

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF RUSH UNIVERSITY
MEDICAL CENTER**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Gloria L. Jarmon
Deputy Inspector General
for Audit Services**

**November 2017
A-05-16-00062**

Office of Inspector General

<https://oig.hhs.gov>

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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.

Report in Brief

Date: November 2017

Report No. A-05-16-00062

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



Why OIG Did This Review

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2015, Medicare paid hospitals \$163 billion, which represents 46 percent of all fee-for-service payments for the year.

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

How OIG Did This Review

We selected for review a stratified random sample of 120 inpatient and outpatient claims with payments totaling \$1.7 million for our audit period.

We focused our review on the risk areas that we had identified during prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements.

Medicare Compliance Review of Rush University Medical Center

What OIG Found

The Hospital complied with Medicare billing requirements for 63 of the 120 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 57 claims, resulting in overpayments of \$814,150 for calendar years 2014 and 2015. Specifically, 51 inpatient claims had billing errors, resulting in overpayments of \$812,744, and 6 outpatient claims had billing errors, resulting in overpayments of \$1,406. 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 approximately \$10.2 million for our audit period.

What OIG Recommends and Auditee Comments

We recommend that the Hospital refund to the Medicare contractor \$10.2 million (of which \$814,150 was overpayments identified in our sample) in estimated overpayments for the audit period for claims that it incorrectly billed; 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.

In written comments on our draft report, the Hospital generally disagreed with our findings and recommendations. The Hospital agreed that for some claims in the sample, the documentation supports a different level of reimbursement. The Hospital disagreed with more than half of the findings on the inpatient rehabilitation claims reviewed and said that it believes the error rate to be much lower than what OIG claims. The Hospital also stated that it did not have a sufficient understanding of OIG's sample methodology to confirm OIG's extrapolated amount or to offer an alternative amount.

We maintain that all of our findings and the associated recommendations are valid. We subjected these claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Each denied case was reviewed by two clinicians, including a physician. We stand by those determinations.

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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 Rush University 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 administrative contractors (MACs) 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 Inpatient Rehabilitation 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). The assignment to a CMG is based on the beneficiary's clinical characteristics and expected resource needs.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.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 claims billed with high-severity-level DRG codes, and
- outpatient claims billed with modifier -59.

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 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.

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

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).

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.

Rush University Medical Center

The Hospital, which is part of Rush University Medical Center, the Hospital approximately \$448 million for 19,379 inpatient and 272,211 outpatient claims for services provided to beneficiaries during CYs 2014 and 2015.

Our audit covered \$26,456,138 in Medicare payments to the Hospital for 2,549 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 or 2015 (audit period). We selected a stratified random sample of 120 claims with payments totaling \$1,671,130 for review. These 120 claims had dates of service in CY 2014 or CY 2015 and consisted of 90 inpatient and 30 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted all 120 claims to 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.

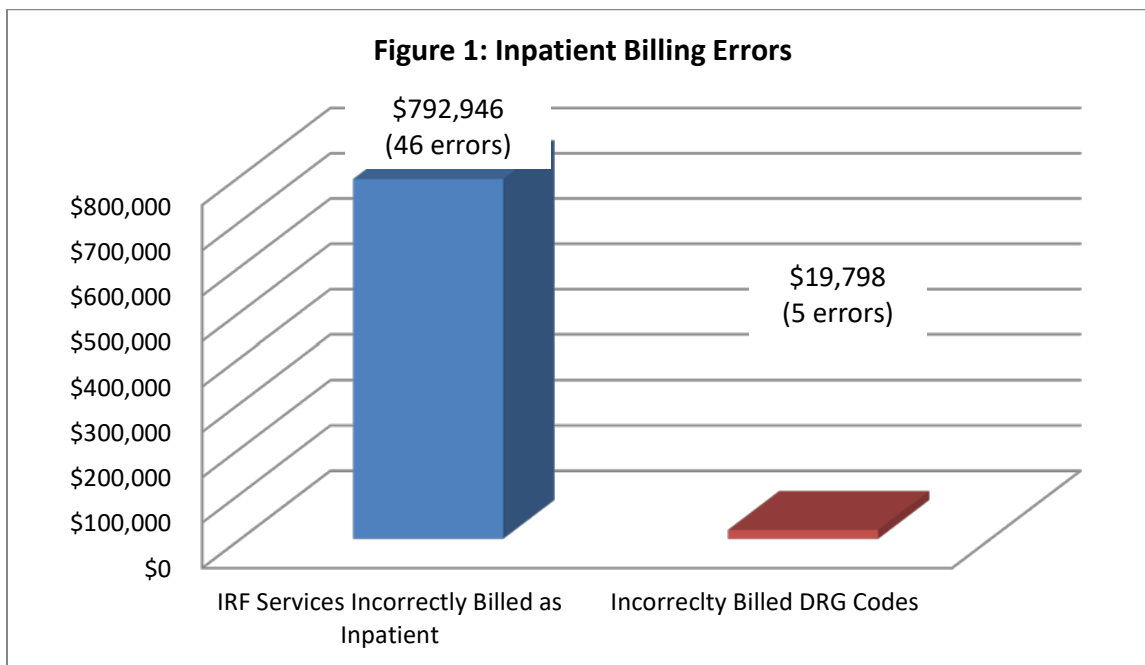
FINDINGS

The Hospital complied with Medicare billing requirements for 63 of the 120 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 57 claims, resulting in overpayments of \$814,150 for the audit period. Specifically, 51 inpatient claims had billing errors, resulting in overpayments of \$812,744, and 6 outpatient claims had billing errors, resulting in overpayments of \$1,406. 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 totaling at least \$10,158,611 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 51 of 90 sampled inpatient claims, which resulted in overpayments of \$812,744, as shown in Figure 1.



