

December 19, 2018

Daniel Levinson
Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Levinson:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, I am writing to express serious concerns about the recent Department of Health and Human Services Office of Inspector General (OIG) audit report, “Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements” (the Report).¹ The Report is one in a long series of OIG audits targeting hospitals for potential Medicare overpayments. The AHA has repeatedly brought its concerns about these audits – including the numerous errors in Medicare law and policy contained in the audit reports – to the attention of the Office of Audit Services (OAS) and OIG counsel.² Unfortunately, problematic OIG hospital audit reports have continued to issue, and the recent report about inpatient rehabilitation facility (IRF) stays is a prime example.

IRFs play a distinct role in the continuum of care, serving patients requiring hospital-level care in combination with intensive therapy. IRF patients include individuals recovering from strokes, brain injuries, spinal cord injuries and other complex injuries or illnesses. To ensure that IRF admissions are targeted to this high-acuity population, the Centers for Medicare & Medicaid Services (CMS) relies upon both extensive IRF admissions criteria and program integrity oversight. IRFs are highly attuned to the detailed coverage criteria that apply to Medicare admissions and the potential for compliance audits. This alone calls the OIG’s findings in the Report into question.

¹ OIG, *Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements*, No. A-01-15-00500 (2018), available at <https://oig.hhs.gov/oas/reports/region1/11500500.asp>.

² The AHA also has raised its concerns to the Centers for Medicare & Medicaid Services (CMS) and the Secretary of Health and Human Services. See attached correspondence.



But after careful review, the AHA believes that the Report very significantly overstates the estimated Medicare overpayment to IRFs for services they furnished in 2013 and contains many other material errors. These errors may discourage Medicare beneficiaries from seeking needed and valuable IRF care, waste scarce IRF and government resources and unfairly damage IRFs' reputations.

The AHA's concerns about the Report fall into three general categories: (1) findings that Medicare claims for IRF services should not have been paid; (2) use of extrapolation to estimate the amount overpaid; and (3) recommendations to CMS. We address each below.

1. The OIG erred in concluding that many IRF stays were not reasonable and medically necessary or lacked appropriate documentation.

The OIG said it used an independent medical review contractor³ to determine whether the 220 IRF stays reviewed in the audit were reasonable and medically necessary and met Medicare documentation requirements. Based on that review, the OIG concluded that 146 of the 220 stays reviewed were not reasonable and medically necessary. The Report noted that these 146 stays also failed to meet Medicare documentation requirements, and that another 29 of the 220 stays were reasonable and necessary, but failed to meet documentation requirements. According to the Report, this means that a total of 175 of the 220 sampled stays – *four out of every five* – should not have been paid by Medicare. And, when the OIG extrapolated from the sampled claims to the universe of dollars paid to IRFs for services in 2013, it found 84 percent – *or \$5.7 billion* – was incorrectly paid. The AHA believes that conclusion is seriously flawed.

First, we note that, without being able to review each sampled claim and the OIG contractor's findings, we do not know whether the contractor made its decisions by inappropriately second-guessing the admitting physician's judgment, relying on post-admission evidence, citing high function in one or two activities of daily living while ignoring others, or ignoring other evidence in the medical record. *These are mistakes that we have seen in many prior OIG hospital audits and have brought to the OIG's attention.*⁴

Moreover, the finding that the vast majority of IRF stays were not medically necessary is inconsistent with the findings made by CMS and its contractors in their audits of IRF

³ We have no insight into the contractor's knowledge of IRF coverage rules, but note that whether an individual qualifies for IRF services is a complex medical judgment. That judgment differs from the similarly complex medical judgment made in admitting a Medicare beneficiary to an acute care hospital. The AHA has seen OIG and CMS contractors err frequently in evaluating the medical necessity of admission to acute care hospitals as well as IRFs.

⁴ See, e.g., OIG, *Medicare Compliance Review of Mount Sinai Hospital for 2012 and 2013*, No. A-02-14-01019 (2017), available at <https://oig.hhs.gov/oas/reports/region2/21401019.pdf>; OIG, *Medicare Compliance Review of Abbott Northwestern Hospital for 2013 and 2014*, No. A-05-15-00043 (2016), available at <https://oig.hhs.gov/oas/reports/region5/51500043.pdf>.

