

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF THE UNIVERSITY OF
MICHIGAN HEALTH SYSTEM**

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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) 2015, Medicare paid hospitals \$163 billion, which represents 46 percent of all fee-for-service payments; accordingly, it is important to ensure that hospital payments comply with requirements.

OBJECTIVE

Our objective was to determine whether the University of Michigan Health System (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims with dates of service in CY 2014 and 2015.

BACKGROUND

The Medicare Program

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

Hospital Inpatient Prospective Payment System

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

Hospital Inpatient Rehabilitation Facility Prospective Payment System

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for inpatient rehabilitation facilities. CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the payment system, CMS established a Federal prospective payment rate for each of 92 distinct case-mix groups (CMGs). Assignment to a

CMG is based on a beneficiary's clinical characteristics and expected resource needs. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital 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.¹ 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 rehabilitation claims,
- inpatient high-severity-level DRGs with Major Complications and Comorbidities (MCC) or Complications and Comorbidities (CC),
- inpatient claims paid in excess of charges,
- inpatient and outpatient manufacturer credits for replaced medical devices, and
- outpatient claims billed with modifier -59.

For 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 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)).

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

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, section 80.3.2.2). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Under section 1128J(d) of the Social Security Act and 42 CFR part 401, subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR §§ 401.305(a)(2), and (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments.

The University of Michigan Health System

The Hospital is a 550-bed acute care teaching hospital located in Ann Arbor, Michigan. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately \$711 million for 24,381 inpatient and 799,293 outpatient claims for services provided to beneficiaries during CYs 2014 and 2015 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$28,633,879 in Medicare payments to the Hospital for 2,582 claims that were potentially at risk for billing errors. These claims consisted of inpatient and outpatient claims paid to the Hospital for services provided to Medicare beneficiaries during CYs 2014 and 2015. We selected for review a stratified random sample of 181 claims with payments totaling \$4,703,043 for review. These 181 claims had dates of service during the audit period and consisted of 139 inpatient and 42 outpatient claims.

We focused our review on the risk areas that we identified during prior reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 120 claims for focused medical review to determine whether the services met medical necessity and coding requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims that the Hospital submitted 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.

