

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF MISSION HOSPITAL  
FOR 2011 AND 2012**

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# ***Office of Inspector General***

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## EXECUTIVE SUMMARY

***Mission Hospital did not fully comply with Medicare requirements for billing inpatient and outpatient services, resulting in overpayments of at least \$443,183 over 2 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 Mission Hospital (Mission), 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.

Mission, which is part of the Mission Health System, is a 795-bed hospital located in Asheville, North Carolina. Medicare paid Mission approximately \$697 million for 53,057 inpatient and 295,685 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered \$18,584,513 in Medicare payments to Mission for 2,105 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 192 claims with payments totaling \$2,760,822. These 192 claims had dates of service in CY 2011 or CY 2012 and consisted of 110 inpatient and 82 outpatient claims.

### WHAT WE FOUND

Mission complied with Medicare billing requirements for 144 of the 192 inpatient and outpatient claims we reviewed. However, Mission did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in overpayments of \$121,594 for CYs 2011 and 2012 (audit period). Specifically, 28 inpatient claims had billing errors resulting in overpayments of \$100,165, and 20 outpatient claims had billing errors resulting in overpayments of \$21,429.

These errors occurred primarily because Mission 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 Mission received overpayments of at least \$443,183 for the audit period.

## **WHAT WE RECOMMEND**

We recommend that Mission:

- refund to the Medicare program \$443,183 in estimated overpayments for claims it incorrectly billed for the audit period and
- strengthen controls to ensure full compliance with Medicare requirements.

## **MISSION HOSPITAL COMMENTS AND OUR RESPONSE**

### **Mission Comments**

In written comments on our draft report, Mission partially agreed with our first recommendation and discussed steps that it had taken or planned to take in regards to our second recommendation. In regards to our first recommendation, Mission agreed that 23 claims were billed incorrectly and described the actions it had taken to correct them.

Mission did not agree that it incorrectly billed 24 short stay claims and said it would appeal all 24 cases. Additionally, Mission did not agree that it incorrectly billed one medical device claim.

Mission also disagreed with our use of extrapolation for the short stay cases and said that:

- the audit report had insufficient information to determine the validity of the sampling and
- it was not provided the details of the statistical sampling methodology.

Mission said that based on the timing of the review and the directive that it should not take action on the claims involved in the audit until the review was finalized, Mission would not have been able to bill Medicare Part B for any of the claims under the timely filing rules.

Mission further stated that four of the DRGs we reviewed have already had record requests and denials from either a RAC or MAC. Mission reasoned that it would be paying these overpayment cases twice if the OIG extrapolation covered a DRG that was for the same time period that the RAC or MAC had already reviewed.

With respect to one of the medical device claims for which Mission did not obtain a manufacturer's credit, Mission said that the case involved a "subclavian crush injury to a cardiac lead," and as such, the manufacturer representative indicated that they do not issue warranty credits for "crush injuries."

## Office of Inspector General Response

In response to Mission's concerns regarding rebilling for certain services that were denied as part of this review, we acknowledge its comments; however, the rebilling issue is beyond the scope of our audit. As stated in the report, we were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because Mission had not billed, and the MAC had not adjudicated, these services prior to the issuance of our draft report.

In regard to Mission's disagreement that it incorrectly billed 24 short stay claims, we submitted for medical review by the MAC Mission's medical record documentation for each of these claims. We also submitted for medical review the additional medical record documentation that Mission gave us subsequent to the MAC's original determination. On the basis of the medical review findings, we continue to maintain that Mission incorrectly billed these 24 claims.

We do not agree with Mission's comment regarding the claim for which it did not seek a manufacturer's credit. The manufacturer's warranty required Mission to return the lead to the manufacturer so that it could determine whether it was eligible for a credit. In its written comments, Mission did not provide any documentation to show that it complied with this requirement of the manufacturer's warranty. Therefore, we continue to question this claim.

Regarding Mission's objections to our statistical sampling and extrapolation, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare. *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).

Furthermore, the use of statistical sampling and extrapolation to determine overpayment amounts in Medicare does not violate due process because the auditee is given the opportunity to appeal the audit results through the Medicare appeals process. *See Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at \*34 (S.D. Tex. 2012).

We disagree with Mission's comment that it was not provided the details of our statistical sampling methodology. Prior to beginning our onsite work at Mission, at both the entrance and exit conferences, and numerous instances during the course of our audit, Mission had questions concerning our sampling frame, sample selection, and extrapolation. On each of these occasions, we thoroughly discussed and answered Mission's questions. Specifically, we discussed the development and definition of our sampling frame and sample unit. We discussed the random selection of our sample, how we applied relevant criteria in evaluating the sample, and the statistical sampling software that we used to apply the correct formulas for the extrapolation. Additionally, we directed Mission to the OIG Web site where, if it had further questions, the statistical software used to extrapolate the results was available for public use.