Inpatient Rehabilitation Facility Services Incorrectly Billed as Inpatient

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 46 of the sampled inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for the higher acute inpatient rehabilitation level of care. The Hospital did not provide a cause for the errors because it continues to believe that these claims met Medicare requirements.

As a result of these errors, the Hospital received overpayments totaling \$792,946.²

Incorrectly Billed Diagnosis-Related-Group Codes

The Act precludes payment to any provider 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).

² 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 its 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.

For 5 of the sampled inpatient claims, the Hospital billed Medicare with an incorrect DRG code. The Hospital did not provide a cause for the errors identified because it believes that the DRG codes were correctly assigned.

As a result of these errors, the Hospital received overpayments of \$19,798.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 6 of the 30 sampled outpatient claims, which resulted in overpayments of \$1,406.

Insufficiently Documented Services

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 4 of the 30 sampled claims, the Hospital incorrectly billed Medicare for services that were not supported in the medical record. The Hospital stated that 2 of these errors occurred because of user error. The Hospital did not provide a cause for 2 of the errors identified because it disagreed with our finding.

As a result of these errors, the Hospital received overpayments of \$912.

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, 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 2 of the 30 sampled claims, the Hospital incorrectly billed Medicare for HCPCS codes, appended with modifier -59, that were already included in the payments for other services billed on the same claim or that did not require modifier -59. The Hospital stated that these errors occurred because of user error.

As a result of these errors, the Hospital received overpayments of \$494.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$10,158,611 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$10,158,611 (of which \$814,150 was overpayments identified in our sample) in estimated 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.

RUSH UNIVERSITY MEDICAL CENTER COMMENTS

In written comments on our draft report, the Hospital generally disagreed with our findings and recommendations. The Hospital agreed that for some claims in the sample, the documentation supports a different level of reimbursement. The Hospital disagreed with more than half of the findings on the inpatient rehabilitation claims reviewed and said that it believes the error rate to be much lower than what OIG claims. The Hospital also stated that it did not have a sufficient understanding of OIG's sample methodology to confirm the OIG extrapolated amount or to offer an alternative amount.

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 subjected these claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Each denied case was reviewed by two clinicians, including a physician. We stand by those determinations.

Regarding the Hospital's comments on our statistical sampling and extrapolation methodology, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology.³ We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software to apply the correct formulas for the extrapolation. We shared the results and methods for arriving at our estimates with the Hospital so that it can replicate the results.

³ 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).

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 a potential 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 Part A/B appeals process has five levels, including a 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 \$26,456,138 in Medicare payments to the Hospital for 2,549 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 the audit period. We selected a stratified random sample of 120 claims with payments totaling \$1,671,130 for review. These 120 claims had dates of service in CY 2014 or CY 2015 and consisted of 90 inpatient and 30 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and submitted all 120 claims to 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 National Claims History file, but we did not assess the completeness of the file.

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

We conducted our fieldwork from October 2016 through April 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 120 claims (90 inpatient and 30 outpatient) totaling \$1,671,130 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;
- reviewed the Hospital's procedures for submitting Medicare claims;
- used an independent medical review contractor to determine whether all 120 sampled claims met medical necessity and coding requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample review to calculate the estimated Medicare 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.

SAMPLE FRAME

Medicare paid the Hospital \$448 million for 19,379 inpatient and 272,211 outpatient claims for services provided to beneficiaries during the audit period based on CMS's National Claims History data.

We downloaded claims from the National Claims History database totaling \$323,715,948 for 11,477 inpatient and 93,373 outpatient claims in 31 risk areas. From these 31 areas, we selected 3, consisting of 52,560 claims totaling \$119,708,570 for further review.

We performed data analysis of the claims within each of the three risk areas. For risk area two, we removed claims with payment amounts less than \$3,000. For risk area three, we removed claims with claim lines containing modifier -59 with payment amounts less than \$100.

We then removed the following:

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

We assigned each claim that appeared in multiple high risk categories to just one category based on the following hierarchy: Inpatient Rehabilitation, Inpatient Claims Billed With High-Severity-Level DRG Codes, and Outpatient Claims Billed With Modifier -59. This resulted in a sample frame of 2,549 unique Medicare claims totaling \$26,456,138.