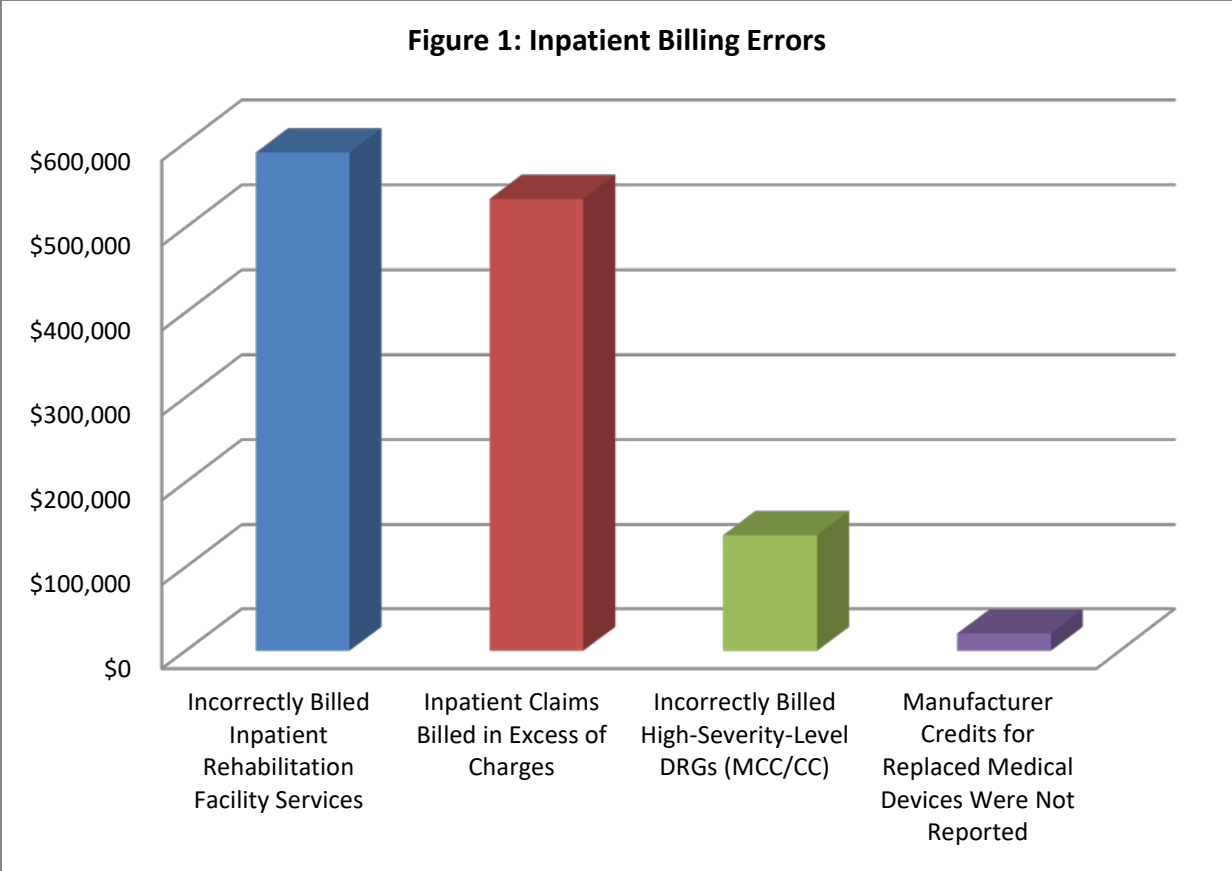
FINDINGS

The Hospital complied with Medicare billing requirements for 108 of the 181 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 73 claims, resulting in overpayments of \$1,294,130 for the audit period. Specifically, 65 inpatient claims had billing errors, resulting in overpayments of \$1,279,439, and 8 outpatient claims had billing errors, resulting in overpayments totaling \$14,691. These errors occurred primarily because the Hospital did not have adequate controls to prevent 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 net overpayments totaling at least \$6,162,201 for the audit period. 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 ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 65 of 139 sampled inpatient claims, which resulted in net overpayments of \$1,279,439, as shown in Figure 1.



Incorrectly Billed Inpatient Rehabilitation Facility Services

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

The *Medicare Benefit Policy Manual* states that the IRF benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care (Pub. No. 100-02, chapter 1, § 110-110.1).

In addition, the *Medicare Benefit Policy Manual* states that for IRF care to be considered reasonable and necessary, the documentation in the patient’s IRF medical record must demonstrate a reasonable expectation that, at the time of admission to the IRF, the patient (1) required the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally required an intensive rehabilitation therapy program; (3) actively participated in, and benefited significantly from, the intensive rehabilitation therapy program; (4) required physician supervision by a rehabilitation physician; and (5) required an intensive and

coordinated interdisciplinary approach to providing rehabilitation (Pub. No. 100-02, chapter 1, § 110.2).

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

For 37² of the 45 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for the higher inpatient rehabilitation facility level of care (36 claims) and for an incorrect CMG classification (1 claim). The medical record documentation reviewed did not support the intensive rehabilitation therapy services that are uniquely provided in IRFs. The Hospital did not provide a cause for the errors because Hospital officials believe the claims met Medicare requirements.

As a result of these errors, the Hospital received net overpayments totaling \$588,008.³

Incorrectly Billed Claims Paid in Excess of Charges

Under Medicare's IPPS, fiscal intermediaries reimburse hospitals a predetermined amount for inpatient services furnished to program beneficiaries, depending on the illness and its classification under a DRG. Claims paid in excess of charges may be vulnerable to incorrect billing because of incorrectly coded DRGs, procedures, units, or charges (e.g., \$10,000 per day for room and board). In addition, unnecessary outlier payments may also result in claims paid in excess of charges. An outlier is an additional payment that is made for atypical cases that generate extremely high costs compared with most cases in the same DRG; these atypical cases are referred to as outliers.

For 12 of the 41 sampled claims, the Hospital billed Medicare for an incorrect DRG code. The Hospital stated that the majority of the errors in this risk area occurred because of miscommunication between the person coding the services and the person performing the treatment. The Hospital's key internal controls did not prevent these errors.

² Thirteen of the thirty-seven claims partially met Medicare coverage requirements for the inpatient rehabilitation facility level of care. The medical reviewers found that these particular claims met medical necessity requirements but lacked complete preadmission screening documentation. These claims did not meet Medicare documentation requirements but had no monetary effect on our statistical estimation.

³ The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status). Until the Hospital bills these Medicare Part B services and the MAC adjudicates them, we do not have enough information to determine the effect on the overpayment amount. The Hospital should contact its MAC for rebilling instructions.

As a result of these errors, the Hospital received overpayments totaling \$533,450.

Incorrectly Billed High-Severity-Level Diagnosis-Related-Group Codes

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1815(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).

