

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF LAFAYETTE
GENERAL MEDICAL CENTER
FOR CLAIMS PAID DURING
2013 AND 2014**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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**April 2016
A-06-15-00022**

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

Lafayette General Medical Center did not fully comply with Medicare requirements for billing inpatient services, resulting in estimated overpayments of at least \$4.4 million 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 2013, Medicare paid hospitals \$156 billion, which represents 45 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.

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

BACKGROUND

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

The Hospital is a 365-bed acute care medical center located in Lafayette, Louisiana. Medicare paid the Hospital approximately \$118 million for 10,380 inpatient and 33,019 outpatient claims from January 1, 2013, through December 31, 2014, for services provided to Medicare beneficiaries with dates of service from January 1, 2012, through December 31, 2014 (audit period). We obtained the claims data from CMS's National Claims History file.

Our audit covered \$19,329,972 in Medicare payments to the Hospital for 2,161 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 134 claims with payments totaling \$2,249,047. These 134 claims consisted of 103 inpatient and 31 outpatient claims.

WHAT WE FOUND

Of the 134 claims we reviewed, the Hospital complied with Medicare billing requirements for 34 of the 103 inpatient claims and all 31 outpatient claims. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 69 inpatient claims, resulting in net

overpayments of \$865,243 for the audit period. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$4,413,989 for the audit period. The Hospital refunded \$287,257 after the start of our review. As a result, the net overpayment was at least \$4,126,732.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare program \$4,126,732 in estimated overpayments for claims that it incorrectly billed,
- ensure that the \$287,257 refunded after the start of our review was recovered by Medicare, and
- strengthen controls to ensure full compliance with Medicare requirements.

LAFAYETTE GENERAL MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed with some of our findings and recommendations. Regarding our first recommendation, the Hospital agreed that it had incorrectly billed 18 of the 69 claims and stated that it had already begun refunding Medicare for those claims. However, the Hospital disagreed that the remaining 51 claims in our findings did not fully comply with Medicare billing requirements and said that it would initiate the appeals process with CMS. For the second recommendation, the Hospital verified that \$261,764 of the \$287,257 had been returned to Medicare, but did not address the remaining amount. Regarding the third recommendation, the Hospital stated that it had previously provided to OIG the actions that it had planned to take to mitigate potential billing errors.

OUR RESPONSE

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We obtained an independent medical review of all of these claims for medical and coding errors, and our report reflects the results of that review. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the claims according to 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 2013, Medicare paid hospitals \$156 billion, which represents 45 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 Lafayette General Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

BACKGROUND

The Medicare Program

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

Hospital Inpatient Prospective Payment System

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.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 claims billed with elective procedures,
- inpatient claims paid in excess of charges,
- inpatient claims billed with high-severity-level DRG codes,
- inpatient claims with payments greater than \$150,000,
- outpatient claims with payments greater than \$25,000, and
- outpatient claims billed for Doxorubicin Hydrochloride.

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

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items or services that “... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Social Security Act (the Act), § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 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). The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).

Lafayette General Medical Center

The Hospital is a 365-bed acute care medical center located in Lafayette, Louisiana. Medicare paid the Hospital approximately \$118 million for 10,380 inpatient and 33,019 outpatient claims

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

from January 1, 2013, through December 31, 2014, for services provided to Medicare beneficiaries with dates of service from January 1, 2012, through December 31, 2014 (audit period). We obtained the claims data from CMS's National Claims History file.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$19,329,972 in Medicare payments to the Hospital for 2,161 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 134 claims with payments totaling \$2,249,047. These 134 claims consisted of 103 inpatient and 31 outpatient claims.

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 103 inpatient claims to an independent contractor 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 submitted by the Hospital for Medicare reimbursement.