claims. For example, CMS's comprehensive error rate testing (CERT) audit of IRF claims for 2013 – the same year as the OIG audit – found an error rate of 17.2 percent – *five times lower than what the OIG found*. And the disparity is even more marked in dollar terms: According to the OIG, CMS's Recovery Audit Contractors (RACs) and Medicare Administrative Contractors (MACs) identified only \$18.5 million in IRF overpayments from 2013 *through 2017*.⁵ The OIG Report does not explain how there could be such a disparity between its findings and CMS's.⁶

And the OIG Report turns IRFs' success rate at the administrative law judge (ALJ) level of the appeals process on its head. The Report implies that, if only ALJs were better informed about IRF coverage by, for example, greater CMS participation in hearings, the ALJs would uphold more IRF claim denials. In fact, we believe that the inability of IRFs to challenge the OIG's findings (first directly with the OIG at the end of the audit and then through the appeals process) **before the Report was issued** allowed the OIG grossly to overestimate the number of IRF claims that should not have been paid as well as the total overpayment for 2013.

A hearing before an ALJ is the first opportunity in the appeals process for a provider to present witnesses to an impartial adjudicator. For example, the treating rehabilitation physician can testify about the beneficiary's need for IRF care and how the regulatory requirements were satisfied. The high rate at which ALJs reverse IRF claim denials demonstrates not – as the OIG suggests – that ALJs need more education on IRF coverage; instead, the high reversal rate shows that OIG's use of a cold, written record seemingly to second-guess a physician's judgment that IRF care is reasonable and medical necessary often results in reversible error. Cold record determinations (made without the benefit of hearing or testimony) frequently lack the context needed to properly evaluate medical necessity for the types of highly complex cases treated in IRFs. Yet that is the basis on which the OIG made its findings in the Report.

2. Extrapolation to the universe of IRF 2013 claims is improper and misleading.

The OIG extrapolated from its findings on the 220 audited claims to conclude that *\$5.7 billion of the \$6.75 billion paid to IRFs for 2013 was for stays that were not reasonable*

⁵ See Report at 5.

⁶ One possible explanation is that the OIG relied on provisions of the Medicare Benefit Policy Manual to determine coverage and documentation requirements for IRF stays despite the fact that manual guidance is not binding. See *Id.* at 2; *contra Clarian Health West LLC v. Hargan*, 878 F.3d 346, 357 (D.C. Cir. 2017) (Medicare manual instructions issued without a notice-and-comment rulemaking "have no binding legal effect"). In addition, we note that the OIG attributes the large number of IRF claims for 2013 that were allegedly paid improperly, in part, to the fact that "CMS's extensive educational efforts and recent postpayment reviews were unable to control an increasing improper payment rate reported by CERT since our 2013 audit period." Report at 6. But the OIG Report and CERT report that reached wildly divergent conclusions about the number of IRF claims that were improperly paid *actually reviewed claims for the same year – 2013*.

and necessary. The AHA believes it is improper and misleading to use extrapolation in these circumstances. By publishing the grossly exaggerated \$5.7 billion overpayment amount, the OIG has impugned the value of services furnished in nearly 400,000 Medicare beneficiary IRF stays in 2013. But more than reputational harm is at issue.

As noted, the IRFs subject to the audit did not have an opportunity to challenge the OIG's conclusion that claims failed to meet Medicare coverage or documentation requirements. Courts that have upheld sampling and extrapolation to determine overpayments on Medicare claims have done so only where there are protections in place. For example, in *Chaves County Home Health Services v. Sullivan*,⁷ the court recognized the importance of being able to challenge each individual claim denial as well as the statistical validity of the extrapolation. But none of the IRFs involved in the OIG audit had those rights.

The AHA is confident that a very large proportion of the 175 claims the OIG said should have been denied would have been reversed on appeal had the providers been able to challenge them. And the OIG's sampling and extrapolation methodologies also may have been called into question. By extrapolating to the universe of claims *before* permitting the IRFs to appeal the OIG's findings,⁸ the Report has grossly overstated the alleged overpayments.

3. The recommendations to CMS are misguided or unnecessary.

The OIG IRF Report makes four recommendations to CMS. We address two.

The OIG recommended that CMS "increase oversight activities for IRFs, such as postpayment medical review, to determine compliance with coverage and documentation requirements, including a review of a subsample of the 135 IRFs in this review that had 1 or more sampled stays that did not comply with Medicare requirements."⁹ The AHA believes that this recommendation would result in a poor use of IRF and CMS resources. Auditing an IRF with one or two stays that allegedly should not have been covered will be onerous for the IRF and the CMS contractor with limited benefits for Medicare. The recommendation fails to acknowledge that CMS RACs and MACs already routinely audit IRF stays. It also fails to recognize that CMS's rules prohibit reopening claims for services furnished in 2013 to recover payments.¹⁰

⁷ 932 F.2d 914 (D.C. Cir. 1991).