For 14⁴ of the 45 sampled claims, the Hospital incorrectly billed Medicare for high-severity-level DRG codes. Hospital officials stated that the Hospital’s internal controls did not fail in preventing three of the questioned claims; however, the internal controls failed for six claims because of miscommunication between the person coding the services and the person performing the treatment. The Hospital did not provide a cause for five of the errors identified because Hospital officials believe the claims met Medicare requirements.

As a result of these errors, the Hospital received overpayments totaling \$137,481.

Manufacturer Credits for Replaced Medical Devices Were Not Reported

Federal regulations require a reduction in the IPPS payment when an implanted device is replaced 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 a partial credit equal to or greater than 50 percent of the device cost (42 CFR § 412.89).

The Manual states that, to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50 and the value code “FD” (chapter 3, § 100.8).

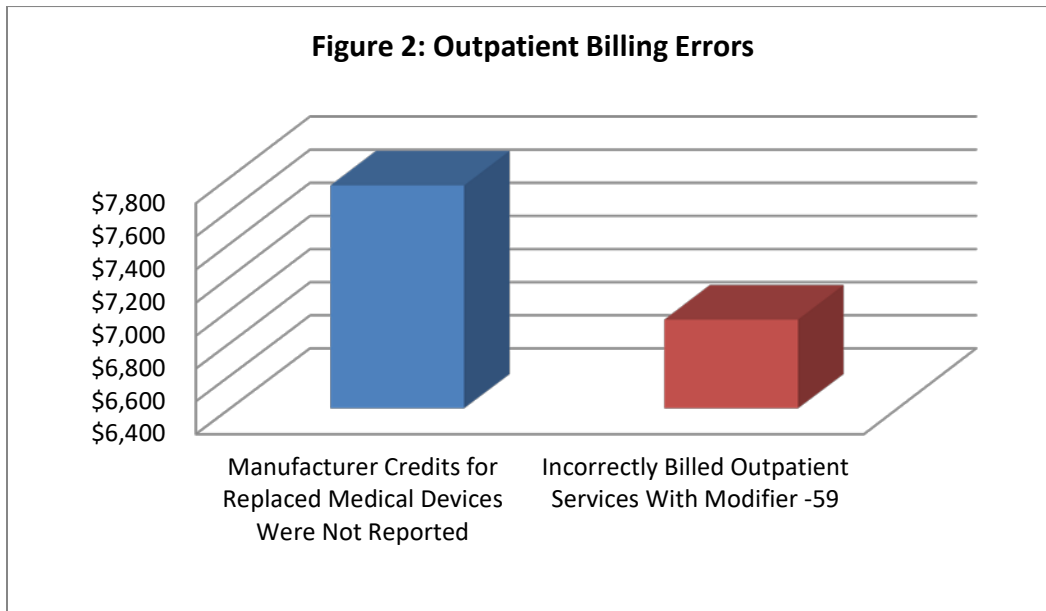
For two of the eight sampled claims, the Hospital did not submit an adjusted claim for the credit of a replaced device. Hospital officials stated that these errors occurred because hospital employees did not follow established internal controls.

As a result of these errors, the Hospital received overpayments totaling \$20,500.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 8 of 42 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$14,691 as shown in Figure 2.

⁴ One of the fourteen claims partially met Medicare coverage requirements for the billing of the DRG. The medical reviewers found that the first 4 days were unallowable but did not affect the payment amount for the entire episode of care. The claim partially met Medicare requirements but had no monetary effect on our statistical estimation.



Manufacturer Credits for Replaced Medical Devices Were Not Reported

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(a)). 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.⁵

For 2 of the 12 sampled claims, the Hospital did not report medical device credits received. The Hospital stated that these errors occurred because Hospital employees did not follow internal controls.

As a result of these errors, the Hospital received overpayments totaling \$7,750.

Incorrectly Billed Outpatient Services With Modifier -59

“The Manual states: ‘The ‘-59’ modifier is used to indicate a distinct procedural service.... This may represent a different session or patient encounter, different procedure or surgery,

⁵ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3). 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.

different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)' (chapter 23, § 20.9.1.1)." 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).

For 6 of the 30 sampled claims, the Hospital billed Medicare using incorrect HCPCS codes appended with modifier -59. The amounts the codes represented were already included in the payments for other services billed on the same claim, or the claim did not require modifier -59. The Hospital stated that these errors occurred mainly because of employee inexperience and incorrect application and/or understanding of coding guidelines.

As a result of these errors, the Hospital received overpayments totaling \$6,941.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$6,162,201 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$6,162,201 (of which \$1,294,130 was overpayments identified in our sample) in estimated net overpayments for incorrectly billed services;
- exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare requirements.