With respect to Mission's concerns about duplicate refunds for reviews of the same claims in our sampling frame, we excluded all claims in our sampling frame from future Recovery Audit Contractor (RAC) review and removed claims from our sample frame that the RAC had

previously reviewed. Additionally, while the RACs do have the authority to extrapolate, CMS told us that the RACS have not done so. For these reasons, our extrapolation would not have caused Mission to pay twice for overpayments in our sampling frame. However, to prevent repaying Medicare twice for claims that Mission may have already repaid due to previous RAC or MAC reviews, Mission should tell CMS which claims in our sampling frame were previously adjusted. CMS could then reduce the amount we recommended that Mission refund (\$443,183) by the amount already repaid.

We continue to recommend that Mission refund to the Medicare program \$443,183 in estimated overpayments and continue to strengthen controls to ensure full compliance with Medicare requirements.

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## 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 Mission Hospital (Mission), 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**

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system. 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 billed with high-severity-level DRG codes,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient same-day discharges and readmissions,
- outpatient claims billed with evaluation and management (E&M) services, and
- outpatient claims with payments greater than \$25,000.

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

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<sup>1</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

## **Mission Hospital**

Mission, which is part of the Mission Health System, is a 795-bed hospital located in Asheville, North Carolina. According to CMS's National Claims History data, Medicare paid Mission approximately \$697 million for 53,057 inpatient and 295,685 outpatient claims for services provided to beneficiaries during CYs 2011 and 2012.

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

Our audit covered \$18,584,513 in Medicare payments to Mission for 2,105 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 192 claims with payments totaling \$2,760,822. These 192 claims had dates of service in CY 2011 or CY 2012 and consisted of 110 inpatient and 82 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 35 claims to medical review to determine whether the services were medically necessary.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Mission 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**

Mission complied with Medicare billing requirements for 144 of the 192 inpatient and outpatient claims we reviewed. However, Mission did not fully comply with Medicare billing requirements for the remaining 48 claims, resulting in overpayments of \$121,594 for CYs 2011 and 2012 (audit period). Specifically, 28 inpatient claims had billing errors resulting in overpayments of \$100,165, and 20 outpatient claims had billing errors resulting in overpayments of \$21,429. These errors occurred primarily because Mission did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

Based on our sample results, we estimated that Mission received overpayments of at least \$443,183 for the audit period. See Appendix B for details on 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 ASSOCIATED WITH INPATIENT CLAIMS**

Mission incorrectly billed Medicare for 28 of 110 sampled inpatient claims, which resulted in overpayments of \$100,165.

### **Incorrectly Billed as Inpatient**

Medicare payments may not be made for items and 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 26 of the 110 inpatient claims, Mission incorrectly billed Medicare Part A for beneficiaries whose level of care and services provided should have been billed as outpatient or outpatient with observation services. The medical records did not document that it was reasonable and necessary for the patient to be admitted to the hospital as an inpatient. For example, one patient came to Mission’s emergency department after fainting at home. The studies performed in the emergency department were negative; however, the patient was admitted for monitoring and further evaluation.

Although medical review determined that all 26 of these claims were incorrect, Mission only agreed that 2 of the 26 inpatient short stay claims were incorrectly billed. Mission stated that the two claims were not screened by their utilization management program to ensure medical necessity criteria were met for the inpatient admission prior to discharge. These 26 errors occurred because system controls were not in place to identify short stays prior to discharge and billing. As a result, Mission received overpayments of \$97,540.<sup>2</sup>

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

Medicare payments may not be made for items and 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)). Additionally, the Manual requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (chapter 1, § 80.3.2.2).

For 2 of the 110 inpatient claims, Mission billed Medicare for incorrect DRG codes. Medical review determined that the secondary diagnosis codes were not sufficiently supported in the medical records. Mission agreed that these two claims lacked documentation to support the secondary diagnosis. Mission attributed these errors to the manual nature of coding and the potential for occasional human error. As a result of these errors, Mission received overpayments of \$2,625.

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<sup>2</sup> Mission 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 on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor prior to the issuance of our report.

## **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

Mission incorrectly billed Medicare for 20 of 82 sampled outpatient claims, which resulted in overpayments of \$21,429.

### **Manufacturer Credits for Replaced Medical Devices Not Obtained**

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if: (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45). The CMS *Provider Reimbursement Manual* (PRM) reinforces these requirements in additional detail (Pub. No. 15-1).<sup>3</sup>

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPPS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.

For 2 of the 82 outpatient claims, Mission did not obtain credits for replaced devices for which credits were available under the terms of the manufacturer’s warranty:

- For one claim, Mission did not attempt to return the cardiac lead from a pacemaker to the manufacturer to determine whether the device was eligible for a warranty credit.
- For one claim, Mission did not obtain a credit for a replaced medical device because the manufacturer’s representative did not return the device. At the conclusion of our onsite work in March 2014, Mission had received a credit for this device; however the Medicare claim had not been adjusted.

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<sup>3</sup> The PRM states: “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program” (part I, § 2102.1). Section 2103 further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) provides the following example: “Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits or payments available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.”