⁸OIG findings are not appealable. This means that providers audited by the OIG have no way to vindicate their rights where they believe the OIG has erred. This also lends support to the AHA's view, consistent with the reasoning in *Chaves County* and other cases, that the audit findings should not be extrapolated unless protections exist.

⁹ *Passim*.

¹⁰ Reopening is permitted where there is evidence of fraud or similar fault. See 42 C.F.R. § 405.980(b)(3). The Report cited no evidence of fraud or similar fault on the part of the IRFs whose claims allegedly should not have been paid by Medicare.

Moreover, as noted, if the IRFs in the audit had been able to use the appeals process to challenge the OIG's findings, we believe it is quite likely that their claims would have been covered. That means that many of the 135 IRFs recommended for potential audit *may not have had any claims that should have been denied*, but they nevertheless would be put through the time, expense and diversion of resources resulting from a Medicare audit.

The AHA also questions the need for the OIG's recommendation that CMS reevaluate the IRF payment system. A demonstration project requiring prior authorization for IRF stays would likely only decrease access to needed IRF care for vulnerable beneficiaries and increase the burden on IRFs and physicians to comply with added paperwork and administrative requirements. In the AHA's view, there already are enough such requirements applicable to IRF services.

Similarly, we question the need for legislative changes that would allow IRF payments to align more closely to costs. Congress sought to move away from linking costs to payment in establishing the prospective payment system (PPS) governing IRF services. The OIG's recommendation appears to be inconsistent with the policy behind the IRF PPS and implies that IRFs made inappropriate decisions to admit Medicare beneficiaries based on financial gain. In fact, IRFs decide to admit Medicare patients based on the clinical judgment of a rehabilitation physician who determines that each beneficiary meets the requirements for IRF care.

Finally, we note that the recommendations related to legislative and regulatory changes do not recognize the recent and substantial reforms authorized by Congress and CMS. First, with the Improving Medicare Post-Acute Care Transformation Act of 2014, Congress authorized the development of a combined payment system for all post-acute settings, including IRFs – a direction in notable contrast with the Report's recommendation. Further, CMS included in the fiscal year 2019 IRF PPS rule a set of material payment and patient assessment reforms for 2020, which the Report overlooks.

We appreciate the opportunity to bring our concerns about the IRF audit to your attention and would be happy to discuss them further.

Sincerely,

/s/

Melinda Reid Hatton
General Counsel

Attachment



**American Hospital
Association®**

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

April 17, 2018

Kimberly Brandt
Principal Deputy Administrator for Operations
Centers for Medicare & Medicaid Services
7500 Security Boulevard - Mail Stop C5-02-00
Baltimore, Maryland 21244

Dear Ms. Brandt:

Once again, thank you for engaging with us on the Office of Inspector General (OIG) hospital audit extrapolation issue. As we discussed at our recent meeting, this issue has plagued our member hospitals and hospital systems for a number of years and, unfortunately, seems to have gotten worse recently with the issuance of a new audit report¹ that a member hospital system brought to our attention.

We detail our concerns about the most recent audit below. We then outline the additional concerns that we have shared with various agencies within the Department of Health and Human Services (HHS) over a number of years.

THE MOST RECENT EXAMPLE OF OIG OVERREACH

A member health system came to us last month because it had gotten a letter from its Medicare Administrative Contractor (MAC) about claims for Hyperbaric Oxygen Therapy (HBOT) services. The letter asked that two of the hospitals in the system conduct a self-audit of hundreds of claims, with dates of service going back to 2012 (essentially, spanning the full six-year lookback applicable to self-reporting of overpayments). The MAC's request is based on a recommendation from the OIG contained in the recent audit report. This report raises serious and, in some cases, new concerns.

Perhaps most concerning, is that *the OIG never presented a draft of the audit report to the Centers for Medicare & Medicaid Services (CMS) for the agency's review and comment*. Rather, the OIG sent a draft to the MAC with "recommendations" for what the MAC should do. This is

¹ OIG, Wisconsin Physicians Service Paid Providers for Hyperbaric Oxygen Therapy Services That Did Not Comply with Medicare Requirements (Feb. 2018), <https://oig.hhs.gov/oas/reports/region1/11500515.pdf>



- The OIG recommended that the MAC "notify the providers responsible for the 44,820 nonsampled claims . . . so that those providers can investigate and return any identified overpayments." Again, many of these hospitals had only a handful (if any) of their claims actually reviewed by the OIG. The MAC has begun notifying hospitals included in the OIG review even though the MAC is simultaneously doing a separate "Targeted, Probe & Educate" audit of these same services at some of the same hospitals.
- The OIG's report indicates that it is performing a similar audit of another MAC, which would compound the problems identified here. This amplifies the need for swift action to address these problems.