UNIVERSITY OF MICHIGAN HEALTH SYSTEM COMMENTS

In written comments on our draft report, the Hospital generally agreed with most of our findings and all recommendations. However, the Hospital disagreed with our inpatient rehabilitation facility findings and questioned our determinations of what constitutes an overpayment in some instances. The Hospital also questioned the use of extrapolation for medical necessity findings.

The Hospital's comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that all of our findings and the associated recommendations are valid. We evaluated compliance and sent more than half of the claims to an independent medical review contractor to determine whether the services met medical necessity and coding requirements. For the claims subjected to a focused medical review, each denied case was reviewed by two clinicians, including a physician. We stand by those determinations. Accordingly, we believe that our findings provide credible information that triggers the requirements of the 60-day rule.

Regarding the Hospital's comments on our statistical sampling and extrapolation methodology, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.⁶ The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology.⁷ We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected sample items from each stratum, applied relevant criteria in evaluating the sample, and used statistical sampling software to apply the correct formulas for the extrapolation.

When selecting an auditee as an audit target, we consider a wide range of risk factors. Nevertheless, we do not need to make a determination of a sustained or high level of payment error or document a failed educational intervention prior to selecting a statistical sample because these requirements apply only to samples performed by Medicare contractors.⁸

The Hospital contends that our sample is not valid because not every claim had the same chance of being selected. These types of differences are common in stratified designs and are fully accounted by the formula that we used to calculate our statistical estimate. We shared the results and methods for arriving at our estimates with the Hospital so that it could replicate the results.

OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to HHS action officials. Action officials at CMS, acting through a MAC or other contractor, will determine whether an overpayment exists and will recoup any overpayments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Parts A and B appeals process has five levels, including a

⁶ See *Yorktown Med. Lab., Inc., v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc., v. Sebelius*, 2014 WL 199061 at *9 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

⁷ See *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012) and *Transyd Enter., LLC, v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

⁸ See the Act § 1893(f)(3); CMS's Medicare Program Integrity Manual, chapter 8.4.1.4 (effective June 28, 2011).

contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a hearing before an Administrative Law Judge. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is re-estimated, depending on the result of the appeal.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$28,633,879 in Medicare payments to the Hospital for 2,582 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 181 claims with payments totaling \$4,703,043. These 181 claims had dates of service in CY 2014 or 2015 and consisted of 139 inpatient and 42 outpatient claims.

We focused our review on the risk areas that we had identified during prior reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 120 claims for focused medical review to determine whether the services met medical necessity and coding requirements.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the 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 our fieldwork from September 2016 through June 2017.

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 181 claims (139 inpatient and 42 outpatient) totaling \$4,703,043 for detailed review (Appendices B and C);
- 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;
- used an independent medical review contractor to determine whether 120 claims met medical necessity and coding requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample review to calculate the estimated Medicare 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 METHODOLOGY

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 downloaded claims from the NCH database totaling \$516 million for 13,994 inpatient and 559,864 outpatient claims in 29 risk areas. From this database, we selected claims from six high risk areas consisting of 45,063 claims totaling \$227,852,685 for further refinement.

We performed data filtering and analyses of the claims within each of the six high risk areas. The specific audit steps performed varied, depending on the Medicare issue, but included such steps as removing claims with certain patient discharge status codes and billing types. We also considered, for example, problem diagnosis codes and procedure codes. We then removed the following:

- all \$0 paid claims,
- inpatient claims billed with high-severity-level DRG codes (MCC/CC) with payment amounts less than \$3,000,
- claims under review by the Recovery Audit Contractor as of July 6, 2016, and
- all duplicated claims within individual risk areas.

We assigned each claim that appeared in multiple high-risk areas to just one area based on the following hierarchy: Inpatient Rehabilitation, Inpatient Claims Billed in Excess of Charges, Inpatient Manufacturer Credits for Replaced Medical Devices, Inpatient Claims Billed With High-Severity-Level DRG Codes (MCC/CC), Outpatient Manufacturer Credits for Replaced Medical Devices, and Outpatient Claims Billed With Modifier -59. This resulted in a sample frame of 2,582 unique Medicare claims in 6 risk areas totaling \$28,633,879.

Table 1: Risk Area Sampled

Risk Area	Number of Claims	Amount of Payments
1. Inpatient Rehabilitation Facility	398	\$11,473,484
2. Inpatient Claims Paid in Excess of Charges	41	1,831,299
3. Inpatient Medical Device Credits	8	415,325
4. Inpatient Claims Billed With High-Severity-Level DRG Codes	600	10,974,740
5. Outpatient Medical Device Credits	12	173,050
6. Outpatient Claims Billed With Modifier -59	1,523	3,765,981
Total	2,582	\$28,633,879

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 areas.

