potential overpayment because it is not reflective of the potential Medicare Part B reimbursement. Orlando Health has calculated the value of that potential reimbursement based on our historical Medicare Part B reimbursement to be \$821,398. As such, we request that the OIG modify the original extrapolated overpayment amount (\$1,453,243) by the calculated Medicare Part B historical reimbursement value of the extrapolated population (\$821,398) and that Orlando Health be requested to pay the restated overpayment amount of \$631,845 ( $\$1,453,243 - \$821,398 = \$631,845$ ). This amount accurately reflects the net overpayment value of the extrapolated claims using the OIG methodology. Since the OIG used extrapolation over the claim population it is only reasonable and appropriate that the same methodology is used for the Medicare Part B reimbursement.

The alternative to applying the average Medicare Part B reimbursement value to the extrapolated population is for the OIG to request our Medicare administrative contractor to reopen all claims in the extrapolation population and prepare to adjudicate these claims under Medicare Part B. Past requests such as this have led to a condensed window for providers to process and resubmit claims resulting in significant administrative burden and costs on behalf of both the provider and administrative contractor. In addition, reopening and adjudicating these claims will result in Medicare beneficiaries receiving an explanation of benefit statement for services as much as four years old and potentially being liable for recalculated out of pocket coinsurance amounts. These new billable patient liabilities will cause not only financial burdens on our Medicare beneficiaries, but also have the potential to



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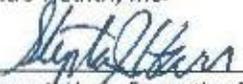
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significantly increase the related correspondence and inquiries to Medicare service centers. Another consideration is the impact these billing changes may have on claims previously billed as inpatient which now will be billed as outpatient and therefore not represent a qualifying stay prior to a skilled nursing facility admission. These respective scenarios could result in the impacted skilled nursing facility provider refunding prior payments to the Medicare administrative contractor and subsequently holding the beneficiary liable for those expenses previously paid by Medicare.

We would like to take this opportunity to communicate how much we appreciated working collaboratively with the Senior Auditor and his team during the course of this audit. We take pride in the quality and cost effectiveness of the care we provide to our patients, and we strive for continuous improvement in all areas of our operations, including providing staff education, ensuring complete and accurate documentation, and maintaining a compliance program. We are confident that the corrective measures Orlando Health has undertaken from this audit have strengthened our controls to ensure full compliance with Medicare requirements.

Sincerely,

Orlando Health, Inc.

By:   
Stephan J. Harr, Executive Vice-President

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