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

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

FINDINGS

Of the 134 claims we reviewed, the Hospital complied with Medicare billing requirements for 34 of the 103 inpatient claims and all 31 outpatient claims. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 69 inpatient claims, resulting in net overpayments of \$865,243 for the audit period. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$4,413,989² 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 69 of the 103 selected inpatient claims that we reviewed. These errors resulted in net overpayments of \$865,243.

² The Hospital refunded \$287,257 of this amount after the start of our review.

Incorrectly Billed as Inpatient

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

According to chapter 1, section 10, of the *Medicare Benefit Policy Manual* (Pub. No. 100-02), factors that determine whether an inpatient admission is medically necessary include:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;
- the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- the availability of diagnostic procedures at the time when and at the location where the patient presents.

For 55 of the 103 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital stated that it had billed 7 of the 55 claims incorrectly because of a clerical error. The Hospital did not provide a cause for the remaining errors because it believed that the claims were correctly billed as inpatient. As a result of these errors, the Hospital received overpayments of \$428,650.³ The Hospital refunded \$20,314 of the overpayments after the start of our review.

Incorrectly Billed Number of Units

The Manual states: "The definition of service units ... is the number of times the service or procedure being reported was performed" (chapter 4, § 20.4).

For 1 of the 103 selected claims, the Hospital submitted the claim to Medicare with the incorrect number of units of sterile supplies used in surgical procedures. Hospital officials stated that the error occurred because the number of units was not properly converted to billable units. As a result, the Hospital received an overpayment of \$261,764. The Hospital refunded the overpayment after the start of our review.

Inpatient Admissions Not Certified by a Physician

With respect to inpatient hospital services (other than inpatient psychiatric hospital services),

³ The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed and adjudicated by the Medicare administrative contractor before issuing our report.

which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment (the Act, § 1814(a)(3)).

For 2 of the 103 selected claims, the Hospital billed Medicare for claims with inpatient orders that were signed by a nonphysician practitioner and not cosigned by a physician. The Hospital stated that it billed one of the claims incorrectly because the written inpatient order was overlooked during the manual process to flag the inpatient order for physician signature. The Hospital did not agree with the remaining error because the inpatient order was entered by a mid-level provider and was not routed for physician signature due to the mid-level provider's scope of practice. As a result of these errors, the Hospital received overpayments of \$155,908.

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)).

For 11 of the 103 selected claims, the Hospital billed Medicare with incorrectly coded claims, resulting in incorrect DRG payments to the Hospital. Specifically, certain procedure or diagnosis codes were not supported by the medical records. The Hospital stated that it had billed 8 of the 11 claims incorrectly, but did not provide a cause for the errors. For 1 of the 11 claims, the Hospital stated that it refunded the entire payment amount because Medicare was the secondary payer and should not have been billed for the services. The Hospital did not provide a cause for the remaining two errors because it believed that the claims were correctly coded. As a result of these errors, the Hospital received net overpayments of \$18,921. The Hospital refunded \$5,179 of the overpayments after the start of our review.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$4,413,989 for the audit period. The Hospital refunded \$287,257 for multiple claims after the start of our review. As a result, the net overpayment was at least \$4,126,732.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$4,126,732 in estimated overpayments for claims that it incorrectly billed,
- ensure that the \$287,257 refunded after the start of our review was recovered by Medicare, and
- strengthen controls to ensure full compliance with Medicare requirements.

**LAFAYETTE GENERAL MEDICAL CENTER COMMENTS AND
OFFICE OF INSPECTOR GENERAL RESPONSE**

LAFAYETTE GENERAL MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital agreed with some of our findings and recommendations. Regarding our first recommendation, the Hospital agreed that it had incorrectly billed 18 of the 69 claims and stated that it had already begun refunding Medicare for those claims. However, the Hospital disagreed that the remaining 51 claims in our findings did not fully comply with Medicare billing requirements and said that it would initiate the appeals process with CMS. For the second recommendation, the Hospital verified that \$261,764 of the \$287,257 had been returned to Medicare, but did not address the remaining amount. Regarding the third recommendation, the Hospital stated that it had previously provided to OIG the actions that it had planned to take to mitigate potential billing errors.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We obtained an independent medical review of all of these claims for medical and coding errors, and our report reflects the results of that review. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the claims according to Medicare requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$19,329,972 in Medicare payments to the Hospital for 2,161 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 134 claims with payments totaling \$2,249,047. These 134 claims consisted of 103 inpatient and 31 outpatient claims.