Mission stated that their key controls were operating as described in its policy and procedure for obtaining credit for replaced devices. However, as a result of our review, Mission reviewed its current policy and procedure and made revisions to ensure followup with vendors. As a result, Mission received overpayments of \$20,442.

### **Incorrectly Billed Evaluation and Management Services**

The Manual states that a Medicare contractor pays an E&M service that is significant, separately identifiable, and above and beyond the usual pre- and post-operative work of the procedure (chapter 12, § 30.6.6(B)). 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)).

For 18 of the 82 outpatient claims, Mission incorrectly billed Medicare for E&M services. For all 18 claims, the E&M services were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure. For example, for seven claims, the Hospital incorrectly billed as E&M services a routine laryngoscopy procedure, which is a routine and normal procedure conducted in the course of postoperative work. Mission attributed the incorrect billing for all 18 claims to clerical and procedural errors, its billing interpretation of E&M guidelines for capturing “above and beyond” work, and a “knowledge deficiency” in one of its hospital departments.

As a result of these errors, Mission received overpayments of \$987.

### **OVERALL ESTIMATE OF OVERPAYMENTS**

On the basis of our sample results, we estimated that Mission received overpayments of at least \$443,183 for the audit period.

### **RECOMMENDATIONS**

We recommend that Mission:

- refund to the Medicare program \$443,183 in estimated overpayments for claims that it incorrectly billed for the audit period and
- strengthen controls to ensure full compliance with Medicare requirements.

### **MISSION HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

#### **Mission Comments**

In written comments on our draft report, Mission partially agreed with our first recommendation and discussed steps that it had taken or planned to take in regards to our second recommendation.

In regards to our first recommendation, Mission agreed that 23 claims were billed incorrectly and described the actions it had taken to correct them.

Mission did not agree that it incorrectly billed 24 short stay claims and said it would appeal all 24 cases. Additionally, Mission did not agree that it incorrectly billed one medical device claim.

Mission also disagreed with our use of extrapolation for the short stay cases and said that:

- the audit report had insufficient information to determine the validity of the sampling and
- it was not provided the details of the statistical sampling methodology.

Mission said that based on the timing of the review and the directive that it should not take action on the claims involved in the audit until the review was finalized, Mission would not have been able to bill Medicare Part B for any of the claims under the timely filing rules.

Mission further stated that four of the DRGs we reviewed have already had record requests and denials from either a RAC or MAC. Mission reasoned that it would be paying these overpayment cases twice if the OIG extrapolation covered a DRG that was for the same time period that the RAC or MAC had already reviewed.

With respect to one of the medical device claims for which Mission did not obtain a manufacturer's credit, Mission said that the case involved a "subclavian crush injury to a cardiac lead," and as such, the manufacturer representative indicated that they do not issue warranty credits for "crush injuries." Mission's comments are included in their entirety as Appendix E.

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

In response to Mission's concerns regarding rebilling for certain services that were denied as part of this review, we acknowledge its comments; however, the rebilling issue is beyond the scope of our audit. As stated in the report, we were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because Mission had not billed, and the MAC had not adjudicated, these services prior to the issuance of our draft report.

In regard to Mission's disagreement that it incorrectly billed 24 short stay claims, we submitted for medical review by the MAC Mission's medical record documentation for each of these claims. We also submitted for medical review the additional medical record documentation that Mission gave us subsequent to the MAC's original determination. On the basis of the medical review findings, we continue to maintain that Mission incorrectly billed these 24 claims.

We do not agree with Missions' comment regarding the claim for which it did not seek a manufacturer's credit. The manufacturer's warranty required Mission to return the lead to the manufacturer so that it could determine whether it was eligible for a credit. In its written comments, Mission did not provide any documentation to show that it complied with this requirement of the manufacturer's warranty. Therefore, we continue to question this claim.

Regarding Mission's objections to our statistical sampling and extrapolation, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare. *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).

Furthermore, the use of statistical sampling and extrapolation to determine overpayment amounts in Medicare does not violate due process because the auditee is given the opportunity to appeal the audit results through the Medicare appeals process. *See Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at \*34 (S.D. Tex. 2012).

We disagree with Mission's comment that it was not provided the details of our statistical sampling methodology. Prior to beginning our onsite work at Mission, at both the entrance and exit conferences, and numerous instances during the course of our audit, Mission had questions concerning our sampling frame, sample selection, and extrapolation. On each of these occasions, we thoroughly discussed and answered Mission's questions. Specifically, we discussed the development and definition of our sampling frame and sample unit. We discussed the random selection of our sample, how we applied relevant criteria in evaluating the sample, and the statistical sampling software that we used to apply the correct formulas for the extrapolation. Additionally, we directed Mission to the OIG Web site where, if it had further questions, the statistical software used to extrapolate the results was available for public use.