Table 1: Risk Area Sampled

Risk Area	Number of Claims	Amount of Payments
Inpatient Rehabilitation Facility	902	\$16,682,833
Inpatient Claims Billed With High-Severity-Level DRG Codes	413	7,292,596
Outpatient Claims Billed With Modifier -59	1,234	2,480,709
Total	2,549	\$26,456,138

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN

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

SAMPLE SIZE

We selected 120 claims for review, as follows:

Table 2: Sampled Claims by Stratum

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Inpatient Rehabilitation Facility	902	60
2	Inpatient Claims Billed With High-Severity-Level DRG Codes	413	30
3	Outpatient Claims Billed With Modifier -59	1,234	30
	Total	2,549	120

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 through three. After generating the random numbers for these strata, we selected the corresponding frame items.

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 Over-payments in Sample
1	902	\$16,682,833	60	\$1,137,859	46	\$792,946
2	413	7,292,596	30	475,586	5	19,798
3	1,234	2,480,709	30	57,685	6	1,406
Total	2,549	\$26,456,138	120	\$1,671,130	57	\$814,150

ESTIMATES

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

Point estimate	\$12,250,998
Lower limit	10,158,611
Upper limit	14,343,385

APPENDIX D: RESULTS OF REVIEW BY RISK AREA

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Inpatient Rehabilitation Facility	60	\$1,137,859	46	\$792,946
Claims Billed With High-Severity-Level Diagnosis-Related-Group Codes	30	475,586	5	19,798
Inpatient Totals	90	\$1,613,445	51	\$812,744
Outpatient				
Claims Billed With Modifier -59	30	57,685	6	1,406
Outpatient Totals	30	\$57,685	6	\$1,406
Inpatient and Outpatient Totals	120	\$1,671,130	57	\$814,150

APPENDIX E: RUSH UNIVERSITY MEDICAL CENTER COMMENTS

Department of Corporate Compliance
707 South Wood Street, Suite 317
Chicago, Illinois 60612-3833

Tel 312.942.5303
Fax 312.942.6875
www.rush.edu

RUSH UNIVERSITY
COLLEGE OF NURSING
RUSH MEDICAL COLLEGE
COLLEGE OF HEALTH SCIENCES
THE GRADUATE COLLEGE



October 5, 2017

Sheri L. Fulcher
Regional Inspector General for Audit Service
Office of Inspector General
Department of Health and Human Services
233 N. Michigan Ave. Suite 1360
Chicago, IL 60601

Re: Report Number A-O5-16-00062 (Rush University Medical Center)

Thank you for providing the report related to the above captioned review conducted by the U.S. Department of Health and Human Services, Office of Inspector General (“OIG”) dated August 29, 2017. While we disagree with some of the factual assertions, we appreciate the care and diligence your office put into the review, as well as the professional manner with which you have approached your communications with us. Rush University Medical Center (“RUMC”) takes seriously its commitment to compliance and to the continued pursuit of excellence in all aspects of the care it provides, including billing and reimbursement.

As you know from our prior communications, there are some cases in the sample where we agree that the documentation supports a different level of reimbursement. However, there are numerous cases which we believe support the level of reimbursement and the medical necessity for those services is strong. Based on your sample of 120 claims cases (60 inpatient rehabilitation, 30 acute care inpatient, 30 outpatient), your report recommends that RUMC repay \$10.2 million to the Medicare contractor. The bulk of this repayment amount is related to inpatient rehabilitation reimbursement (97.4% of OIG’s estimated overpayment in the sample). We are unable to make the repayment at this time for two reasons: (a) we disagree with the conclusions of your reviewer for over one-half of the inpatient rehabilitation cases OIG reviewed and we believe the error rate to be much lower than OIG claims, and (b) we do not have sufficient visibility into the OIG’s sampling methodology to be able to confirm that the amount is an appropriate extrapolation or even to substitute into the OIG’s methodology what we believe the accurate error rate to be and provide an alternative extrapolated amount.

That said, we are committed to making prompt repayment of any overpayments we have identified, and we will continue to work with you and other appropriate government representatives regarding a process for quantifying any overpayment and potential refund amounts. To that end and as a result of RUMC’s inability to replicate OIG’s methodology or approach to reviewing the cases during the two year calendar year period 2014 and 2015, RUMC’s compliance program undertook a full six (6) year look-back audit from January 1, 2011

Department of Corporate Compliance
707 South Wood Street, Suite 317
Chicago, Illinois 60612-3833

Tel 312.942.5303
Fax 312.942.6875
www.rush.edu

RUSH UNIVERSITY
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RUSH MEDICAL COLLEGE
COLLEGE OF HEALTH SCIENCES
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through December 31, 2016 for inpatient rehabilitation reimbursement to assess more than what the OIG examined. We believe the financial error rate across this period to be substantially less than what OIG identified in its sample.

Sincerely,

A handwritten signature in black ink, appearing to read 'Janis Anfossi'.

Janis Anfossi, JD MPH
Associate Compliance Officer
Rush University Medical Center

cc: Carl Bergetz, General Counsel
Cynthia Boyd, MD, Vice President Compliance