Conducting a 100 percent retrospective review of all HBOT services at all these hospitals is enormously time and resource-intensive and thereby adds even more to the cost of health care. It will tie up hospitals' auditing staffs for months and cost the hospitals tens of thousands of dollars. Yet the hospitals believe that is what they must do; otherwise, they risk some type of adverse action by CMS, owing significant amounts of interest on alleged overpayments, further scrutiny by the OIG or even a potential False Claims Act action.

LITANY OF THE ERRORS IN PRIOR OIG AUDITS

- The OIG improperly relies on post-admission outcomes to conclude that inpatient admissions were wrongly billed. The OIG regularly relies on post-admission patient outcomes, such as actual length of stay or actual rehabilitation outcomes, to conclude that inpatient hospital admissions and inpatient rehabilitation facility admissions were not medically necessary.² This directly violates Medicare regulations, which dictate that an admission is covered by Medicare if the physician reasonably *expects* at the time of the patient's admission that the relevant requirements for admission are met.
- The OIG has required hospitals to meet admission order requirements that were not in effect when the admission occurred – or that simply do not exist.
 - In multiple audits, the OIG found that a hospital wrongly billed for an inpatient admission because there was no written physician order at or before the time of admission, as required by an October 2013 regulation that CMS now has rescinded. Even if that regulation were consistent with the Medicare statute – and we strongly believe that it was not – the OIG required at least one hospital to have a physician order for admissions that occurred *before the regulation took effect*.³

² See, e.g., OIG, Medicare Compliance Review of Mount Sinai Hospital for 2012 and 2013, at 28-37 (Apr. 2017), <https://oig.hhs.gov/oas/reports/region2/21401019.pdf> [Mount Sinai Compliance Review]; OIG, Medicare Compliance Review of Abbott Northwestern Hospital for 2013 and 2014 (Dec. 2016), <https://oig.hhs.gov/oas/reports/region5/51500043.pdf> [Abbott Northwestern Compliance Review].

³ See Mount Sinai Compliance Review at 38-39.

and not simply to obtain the heart biopsy. The OIG ignored this evidence and wrongly concluded that the hospital should not have billed separately for the procedures. In a later nationwide review of the same issue, the OIG repeated its mistake of assuming that a catheterization is simply part of a heart biopsy, even when there is a separate diagnostic reason for the catheterization.⁸

- In one audit, the hospital used modifier -59 to bill separately for two genetic laboratory tests for breast cancer.⁹ The hospital provided coding guidance showing that the procedures are distinct because they test for different genetic alterations – one test looks for “common” breast cancer gene alterations and the other looks for “uncommon” alterations. The OIG ignored that coding guidance and found that the hospital should not have billed separately.
- In still other audits, the OIG found that a hospital should not have billed separately for services related to intensity-modulated radiation therapy (IMRT) because those services were part of developing the IMRT plan. The Medicare manual and AMA coding guidance allow providers to bill separately for any services “not provided as part of developing the IMRT treatment plan.”¹⁰ In at least one audit, the hospital furnished evidence that the services provided were separate from the IMRT plan, but the OIG disregarded this evidence.¹¹ In another audit, the OIG suggested that certain services were always part of the IMRT planning service and could never be billed separately, even though this interpretation directly contradicted CMS guidance.¹²
- Even when CMS corrected the OIG’s errors in interpreting CMS coverage policy, the OIG insisted on its own interpretation. In a recent review,¹³ the OIG misinterpreted CMS coverage policy for outpatient physical therapy, requiring audited claims to show an expectation that physical therapy will significantly improve the patient’s condition, to include functional reporting codes and severity modifiers in all cases, and to list the same therapist on the claim and on the medical record. Each of these “requirements” goes beyond the actual CMS coverage policy, as CMS recognized by responding that the

⁸ See OIG, Hospitals Nationwide Generally Did Not Comply with Medicare Requirements for Billing Outpatient Right Heart Catheterizations with Biopsies, at 4-5 (Mar. 2017), <https://oig.hhs.gov/oas/reports/region1/11300511.pdf>.