With respect to Mission's concerns about duplicate refunds for reviews of the same claims in our sampling frame, we excluded all claims in our sampling frame from future Recovery Audit Contractor (RAC) review and removed claims from our sample frame that the RAC had previously reviewed. Additionally, while the RACs do have the authority to extrapolate, CMS told us that the RACS have not done so. For these reasons, our extrapolation would not have caused Mission to pay twice for overpayments in our sampling frame. However, to prevent repaying Medicare twice for claims that Mission may have already repaid due to previous RAC or MAC reviews, Mission should tell CMS which claims in our sampling frame were previously adjusted. CMS could then reduce the amount we recommended that Mission refund (\$443,183) by the amount already repaid.

We continue to recommend that Mission refund to the Medicare program \$443,183 in estimated overpayments and continue to strengthen controls to ensure full compliance with Medicare requirements.

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

### **SCOPE**

Our audit covered \$18,584,513 in Medicare payments to Mission for 2,105 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 192 claims with payments totaling \$2,760,822. These 192 claims had dates of service in CY 2011 or CY 2012 and consisted of 110 inpatient and 82 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 35 claims to medical review to determine whether the services were medically necessary.

We limited our review of Mission'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 Mission for Medicare reimbursement.

We conducted our fieldwork at Mission, in Asheville, North Carolina, from February through May 2014.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Mission's inpatient and outpatient paid claims data from CMS's National Claims History File for CYs 2011 and 2012 (audit period);
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for the audit period;
- used computer matching, data mining, and other analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 192 claims (Appendix B) totaling \$2,760,822 for detailed review;
- 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 Mission provided to support the sampled claims;
- requested that Mission conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed Mission’s procedures for classifying hospital stays (outpatient, outpatient with observation services, or inpatient admission), case management, coding, and Medicare claim submission;
- used CMS’s Medicare contractor medical review staff to determine whether 35 sampled claims met medical necessity requirements;
- discussed the incorrectly billed claims with Mission personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustment;
- used the results of the sample to estimate the Medicare overpayments to Mission (Appendix C); and
- discussed the results of our review with Mission 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

### POPULATION

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

### SAMPLING FRAME

According to CMS's National Claims History data, Medicare paid Mission \$697,089,046 for 53,057 inpatient and 295,685 outpatient claims for services provided to beneficiaries. For the 35 risk areas, Medicare paid Mission \$683,458,173 for 52,157 inpatient and 295,685 outpatient claims for services provided to beneficiaries.

From these 35 risk areas, we selected 8 consisting of 2,493 claims totaling \$20,948,535 for further refinement.

We then removed claims as follows:

- \$0 paid claims;
- claims duplicated within individual risk areas by assigning each:
  - inpatient claim that appeared in multiple risk areas to just one area based on the following hierarchy: 1) Inpatient Manufacturer Credits for Replaced Medical Devices, 2) Inpatient Same-Day Discharges and Readmissions, 3) Inpatient Transfers, 4) Inpatient Claims Billed With High-Severity-Level Diagnosis-Related-Group Codes, and 5) Inpatient Short Stays and
  - outpatient claim that appeared in multiple risk areas to just one area based on the following hierarchy: 1) Outpatient Manufacturer Credits for Replaced Medical Devices, 2) Outpatient Claims Billed With Evaluation and Management Services, and 3) Outpatient Claims With Payments Greater Than \$25,000;
- claims under review by the Recovery Audit Contractor (RAC) as of December 23, 2013;
- claims previously suppressed in the RAC data warehouse as of January 5, 2014; and
- additional inpatient claims billed with high-severity-level DRGs suppressed in the RAC data warehouse as of January 24, 2014.

This resulted in a sampling frame of 2,105 unique Medicare claims in 7 risk areas totaling \$18,584,513.

<b>Risk Area</b>	<b>Number of Claims</b>	<b>Amount of Payments</b>
Inpatient Claims Billed With High-Severity-Level Diagnosis-Related-Group Codes	1,549	\$13,653,226
Inpatient Short Stays	176	720,678
Inpatient Manufacturer Credits for Replaced Medical Devices	30	704,154
Inpatient Same-Day Discharges and Readmissions	5	40,183
Outpatient Claims With Payments Greater Than \$25,000	85	3,196,059
Outpatient Manufacturer Credits for Replaced Medical Devices	17	236,847
Outpatient Claims Billed With Evaluation and Management Services	243	33,366
<b>Total</b>	<b>2,105</b>	<b>\$18,584,513</b>

**SAMPLE UNIT**

The sample unit was a Medicare paid claim.

**SAMPLE DESIGN**

We used a stratified random sample. We divided the sampling frame into 7 strata based on risk area.