SAMPLE SIZE

We selected 181 claims for review, as follows:

Table 2: Sampled Claims by Stratum

Stratum	Risk Area	Sample Size
1	Inpatient Rehabilitation Facility	45
2	Inpatient Claims Paid in Excess of Charges	41
3	Inpatient Medical Device Credits	8
4	Inpatient Claims Billed With High-Severity-Level DRG Codes	45
5	Outpatient Medical Device Credits	12
6	Outpatient Claims Billed With Modifier -59	30
	Total Sampled Claims	181

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata one, four, and six. After generating the random numbers for these strata, we selected the corresponding claims in the sampling frame. We selected all claims in strata two, three, and five.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments paid to the Hospital during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Net Overpayments in Sample
1	398	\$11,473,484	45	\$1,293,598	37**	\$588,008
2*	41	1,831,299	41	1,831,299	12	533,450
3*	8	415,325	8	415,325	2	20,500
4	600	10,974,740	45	900,804	14***	137,481
5*	12	173,050	12	173,050	2	7,750
6	1,523	3,765,981	30	88,967	6	6,941
Total	2,582	\$28,633,879	181	\$4,703,043	73	\$1,294,130

* We reviewed all claims in this stratum.

** Of these 37 incorrectly billed claims, 13 had no monetary effect.

*** Of these 14 incorrectly billed claims, 1 had no monetary effect.

ESTIMATES

**Estimates of Overpayments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$7,947,737
Lower limit	6,162,201
Upper limit	9,733,273

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Under/Over-payments	Value of Net Overpayments
Inpatient				
Inpatient Rehabilitation Facility*	45	\$1,293,598	37	\$588,008
Inpatient Claims Paid in Excess of Charges	41	1,831,299	12	533,450
Inpatient Claims Billed With High-Severity-Level DRG Codes*	45	900,804	14	137,481
Inpatient Manufacturer Credits for Replaced Medical Devices	8	415,325	2	20,500
Inpatient Total	139	\$4,441,026	65	\$1,279,439
Outpatient				
Outpatient Manufacturer Credits for Replaced Medical Devices	12	\$173,050	2	\$7,750
Outpatient Claims Billed With Modifier -59*	30	88,967	6	6,941
Outpatient Total	42	\$262,017	8	\$14,691
Inpatient and Outpatient Totals	181	\$4,703,043	73	\$1,294,130

*We submitted all of these claims for a focused medical review to determine whether the services met medical necessity and coding requirements.

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 area we reviewed. However, we have organized this report's findings by the type 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.



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November 28, 2017

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

Re: Report Number A-05-16-0064

Dear Ms. Fulcher:

The University of Michigan Health System (UMHS) is submitting this letter in response to the preliminary findings of the Department of Health and Human Services Office of Inspector General (“OIG”) resulting from an audit of UMHS 2014 and 2015 claims. OIG’s audit was conducted as part of a series of hospital compliance reviews and focused on areas it deemed at risk of noncompliance with Medicare billing requirements. OIG’s report was not triggered by any particular concerns with UMHS, specifically. Its preliminary findings were contained in a draft report, dated October 2017 (the “Draft Audit Report”).

The principal findings in the Draft Audit Report are as follows:

- UMHS complied with 108 of the 181 inpatient and outpatient claims reviewed.
- 65 inpatient claims did not completely comply with applicable billing rules, resulting in an overpayment calculation of \$1,279.439 million.
- 8 outpatient claims had billing errors, resulting in an overpayment calculation of \$14,691.

These findings reflect the aggregation of OIG’s separate review of six different areas, namely: (1) inpatient rehabilitation claims; (2) inpatient claims paid in excess of charges; (3) inpatient claims billed with high-severity-level DRGs; (4) inpatient medical device credits; (5) outpatient medical device credits; and (6) outpatient claims billed with Modifier -59. Based on these findings, the Draft Audit Report proposes the following recommendations:

1. UMHS should refund to its Medicare contractor \$6,162,201, which is the amount OIG calculates as the extrapolated value of the amount OIG deemed to be billed in error.



2. UMHS should exercise reasonable diligence to identify and return other payments on claims similar to those deemed to be in error by OIG for periods outside of the audit. Such a determination should be in accordance with the 60-Day Repayment Rule.¹
3. UMHS should strengthen controls to ensure full compliance with Medicare requirements.