⁹ See Abbott Northwestern Compliance Review.

¹⁰ Medicare Claims Processing Manual, ch. 4, § 200.3.1; AMA, CPT Assistant 09:11 (Nov. 2009).

¹¹ See OIG, Medicare Compliance Review of NorthShore University Health System, at 23-24 (Dec. 2016), <https://oig.hhs.gov/oas/reports/region5/51500044.pdf> [NorthShore Compliance Review].

¹² Mount Sinai Compliance Review, at 41-42.

¹³ OIG, Many Medicare Claims for Outpatient Physical Therapy Services Did Not Comply with Medicare Requirements (Mar. 2018), <https://oig.hhs.gov/oas/reports/region5/51400041.pdf>.

wholesale. Even in the context of a claim review under a Corporate Integrity Agreement, which would involve a provider charged with fraud or other misconduct, the OIG requires the review entity to extrapolate only if the error rate is 5 percent or higher.¹⁷

- The OIG repeatedly identified claims as wrongly billed when a hospital did not report a medical device credit, even when the hospital never actually received the credit. CMS regulations require hospitals to report the value of device credits only if the hospital *receives* a credit or a replacement device at no cost.¹⁸ Yet the OIG refused to follow the language of the regulation.¹⁹ It appears to have changed its interpretation on this point only after CMS clarified its policy on device credits, at the AHA's request.
- The OIG repeatedly identified claims as overpayments even when the claim fell outside the applicable reopening period. The OIG repeatedly identified claims as improperly billed and recommended that the Medicare contractor demand repayment of claim amounts even when the claim was submitted outside the period during which the contractor was authorized to reopen the claim.²⁰ Again, the OIG appears to have stopped this practice only after CMS instructed its contractors not to demand repayment for claims identified by the OIG that fall outside the reopening period.
- The OIG has repeatedly concluded that claims were billed to the wrong diagnosis code even when the code was appropriate under CMS coding guidance. In multiple audits,²¹ the OIG found that hospitals wrongly billed claims for various forms of protein malnutrition under ICD-9 code 260, which the OIG has said is exclusively for a specific form of malnutrition called Kwashiorkor. The OIG relied on AHA Coding Clinic Guidance from October 2009 to support its conclusion and stated that coding related questions were handled by the AHA Coding Clinic. Not only is AHA Coding Clinic guidance not a basis for Medicare payment decisions or the equivalent of binding CMS guidance, but CMS's *actual* ICD-9 coding guidance supports use of code 260 for multiple types of protein malnutrition (not solely Kwashiorkor). At the time the claims at issue were filed, the ICD-9's tabular list indicated that code 260 was used for Kwashiorkor but the ICD-9's alphanumeric index stated it could be used for protein

¹⁷ OIG, Corporate Integrity Agreement FAQ, <https://oig.hhs.gov/faqs/corporate-integrity-agreements-faq.asp>.

¹⁸ 42 C.F.R. § 412.89 (a hospital must report a credit on its claim if “(1) a device is replaced without cost to the hospital; (2) The provider received full credit for the cost of the device; or (3) The provider receives a credit equal to 50% or more of the cost of the device”).

¹⁹ See, e.g., Mount Sinai Compliance Review at 37-38; Abbott Northwestern Compliance Review at 29-31.

²⁰ See, e.g., Mount Sinai Compliance Review at 43-45.

²¹ See, e.g., OIG, CMS Did Not Adequately Address Discrepancies in the Coding Classification for Kwashiorkor (Nov. 2017), <https://oig.hhs.gov/oas/reports/region3/31400010.pdf>.

Meeting with the American Hospital Association, UW Health and Mount Sinai Health System February 13, 2018

Issue: There is an urgent need for the Centers for Medicare & Medicaid Services (CMS) to take a more active role in addressing and preventing the serious problems that flow from the "hospital compliance reviews" conducted by the Office of Inspector General (OIG). The OIG's hospital audits regularly include fundamental substantive and procedural errors and inaccuracies. These flaws result in vastly overstated repayment demands, unwarranted reputational harm, diversion of hospital and physician time from patient care and other problems. Although recent OIG audits make clear that OIG findings represent only *recommendations* to CMS, the agency seemingly acquiesces to the audit findings, leaving hospitals with the lengthy Medicare claim appeals process as their only recourse to recover disputed Medicare reimbursement; the hospitals are never able to recover from the reputational and other harms.