**SAMPLE SIZE**

We randomly selected 192 claims for review as follows:

<b>Stratum</b>	<b>Risk Area</b>	<b>Claims in Sample</b>
1	Inpatient Claims Billed With High-Severity-Level Diagnosis-Related-Group Codes	40
2	Inpatient Short Stays	35
3	Inpatient Manufacturer Credits for Replaced Medical Devices	30
4	Inpatient Same-Day Discharges and Readmissions	5
5	Outpatient Claims With Payments Greater Than \$25,000	30
6	Outpatient Manufacturer Credits for Replaced Medical Devices	17
7	Outpatient Claims Billed With Evaluation and Management Services	35
	<b>Total</b>	<b>192</b>

## **SOURCE OF RANDOM NUMBERS**

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

## **METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the claims within strata 1, 2, 5, and 7. After generating the random numbers for these strata, we selected the corresponding claims in each stratum. We selected all claims in strata 3, 4, and 6.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments paid to Mission for the audit period.

## APPENDIX C: SAMPLE RESULTS AND ESTIMATES

### SAMPLE RESULTS

	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	1,549	\$13,653,226	40	\$401,719	2	\$2,625
2	176	720,678	35	144,753	26	97,540
3	30	704,154	30	704,154	0	0
4	5	40,183	5	40,183	0	0
5	85	3,196,059	30	1,228,459	0	0
6	17	236,847	17	236,847	2	20,442
7	243	33,366	35	4,707	18	987
<b>Total</b>	<b>2,105</b>	<b>\$18,584,513</b>	<b>192</b>	<b>\$2,760,822</b>	<b>48</b>	<b>\$121,594</b>

### ESTIMATES

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

Point Estimate	\$517,781
Lower limit	\$443,183 <sup>4</sup>
Upper limit	\$595,004

<sup>4</sup> In accordance with OAS policy, we did not use the results from stratum 1 in calculating the estimated overpayments. Instead, we calculated the estimated overpayments by adding the actual overpayments from stratum 1 (\$2,625) to the lower limit (\$440,558), which totaled \$443,183.

**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 Over-payments</b>	<b>Value of Over-payments</b>
<b>Inpatient</b>				
Short Stays	35	\$144,753	26	\$97,540
Claims Billed With High-Severity-Level DRG Codes	40	401,719	2	2,625
Manufacturer Credits for Replaced Medical Devices	30	704,154	0	0
Same-Day Discharges and Readmissions	5	40,183	0	0
<b>Inpatient Totals</b>	<b>110</b>	<b>\$1,290,809</b>	<b>28</b>	<b>\$100,165</b>
<b>Outpatient</b>				
Manufacturer Credits for Replaced Medical Devices	17	\$236,847	2	\$20,442
Claims Billed With Evaluation and Management Services	35	4,707	18	987
Claims With Payments Greater Than \$25,000	30	1,228,459	0	0
<b>Outpatient Totals</b>	<b>82</b>	<b>\$1,470,013</b>	<b>20</b>	<b>\$21,429</b>
<b>Inpatient and Outpatient Totals</b>	<b>192</b>	<b>\$2,760,822</b>	<b>48</b>	<b>\$121,594</b>

**Notice:** The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at Mission. 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: MISSION HOSPITAL COMMENTS



August 18, 2014

**Via FedEx and Electronic Submission via E-Mail**

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: OIG Draft Report Number A-04-14-03077  
Medicare Compliance Review of Mission Hospital, Inc.

Dear Ms. Pilcher:

Enclosed is our response to the Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled *Medicare Compliance Review of Mission Hospital for the Period January 1, 2011 through December 31, 2012*. Mission Hospital Inc. (Mission) is committed to compliance with all regulations including Medicare requirements for billing inpatient and outpatient services. Mission takes compliance seriously and has a robust compliance program that focuses on staying abreast of the complex rules and regulations applicable to ensure complete and accurate documentation exists for claims submitted to Medicare.

Mission appreciates the opportunity to respond to this draft report and will be providing statements of concurrence and non-concurrence along with any necessary corrective action taken or planned as requested. We would like to make specific note that we take exception with the findings of alleged billing errors and in particular the statements that "Mission did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors."

The draft report contains two recommendations: Mission refund to the Medicare program \$443,183 in *estimated* overpayments for claims it incorrectly billed for the audit period and that Mission strengthen controls to ensure full compliance with Medicare requirements. We will address each of these findings within the risk areas where alleged or estimated overpayments occurred.

12 Ardmore Street, Asheville, NC 28803 (828) 213-3523 jcr.williams@msj.org

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

### **Incorrectly Billed as Inpatient**

Mission disagrees with the finding that 26 inpatient short stay cases were billed incorrectly resulting in an overpayment of \$97,540. We do however agree that two of the 26 cases were billed incorrectly. One of the two cases had a status change from observation to inpatient but was subsequently discharged before being screened by Case Management. The other patient was approved for inpatient status by an external physician reviewer, but was subsequently discharged on the same calendar day as the admission. The total overpayment for these cases was \$7,120.

Corrective actions taken include our continued Case Management review of cases as noted below and the implementation of an information technology discharge alert in October 2013 to assist with identifying short length of stay cases prior to discharge and billing as an additional internal control measure.