Essentially, in OIG’s view, known overpayments should be returned, and additional due diligence is needed to determine whether there is any further liability. Enhanced controls are needed to prevent similar overpayments in the future. While UMHS does not disagree with any of these recommendations *per se*, it does, question OIG’s determinations of what constitutes an overpayment in some instances.

Set forth below is a description of UMHS’s assessment of OIG’s findings broken down by risk area, as well as a description of UMHS’s intended further actions with respect to each such area.

Inpatient Rehabilitation Facility Claims

UMHS disagrees with OIG’s position regarding purported billing errors pertaining to inpatient rehabilitation claims. As noted by OIG in the Draft Audit Report, inpatient rehabilitation services are appropriate where, as determined at the time of admission, the patient:²

- (1) required the active and ongoing therapeutic intervention of multiple therapy disciplines;
- (2) generally required an intensive rehabilitation therapy program;
- (3) actively participated in, and benefited significantly from, the intensive rehabilitation therapy program;
- (4) required physician supervision by a rehabilitation physician; and
- (5) required an intensive and coordinated interdisciplinary approach to providing rehabilitation.

UMHS’s review of the claims in the inpatient rehabilitation sample indicates that these medical necessity criteria were met in all cases. Therefore, we do not believe any repayment is necessary with respect to this subset of claims.

The differences in the assessment of these claims ostensibly relates to different presumptions as to the patient population that can benefit from inpatient rehabilitation services. OIG’s medical

¹ The 60 Day Repayment Rule is codified at 1128J(d) of the Social Security Act and 42 C.F.R. Part 401, Subpart D.

² Draft Audit Report, pp. 5-6 (citing to the Medicare Benefit Policy Manual, CMS Pub. No. 100-02, chapt. 1, § 110.2). Note that, although OIG describes the third criterion as requiring active participation in the therapy and achievement of a significant benefit, the Medicare Benefit Policy Manual only requires an *expectation* that such criteria will be met.



reviewers consistently took the position that IRF services were not medically necessary unless, along with a specific diagnosis, patients also had a specific medical acuity.

For example, the OIG reviewers consistently found that patients did not meet medical acuity requirements if they did not have a pressure ulcer, or significant bowel or bladder dysfunction issues. This is a spinal cord injury-centric view of medical necessity which is not supported by the regulations. Some patients in the sample had other medical complications, such as tube feeding requirements in the face of diabetes mellitus and peritoneal dialysis management after amputation and cardiovascular risk factors (such as, Coronary Artery Disease (CAD) and congestive heart failure) after an amputation. These examples indicate that the definition of medical acuity in a diverse patient population needs to be broad to address their needs and the need for medical management based on an individual patient's needs. A general requirement that medical acuity equates to the presence of a pressure ulcer, or bowel or bladder dysfunction is a vast over-simplification of the assessment of medical necessity.

The OIG reviewers' analysis of medical necessity also seems to suggest that specific patients, whose post-rehabilitation goals might be limited, should not be afforded the benefits of receiving IRF care. For instance, if a patient has a spinal cord injury or an amputation, optimal functionality may be reached when the patient can independently use a wheelchair. UMHS routinely provides inpatient rehabilitation care to patients with C5 spinal cord injuries, or amputations, whose rehabilitation goal is to resume use of a wheelchair, which makes a significant difference to their quality of life. Nothing in any publicly available CMS guidance states that gaining independence at a wheelchair level is not an indication for admission to an IRF.

Other presumptions used by the OIG reviewers evidence idiosyncratic views held by the auditors. For instance, in some cases, UMHS accepts patients who might not be able to restore full functionality. However, since they have access to assistance at home, it is acceptable to restore sufficient functionality that allows them to remain at home with that assistance, even if that is less than full functionality. Similarly, if a patient with pre-existing neurological impairment suffers from new functional decline, OIG's reviewers would consider it not medically necessary to assist that patient in regaining his or her prior level of functionality. Since it respects the dignity of these patients seeking to remain as autonomous as possible, UMHS admits these patients and assists them in achieving their goals, which is preferable to accepting preventable, further decline.

UMHS's physiatrists have found that, in many cases, each of these patient types can, and often do, benefit from inpatient rehabilitation services. UMHS is an academic medical center, and thus it is part of its mission to achieve improvement in health and functioning in even the most complex of cases. Accordingly, we disagree with the reflexive judgment of OIG's reviewers and intend to continue to admit these patients, whose needs, addressable as they are, UMHS refuses to ignore. Indeed, in the absence of any stated CMS criteria supporting the presumptions used by OIG's reviewers, we question their authority to recommend the disallowances that they have. OIG and its medical reviewers are to audit, not establish, CMS policy.³

³ 5 U.S.C. § 6(a).