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted 103 inpatient claims to an independent contractor 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 submitted by the Hospital for Medicare reimbursement.

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 CMS's National Claims History file, but we did not assess the completeness of the file.

We conducted our audit work from April through October 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's National Claims History file for the audit period;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 134 claims (103 inpatient and 31 outpatient) totaling \$2,249,047 for detailed review (Appendix B);
- reviewed available data from CMS's Common Working File for the selected 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 selected 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 103 selected inpatient 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 adjustment;
- 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 consisted of inpatient and outpatient claims paid from January 1, 2013, through December 31, 2014, to the Hospital for services provided to Medicare beneficiaries with dates of service from January 1, 2012, through December 31, 2014 (audit period).

SAMPLING FRAME

We obtained a database of claims from CMS's National Claims History file totaling approximately \$118 million for 10,380 inpatient and 33,019 outpatient claims in 25 risk areas. From these 25 risk areas, we selected 6 risk areas consisting of 6,035 claims totaling \$43,663,093.

We performed data analysis of the claims within each of the six 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. We also considered, for example, problem diagnosis codes and procedure codes. For risk area one (see chart below), we removed claims on the Inpatient Only Procedure List. For risk area two, we removed claims for which the payment amount was less than \$1,000 over the charged amount.

We then removed the following:

- claims with payment amounts under \$1,000,
- claims that were under review by the Recovery Audit Contractor, and
- duplicated claims within individual risk areas.

We assigned the duplicated inpatient claims that appeared in multiple risk areas to risk area two. We removed the duplicated outpatient claims from risk area five that appeared in another risk area. This resulted in a sampling frame of 2,161 inpatient and outpatient claims in six risk areas totaling \$19,329,972 paid during the period January 1, 2013, through December 31, 2014.

Table 1: Risk Areas Sampled

Risk Area	Number of Claims	Amount of Payments
1. Inpatient Claims Billed With Elective Procedures	306	\$2,650,155
2. Inpatient Claims Paid in Excess of Charges	60	556,590
3. Inpatient Claims Billed With High-Severity-Level DRG Codes	1,738	14,097,667
4. Inpatient Claims With Payments Greater Than \$150,000	3	575,298
5. Outpatient Claims With Payments Greater Than \$25,000	53	1,445,898
6. Outpatient Claims Paid for Doxorubicin Hydrochloride	1	4,364
Total	2,161	\$19,329,972

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

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

SAMPLE SIZE

We selected 134 claims for review as follows:

Table 2: Sampled Claims by Stratum

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Claims Billed With Elective Procedures	306	30
2	Inpatient Claims Paid in Excess of Charges	60	30
3	Inpatient Claims Billed With High-Severity-Level DRG Codes	1,738	40
4	Inpatient Claims With Payments Greater than \$150,000	3	3
5	Outpatient Claims With Payments Greater Than \$25,000	53	30
6	Outpatient Claims Paid for Doxorubicin Hydrochloride	1	1
	Total	2,161	134

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 1, 2, 3, and 5. After generating the random numbers for these strata, we selected the corresponding frame items. We selected all claims in strata 4 and 6.