Only one of the remaining 24 cases had not been reviewed by Case Management prior to the patients' discharge. The other 23 cases had been reviewed by Case Management (contrary to the report); 5 were additionally reviewed by an external physician advisor and all contained appropriate documentation to support an inpatient level of care. Mission Case Management utilizes InterQual®, a nationally recognized, evidence-based screening criterion for inpatient acute level of care determinations. Additionally, all 24 cases were reviewed by a secondary physician advisor in connection with the Compliance Review to ensure that the criteria for inpatient status was met. The physician advisors determined that all 24 cases met inpatient criteria. Supporting documentation complete with medical evidence and references relied upon which we believe support the inpatient admission were provided to the auditors. During the Compliance Review and the Exit Conference, the auditors were not able to talk about the cases on a substantive basis as they had not "done the work" but relied upon the Medicare Administrative Contractor's (MAC's) review.

Mission's Case Management program includes timely screening of admissions and monitoring of accuracy through reports, denial activity and internal audits to ensure compliance with the Centers for Medicare and Medicaid (CMS) admission and billing policies and guidelines. Case Managers screen admissions 16 hours per day, 7 days a week, 365 days per year in collaboration with the providers and secondary physician

advisors to ensure the appropriate level of care is provided and medical necessity criteria are met for each admission.

The following internal controls are in place to ensure compliance with CMS's admission and billing policies and guidelines:

1. Timely screening of admissions using InterQual® Acute Level of Care Screening Criteria;
2. Secondary physician advisor review of all cases not meeting screening criteria;
3. Information technology alerts to Case Managers and as applicable, to providers for admission status changes and for select length of stay periods;
4. Initial InterQual® training; annual inter-rater reliability testing and audits of individual Case Manager reviews;
5. Continuing education to providers and hospital personnel of CMS regulatory changes;
6. Committee oversight and monitoring of high risk areas through various sources including the *Short Term Acute Care Program for Evaluating Payment Patterns Electronic Report (PEPPER)*. During the period 1<sup>st</sup> Quarter 2011 through 4<sup>th</sup> Quarter 2013, there were no short stay outliers identified on Mission's PEPPER reports.
7. Audit and Compliance Services staff regularly audit high risk areas as identified by OIG and CMS, and also perform targeted reviews based upon risk analysis and other areas where potential billing errors are likely to occur. Results of these audits are reviewed with leadership for corrective action if necessary including any required follow-up activity.

Mission would like to make the following points in general about the cases reviewed:

1. Patients presenting who required medically necessary inpatient care were appropriately billed as inpatient status despite the length of stay.
2. The decisions to admit the patients to inpatient status were based on the information that was available at the time of presentation.<sup>1</sup> The hospital course, either duration or findings, cannot be used to determine patient status and cannot be used as an argument for or against patient status.

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<sup>1</sup>Medicare Intermediary Manual, paragraph 3101, "... reviewers should consider only the medical evidence which was available to the physician at the time an admission decision had to be made, and do not take into account other information (e.g. test results) which became available only after admission."

3. Observation status was appropriate for patients for whom it was not clear if admission was necessary at the time of initial evaluation and for whom more time was required to determine whether inpatient status was appropriate.

CMS guidance<sup>2</sup> clearly states that the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors at the time of presentation based on the information available at that time and includes factors such as:

1. The patient's history and current medical needs
2. The types of facilities available to inpatients and outpatients, the hospital's by-laws and admission policies and the relative appropriateness of treatment in each setting
3. The severity of signs and symptoms exhibited by the beneficiary
4. The medical probability of something adverse happening to the beneficiary
5. The need for diagnostic studies that are appropriately outpatient services to assist in assessing the need for inpatient admission
6. The availability of diagnostic procedures at the time and location that the beneficiary presents

Using these criteria, we remain certain that the cases met the standard of inpatient admission given CMS guidance.<sup>3</sup> Mission will be appealing all 24 cases. The report footnotes the possibility of billing Medicare Part B for these services, but indicates that OIG was not able to determine the effect that billing Medicare Part B

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<sup>2</sup> Medicare Benefit Policy Manual, Chapter 1, Section 10

<sup>3</sup> Mission takes great exception with the reference to the 'example' case cited in the report on page 4 of the Draft as referencing that one patient "came to Mission's emergency department after fainting at home. The studies performed in the emergency department were negative; however, the patient was admitted for monitoring and further evaluation." The reference fails to accurately reflect the patient's condition and care as the medical records clearly documented that it was reasonable and necessary for the patient to be admitted to the hospital as an inpatient. The presenting symptoms and the pre-existing medical problems made inpatient admission of the beneficiary medically necessary and appropriate. This patient was at high risk for morbidity and mortality from lethal cardiac dysrhythmia related to syncope and underlying cardiomyopathy and structural heart disease. These medical issues mandated placement in an inpatient setting because a less intensive setting would have presented a significant and direct threat to the patient's medical condition, safety and health. The inpatient admission fulfilled the widely accepted 2010 InterQual® criteria for an acute inpatient level of medical care. Additional information regarding the treatment of syncope from the American College of Emergency Physicians guidelines as well as articles published in the Emergency Medicine Clinics of North America was provided to the reviewers to support this patient's inpatient admission. However, the reviewers were not able to comment on this or any of the 24 cases since they had no medical background and merely accepted the findings of the MAC based upon its biased review.