In light of the disagreements between OIG and UMHS regarding the medical necessity of the services in question, it is inappropriate to perform an extrapolation at this time. As an initial matter, it must be recognized that, by law, Medicare contractors cannot use extrapolations unless either (1) there is a sustained or high level of payment error; or (2) there is a failure of documented educational interventions.⁴ In the matter here, the Medicare contractor has not historically found a high level of payment error with respect to inpatient rehabilitation claims. Therefore, OIG cannot recommend to the contractor that it use an extrapolation without that predicate. Extrapolation would be allowed under the statute only if a final, unappealed determination on the claims at issue demonstrated a high error rate. Such a determination will only occur after there has been a significant amount of further input by UMHS and the Medicare contractor, as well as decision-making by a neutral arbiter.

Extrapolation is particularly unwarranted here, given that OIG’s findings all relate to medical necessity questions. In the analogous circumstance of potential False Claims Act liability, courts have found as follows with respect to the application of extrapolation to medical necessity questions:⁵

Because “each and every claim at issue” [is] “fact-dependent and wholly unrelated to each and every other claim,” and determining eligibility for “each of the patients involved a highly fact-intensive inquiry involving medical testimony after a thorough review of the detailed medical chart of each individual patient,” . . . the case [is] not “suited for statistical sampling.”

Similarly, questions of medical necessity pertaining to the inpatient rehabilitation services at issue here require individualized determinations that undercut any contention that one claim is like another, much less serving as a representation of a larger universe. We therefore request that OIG remove its recommendation that there be an extrapolation of these claims.

We also note that, if required to do so, UMHS will challenge the extrapolation on the grounds that this judgmental sample is not representative of the universe. OIG stratified the claims so as to conduct a review of high-risk areas, and thus the review claims do not reflect a statistically valid, random sample. It would be inappropriate for OIG’s error rates to be extrapolated to a larger universe that is not composed of similarly situated claims.

Given UMHS’s medical necessity determinations, there is no obligation to expand the period under consideration pursuant to the 60-Day Repayment Rule. The 60-Day Repayment Rule requires repayment of overpayments within 60 days of the overpayment being “identified.”⁶ Such

⁴ Social Security Act, § 1893(f)(3).

⁵ United States ex rel. Misty Wall v. Vista Hospice Care, Inc., 2016 WL 3449833, at *12 (N.D. Tex. 2016).

⁶ Social Security Act, § 1128J(d)(2)(A).



identification occurs “when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.”⁷ Reasonable diligence is thus necessary to elucidate whether underlying facts and law do in fact demonstrate that an overpayment has been made. UMHS acknowledges that a government audit, such as the OIG’s audit here, could constitute “credible information” that triggers 60-Day Repayment Rule obligations. However, according to the guidance implementing the 60-Day Repayment Rule, providers are required to act on audit results by “conduct[ing] reasonable diligence to confirm or contest the audit’s findings.”⁸ UMHS has conducted a thorough review of the medical records at issue, and it has determined that the services are medically necessary. If UMHS’s Medicare contractor nevertheless opts to follow OIG’s recommended disallowances of these claims, then UMHS, consistent with the 60-Day Repayment Rule guidance, intends to contest those findings. Therefore, through its exercise of reasonable diligence leading to a decision to appeal any denied claims, UMHS has upheld its 60-Day Repayment Rule obligations.

Similarly, there are no additional controls that UMHS needs to implement. Rather, UMHS will continue its routine, internal auditing to ensure that the services rendered in its inpatient rehabilitation unit continue to meet the medical needs of Medicare beneficiaries admitted to the inpatient unit.

Inpatient Billed High-Severity-Level Diagnosis-Related Group Codes

UMHS agrees in part and disagrees in part with OIG’s findings pertaining to this subset of claims. As to the claims that OIG has questioned on medical necessity grounds, UMHS continues to assert that medical necessity was present, and, if necessary, it will appeal any adverse determinations regarding these claims. Accordingly, UMHS will neither expand on OIG’s review to include other years nor otherwise implement new controls with respect to these claims. Additionally, for all of the reasons stated above with respect to inpatient rehabilitation claims, we request that OIG not subject these claims to extrapolation.