ESTIMATION METHODOLOGY

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

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	306	\$2,650,155	30	\$222,782	27	\$203,663
2	60	556,590	30	287,068	22	185,301
3	1,738	14,097,667	40	350,425	18	62,127
4	3	575,298	3	575,298	2	414,152
5	53	1,445,898	30	809,110	0	0
6	1	4,364	1	4,364	0	0
Total	2,161	\$19,329,972	134	\$2,249,047	69	\$865,243

ESTIMATES

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

Point estimate	\$5,561,550
Lower limit	\$4,413,989
Upper limit	\$6,709,110

APPENDIX D: RESULTS OF REVIEW

Table 5: Results of Review by Risk Area

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Under/Over-payments	Value of Net Over-payments
Inpatient				
Claims Billed With Elective Procedures	30*	\$222,782	27	\$203,663
Claims With Payments in Excess of Charges	30*	287,068	22	185,301
Claims Billed With High-Severity-Level Diagnosis-Related-Group Codes	40*	350,425	18	62,127
Claims With Payments Greater Than \$150,000	3*	575,298	2	414,152
Inpatient Totals	103	\$1,435,573	69	\$865,243
Outpatient				
Claims With Payments Greater Than \$25,000	30	\$809,110	0	\$0
Outpatient Claims Paid for Doxorubicin Hydrochloride	1	4,364	0	0
Outpatient Totals	31	\$813,474	0	\$0
Inpatient and Outpatient Totals	134	\$2,249,047	69	\$865,243

*We submitted these claims to an independent contractor for 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 areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX E: LAFAYETTE GENERAL MEDICAL CENTER COMMENTS

Lafayette General *Health*

March 3, 2016

Lafayette General
Medical Center
University Hospital & Clinics
Lafayette General
Surgical Hospital
St. Martin Hospital
Acadia General Hospital
Abrom Kaplan
Memorial Hospital
LGMD Physician Group
Cancer Center of Acadiana
CyberKnife Center Louisiana
Lafayette Behavioral
Health Unit
Lafayette General
Endoscopy Center
Lafayette General Imaging
Lafayette General
Telemedicine Clinic

Affiliates:

Abbeville General Hospital
Bunkie General Hospital
Franklin Foundation
Hospital
Opelousas General
Health System
Savoy Medical Center

*Metabolic and Bariatric
Surgery Accredited Center*
*Advanced Certified Primary
Stroke Center*
*Neuroscience Center of
Excellence*
*Center of Excellence in
Minimally Invasive Gynecology*
*Commission on Cancer
Accredited Program*
*Consumer Choice Award
'09-'10, '10-'11, '11-'12,
'12-'13 and '13-'14*
*America's Best Hospitals
for Orthopedics*
*America's Best Hospitals
for Obstetrics*
*America's Best 100 Hospitals
for Patient Experience*

LafayetteGeneral.com

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RE: Report Number: A-06-15-00022

Dear Ms. Wheeler,

Lafayette General Medical Center appreciates the opportunity to review and respond to the OIG Draft Report # A-06-15-00022 sent to us on February 2, 2016.

Lafayette General Medical Center (LGMC) staffs a total of 410 licensed beds and is the largest full-service, acute-care medical center, with two campuses in the nine-parish area of Acadiana. LGMC provides families with comprehensive medical services at every level of care. Our vision is to be a premiere teaching facility and the hospital of choice for patients, physicians, and employees.

Lafayette General has the busiest emergency department in Acadiana and handles the highest level of trauma in the region. The hospital's 32-bed adult intensive care unit (ICU) is staffed 24/7 by intensivists (physicians specializing in critical care), while the 25-bed neonatal intensive care unit (NICU) boasts benchmark status in Key Performance Indicators by the Vermont Oxford Network.

Our full-service, tertiary care facility offers a highly trained staff and excellent physicians to bring about positive patient outcomes. Lafayette General Medical Center is recognized by federal and state tax laws as a 501(c)(3) not-for-profit corporation. As a community-owned and operated hospital, all decisions are made locally by an experienced administrative team and a volunteer Board of Trustees, composed of a diverse group of community leaders.