would have on the overpayment amount because they had not been billed and adjudicated by the MAC prior to the issuance of the OIG's draft report. There are several issues with this statement. First, we do not agree with the findings that these claims were not appropriately billed as inpatient claims, so we would not have rebilled these claims without losing our right to appeal them. Second, even if we agreed that the patients should have been treated under an observational level of care which we do not, based on the timing of the review and the directive that no action be taken on the claims involved in the audit until the review was finalized, we would not have been able to bill Medicare Part B for any of the claims the timely filing rules.

Even though Mission was not able to bill Medicare Part B for these services, the fact remains that any alleged overpayment should take into account that OIG does not assert that the services were not appropriate or medically necessary; the only issue in dispute is the patient status as inpatient versus outpatient observation. There is no allegation that any of these claims were fraudulent or that the treating physician's decision was clearly erroneous. Therefore, the treating physician's decision to admit should be given deference, particularly over the bias of the MAC review. Given Mission's case management review as well as the independent review which substantiates the treating physicians' decisions to admit the patients at issue, it is clear that even if the MAC or other auditor/reviewer were to disagree, Mission was without fault and should not be liable for any alleged overpayment. Furthermore, any alleged overpayment should be offset or reduced by the amount that Mission would have been paid had the services been billed as outpatient.

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

Mission agrees with the findings on the two cases identified based on lack of documentation to support the secondary diagnosis listed on the billed claims. These errors were attributed to the manual nature of coding and the potential for occasional human error.

Mission has internal controls in place for identifying high risk coding areas. These high risk areas are closely monitored by both Internal Coding Auditors as well as our Clinical Documentation Improvement (CDI) Coordinator. Our Internal Coding Auditors review 100% of both inpatient and outpatient coding daily on the identified high risk coding areas for accuracy of both principal and secondary diagnosis as well as procedure codes.

The CDI Coordinator reviews high risk coding and supporting documentation records daily.

Both areas provide feedback and education to the coding staff when errors are identified. The coders are responsible for collecting any coding errors. If the claim has already been submitted, the coder will request a rebill. We consistently maintain a monthly internal DRG accuracy rate of 95% or above. Additionally, external coding audits are performed annually with results consistently the same as our internal audits.

Mission has an education team that provides ongoing coding education to both the coders and the CDI specialists. In addition, we have a physician advisor who provides education regarding appropriate documentation based on clinical criteria to physicians, coders and CDI specialists.

The corrective action related to these two claims involved returning these cases to the original coders for coding correction and for a learning opportunity. Additionally, they were presented at a coding staff meeting for educational purposes for the benefit of all coding staff. Internal Coding Auditors and our CDI Coordinator will continue to perform internal audits to ensure high levels of accuracy are maintained and any errors are kept to a minimum.

The case that was identified as overpaid based on the physician's documentation of a condition without supporting documentation was also discussed with the coding staff. The coders will continue to receive education by our physician advisor regarding clinical indicators and the need to query when a condition is stated but may not meet clinical criteria. This is an ongoing process and this case will be used to provide education for the coders and CDI specialists. It has also been forwarded to our physician advisor so he can include it in the educational presentations to the medical staff as well.

#### **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

##### **Manufacturer Credits for Replaced Medical Devices Not Obtained**

Mission agrees with one of the two claims that were denied. As noted in the report, the manufacturer's representative did not return the device for which a credit was due. Upon our review and inquiry, a credit memo was issued in the amount of \$16,101. This claim

was reprocessed subsequent to the audit as we were advised not to process any adjusted claims until the audit was completed.

The claim that we disagree with was a case involving a “subclavian crush injury to a cardiac lead.” The manufacturer representative clearly indicated that they do not issue warranty credits for “crush injuries.” Warranty credits would be issued for leads failing “to function within expected operating specifications due to defects in materials or workmanship.”<sup>4</sup> The medical record documentation supported the clinic indication of a crush injury; therefore, no credit was available to be obtained.

Mission implemented a Warranty Device Credit Policy in 2004 and recently revised to update more current practices. We have a stringent follow-up procedure in place with manufacturing companies to determine when warranty credits are due. We believe our controls were operating properly and as prescribed per policy and procedure.

#### **Incorrectly Billed Evaluation and Management (E/M) Services**

Mission agrees with the findings noted in the draft report and acknowledges receiving an overpayment of \$987. The incorrect billing for these claims was attributed to clerical and procedural errors and the misinterpretation of E/M guidelines for capturing additional work that was “above and beyond” the separately billable procedure. Further detail regarding how these errors occurred has previously been provided to the auditors. The following corrective actions were taken to address the clerical errors and knowledge deficits identified.

Item #158

The department was closed in October 2013 and no corrective action is applicable.