As to OIG’s findings with respect to potential coding errors, UMHS agrees with its determination of a billing error pertaining to six claims, but disagrees with its findings with the remaining three claims. For some of the claims where there was an error, the conversion to ICD-10 standing alone will prevent similar errors for occurring. OIG’s findings have also underscored the importance of coders submitting clarifying queries to the treating physician where appropriate. UMHS has therefore emphasized the importance of its physician query practice to its coders. UMHS has also effectuated repayment of these claims. Since OIG’s findings with respect to this subset of claims are all individualized, UMHS does not view these findings as being credible information of other potential errors. Thus, it is not conducting a follow-on audit pertaining to this

⁷ 42 C.F.R. § 401.305(a)(2).

⁸ 81 Fed. Reg. 7654, 7667 (Feb. 12, 2016).



claims subset. Additionally, in light of how claim-specific these errors are, UMHS believes that extrapolation is inappropriate here and requests that OIG remove that as a recommendation.

Inpatient Claims Paid in Excess of Charges

UMHS agrees with OIG's findings pertaining to this subset of claims, and UMHS has repaid all of the claims in OIG's sample identified as being in error. To a large extent, the errors identified by OIG in this subset would not have occurred in an ICD-10 environment. The conversion to ICD-10 is therefore part of the solution going forward. Through OIG's audit, it was also learned that there are specific services that have an elevated risk of being miscoded. Accordingly, UMHS has placed certain flags in its billing system to identify when these services are being furnished so as to ensure that they can be reviewed more closely before a claim is submitted. Through these modifications to UMHS's billing processes, the accuracy of its billing for similar services will be improved. UMHS will also comply with the 60-Day Repayment Rule by performing a look-back of claims for these same procedures that evidenced an elevated risk of miscoding in OIG's audit. Repayments will be made, where required. As UMHS will be doing an individualized review of all of the claims that evidence this elevated risk, an extrapolation is not necessary, since it would result in duplicate disallowances. UMHS therefore requests that OIG remove its recommendation that the errors associated with this area be subject to extrapolation.

Manufacturer Credits for Replaced Devices Explanted on an Inpatient Basis

UMHS agrees with OIG's findings pertaining to this subset of claims. Claim adjustments were submitted to WPS on October 10, 2016 for the 2 patients whose medical device credits were not reported (\$20,500). Consistent with the 60-Day Repayment Rule, UMHS is reviewing whether similar claims (pertaining to explanted cardiac devices) outside the audit period evidence similar issues where an adjustment claim was not submitted after a credit has been received. This claim-by-claim review vitiates the need to extrapolate the error rate to the universe of claims, and UMHS therefore requests that OIG remove that recommendation.

Additionally, to prevent similar errors in the future, UMHS implemented a software update that transmits reminders to staff involved in billing functions relating to explanted cardiac devices. These reminders continue to appear until all open questions regarding whether a credit has been issued are resolved.

Incorrectly Billed Outpatient Services with Modifier -59

UMHS agrees with OIG's findings pertaining to this subset of claims, as it relates to the application of Modifier-59 and is in the process of repaying these claims. Consistent with the 60-Day Repayment Rule, UMHS will review for errors in claims outside the audit period that are similar to those claims evidencing errors identified in OIG's audit. Additionally, given that most



of the errors in this claims subset resulted from new coding staff in an unfamiliar area, UMHS is enhancing its training of these staff, auditing of their work, and coder on-boarding training. UMHS is confident that these measures will increase the accuracy of the use of Modifier -59 going forward.

Manufacturer Credits for Replaced Devices Explanted on an Outpatient Basis

UMHS agrees with OIG’s findings pertaining to this subset of claims. Claim adjustments were submitted to WPS on October 10, 2016 for the 2 patients whose medical device credits were not reported (\$7,750). Consistent with the 60-Day Repayment Rule, UMHS is reviewing whether similar claims (pertaining to explanted cardiac devices) outside the audit period evidence similar issues where an adjustment claim was not submitted after a credit has been received. This claim-by-claim review vitiates the need to extrapolate the error rate to the universe of claims, and UMHS therefore requests that OIG remove that recommendation.

Additionally, to prevent similar errors in the future, UMHS implemented a software update that transmits reminders to staff involved in billing functions relating to explanted cardiac devices. These reminders continue to appear until all open questions regarding whether a credit has been issued are resolved.

UMHS thanks OIG for the opportunity to provide feedback on the Draft Audit Report, and it appreciates the professionalism and cooperative spirit of its auditors, as well as the information furnished through the audit process. As we trust was demonstrated through OIG’s review, UMHS takes its compliance efforts very seriously. As indicated above, we agree with OIG’s assessment that certain areas require improvement, and we appreciate OIG’s having brought these matters to our attention. As to those areas where we are not in agreement, we request that OIG reconsider its initial findings, and in any event, we request that OIG not extrapolate any medical necessity findings.

Sincerely,

Jeanne Strickland