LGMC continues to meet the community's growing needs, including Center of Excellence status in Minimally Invasive Gynecology and Neuroscience, as well as the distinction as an Accredited Cancer Program, Advanced Certified Primary Stroke Center and Accredited Center for Metabolic and

Bariatric Surgery. A leader in technology, LGMC was the first to bring the da Vinci® (a robotic surgical system), CyberKnife® (a stereotactic radiosurgery system) and Medtronic O-Arm (a surgical imaging system) to Acadiana.

LGMC is committed to compliance with all federal healthcare regulations and standards by educating our physicians, Patient Access/Registration, Case Management, and Health Information Management staff. This commitment is also demonstrated by the organization's investment in a proactive compliance program with a history of auditing, monitoring, and returning overpayments.

In the draft report findings the OIG reviewed 134 claims (103 inpatient claims and 31 outpatient claims); the report asserted that LGMC complied with Medicare billing requirements for 34 inpatient claims and all 31 outpatient claims.

We respectfully disagree with the OIG's findings for 51 of the 69 billing errors associated with the 103 inpatient claims, and agree with the findings for the remaining 18 inpatient claims.

Incorrectly Billed as Inpatient

The OIG reviewed 103 inpatient claims to determine if the hospital billed for inpatient services appropriately. The OIG identified 55 claims that should have been billed as outpatient or outpatient with observation services. The hospital agrees with 7 of the 55 claims and respectfully disagrees with the remaining 48.

The decision to admit a patient for inpatient services is a complex medical judgement that can only be made by a physician. Per the CMS Benefit Policy Manual Chapter 1 "The decision to admit a patient is a complex medical judgement which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting". These 47 claims had inpatient admission orders documented in the medical record based upon the physician's medical judgement made at the time care was provided to the patient.

Once the OIG issues the final report, the hospital will initiate the appeals process with CMS for these 48 claims.

Incorrectly Billed Number of Units

For 1 of the 103 selected inpatient claims, the OIG identified an incorrectly billed number of units. The hospital agrees with the OIG findings and verified that the overpayment has been returned to Medicare, in the amount of \$261,764.

Inpatient Admissions Not Certified by a Physician

For 2 of the 103 selected inpatient claims, the OIG asserts that the hospital billed Medicare for claims with inpatient orders not signed by a physician. The hospital disagrees with 1 of these 2 claims. On review, the hospital identified an inpatient order entered into the medical record by a mid-level provider practicing within their scope of practice. In addition, the patient stay exceeded 2 midnights and met medical necessity for hospital inpatient services.

Once the OIG issues the final report, the hospital will initiate the appeals process with CMS for this claim.

Incorrectly Billed Diagnosis-Related Group Codes

For 11 of the 103 selected inpatient claims, the OIG indicated the hospital billed Medicare in error due to incorrect DRG assignment. The hospital disagrees with 2 of these 11 claims. For the first claim in question, the auditor stated that, based on their "coding review of the medical record, the DRG assignment is not substantiated as billed. Although the medical record supports the submission of principal diagnosis code 433.10 (carotid artery stenosis) and primary procedure code 38.12 (carotid endarterectomy) and both are substantiated by the medical record documentation, the patient was not admitted to the hospital prior to completion of the inpatient only procedure." On review of the medical record, an inpatient order signed by the physician prior to the start of the inpatient only procedure is included in the record. The second claim in question was reviewed by the hospital and no other documentation in the record was identified as it relates to dehydration; therefore, the coding was appropriate and based on the physician documentation in the patient's chart.

Once the OIG issues the final report, the hospital will initiate the appeals process with CMS for these 2 claims.

The hospital has provided all requested documents to OIG as it relates to internal controls and action plans to mitigate potential billing errors. In addition, the hospital begun refunding monies to Medicare for claims with errors identified and agreed upon for the 103 selected inpatient claims. LGMC is committed to our Code of Conduct and being in compliance with all Federal and State laws, regulations, and programs.

If you have any questions or require any additional information, please contact me at 337-289-7991.

Sincerely,



Sandra A. Keller, RN, BSN, CHC
Vice President of Corporate Compliance
Lafayette General Health