Item #161, 172, 175, 177, 179, 180, 183, 186

This error was identified during an internal audit in 2013. The Wound Clinic staff no longer adds an E/M level for the work involved with a new patient visit or for a change in condition on the same date as a separately billable procedure. The computer-assisted coding (CAC) software within the Intellicure system suggests both a procedure code and an E/M level when documentation seems to support both. The Intellicure system was

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<sup>4</sup> St. Jude Medical Lifetime Limited Warranty, Implantable Cardiac Defibrillation Leads

originally designed for professional billing and lacks some discernment capabilities helpful for facility billing. For that reason, the module within the software that calculates and suggests E/M levels was disabled for facility billing. This has prevented the facility from inappropriately billing an E/M level along with a separately billable procedure on the same date.

Item #163, 166, 167, 170, 171, 176, 185

Education regarding the rules for billing both an E/M and a procedure on the same date was provided on 1/30/2014 when the problem was identified. The Radiation Therapy clinic staff no longer adds an E/M level when the follow-up visit is made only for the laryngoscopy procedure.

Item #188, 189

This modifier -25 scenario involves multiple hospital departments including Radiology, the Radiation Therapy clinic, Billing, Charge Master, and Coding. A multi-disciplinary team has been convened to develop a process to provide a secondary level of coding/modifier review prior to billing.

#### RECOMMENDATIONS

In summary, Mission agrees to refund the Medicare program in the amount of \$29,913 derived as follows:

Stratum 1	Incorrectly Billed DRG Codes	2	\$ 2,625
Stratum 2	Incorrectly Billed as Inpatients	2	\$ 7,120
Stratum 6	Manufacturer Credits	1	\$19,181
Stratum 7	Incorrectly Billed E & M Codes	<u>18</u>	<u>\$ 987</u>
Total Estimated Overpayments		<u>23</u>	<u>\$29,913</u>

Adjusted claims have been submitted on the 23 accounts noted above in the amount of \$29,913. However, Mission fundamentally disagrees with the use of extrapolation for the short stay cases and contests any overpayment alleged based on extrapolation. The information contained in the report is insufficient to determine the validity of the sampling. We were not provided the details of the statistical sampling methodology. However, even if we were to agree with sampling itself, given the extent of Recovery

Audit Contractor (RAC) reviews on short stay claims during this same time period, it is inappropriate to use extrapolation in this case to arrive at an estimated overpayment. The primary issue relates to the DRGs that were being denied as inpatient claims. Four of the DRGs reviewed have already had record requests and denials from either a RAC or MAC. It would be inappropriate to extrapolate these cases as we would be paying for these overpayments twice.<sup>5</sup> While the population of records in these DRG categories may not be that great, the alleged error rate is substantial. More than a majority of these accounts have already been recouped or are in various stages of appeal. Therefore, extrapolation is not appropriate and would violate Mission's due process rights.

### Summary

Mission is committed to fully complying with all Medicare laws, rules and regulations. A strong culture of compliance exists within Mission and is evidenced by an effective compliance program that addresses all facets of compliance including Medicare billing compliance. Our internal controls are reviewed continually and updated as needed where appropriate. The effectiveness of our compliance program was evident to the reviewers who commented on how well Mission performed in the areas reviewed. We do not take external audits lightly. In fact, we took this OIG audit very seriously by focusing swiftly on the data collection and production of records, engaging key stakeholders throughout the audit, providing the auditors all requested information in a timely manner and answering questions along the way. We came to agreement very quickly with the majority of the findings, but simply cannot agree with the decision that the 24 short stay cases were not appropriately billed as inpatient and will therefore be appealing these cases. Mission maintains that to extrapolate overpayments based on these cases is inappropriate given the audit activity that has already taken place. Therefore, Mission respectfully requests that the OIG revise the draft report to remove extrapolation from this review and reflect a decreased estimated overpayment of \$29,913 as noted herein.

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<sup>5</sup> There were 12 DRGs associated with the claims identified as involving overpayments. At least four of the 12 DRGs have been the subject of multiple RAC reviews. For example, OIG asserts that two claims involving DRG 312 involved overpayments. Mission billed a total of 240 claims with DRG 312 for the time frame at issue in this review. Of those 240 claims, the RAC had previously requested 160 records and many of the denials remain under appeal. Similarly, OIG reviewed and denied two claims involving DRG 392. Of 267 total cases involving DRG 392 in the same time period, the RAC requested 202 for review and many of the denials remain under appeal. While the OIG did not review the same claims as had been reviewed by the RAC, it is clearly inappropriate to extrapolate any overpayment based on prior review of such a substantial number of these claims.

Thank you for giving Mission the opportunity to provide this response to the draft report. Please do not hesitate to contact me should there be any questions regarding our response to the draft report.

Charles Ayscue  
SVP & Chief Financial Officer  
Mission Health, Inc.

Jeri Williams  
SVP & Corporate Compliance Officer  
Mission Health, Inc.