Background: The American Hospital Association (AHA) and many individual hospitals have raised serious concerns for several years about OIG Medicare payment audits. The audits have continued despite efforts by the AHA and hospitals to engage the OIG, CMS and the Department of Health and Human Services (HHS) to make improvements. Most recently, in September 2017, the AHA and two of its member hospitals met with leadership from the CMS Office of Financial Management (OFM) and Center for Program Integrity as well as representatives of the OIG to explain the many procedural and substantive errors in the audits and the actions CMS takes in reviewing and responding to the audits.

After its last meeting with CMS and the OIG, the AHA sent a letter to Jennifer Main, the CMS Chief Financial Officer and head of OFM, making specific, detailed suggestions for steps CMS should take in response to the audits. (A copy of that October 2, 2017 letter and the prior correspondence between the AHA and the OIG, CMS and HHS are attached.) To date, Ms. Main has not responded to the AHA's October 2017 letter.

What CMS Can Do: The AHA and its member hospitals urge CMS to implement the suggestions contained in the AHA's October 2017 letter, which can be briefly summarized as asking CMS (and its contractors):

- To wait until a hospital exhausts its appeals to determine the hospital's error rate and *extrapolate only when the error rate is significant.*
- To allow rebilling of denied inpatient claims regardless of the usual timely filing period.
- To extrapolate only the difference between the inpatient payment and outpatient payment amounts for inpatient hospital denials.
- To provide feedback to the OIG to facilitate issuance of an amended audit report and improvements in audits.
- To review and address legal issues raised by hospitals *before an audit is performed and before a repayment demand is issued.*

The AHA stands ready to work with CMS, the OIG and HHS to implement these and other ideas for improving the audit and repayment processes.



**American Hospital
Association®**

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

October 2, 2017

Jennifer Main
Chief Financial Officer
Director, Office of Financial Management
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Main:

Thank you for meeting last month with the American Hospital Association (AHA) and two of our member hospital systems to discuss the urgent need for the Centers for Medicare & Medicaid Services (CMS) to take a more active role in addressing and preventing the serious problems that flow from the “hospital compliance reviews” conducted by the Office of Inspector General (OIG). We appreciate your engagement with us on this critical issue and we look forward to working with you to improve CMS’s process for reviewing and implementing these OIG audits.

As we discussed, we understand the need for robust and effective review of billing and payment practices by all Medicare providers, including hospitals. However, the OIG’s hospital audits regularly include fundamental flaws and inaccuracies, both in the OIG’s understanding and application of Medicare payment rules and in the procedures the OIG uses to conduct the audits. These flaws result in vastly overstated repayment demands, unwarranted reputational harm, and diversion of hospital and physician leaders’ time from their core mission of caring for patients. The OIG’s mistaken legal interpretations also result in uneven application of Medicare payment rules, both because only some hospitals are subject to OIG audits, and because there is a lack of consistency in the appeals process. In addition, the audits frequently do not provide a basis for making further improvements to a hospital’s practices or procedures because auditors too often review obsolete standards and include large numbers of incorrect claim denials. Moreover, many of the claim denials that are not appealed by hospitals typically involve complex medical judgments that OIG audits are not well equipped to evaluate.

The negative effects of the audits are exacerbated because the OIG regularly extrapolates its findings to all claims in the audit period, even though many hospitals (including those with whom you met) have a documented history of successfully appealing most or almost all of the

virtually identical claim denials in the audit.¹ As a result, it is premature for CMS to issue a repayment demand based on the OIG's extrapolated findings.² Extrapolation often inflates the repayment demand from tens of thousands to millions of dollars, which forces hospitals to appeal each claim (even when they otherwise would not have done so) and creates a severe financial and reputational impact on the hospital that continues long after the OIG's errors are corrected on appeal. During our meeting, we were surprised and disappointed to hear that the OIG now plans to extrapolate in every single hospital audit, despite the legal and statistical limitations on extrapolation and the significant concerns about the OIG's sampling and extrapolation methodologies. This decision to extrapolate in every audit is of serious concern, which we intend to convey to Department of Health and Human Service (HHS) officials, as it will only increase the already serious effects of improper extrapolation.³

These flawed hospital audits have gone on for years despite previous efforts by the AHA to engage CMS, the OIG and HHS to make improvements. When hospitals object to the numerous errors in the audits, the OIG and CMS tell the hospitals that they can appeal the repayment demand. But appeals consume vast amounts of time and money for both the hospital and the government, which could be better spent by the hospitals on patient care and by the government on rooting out actual cases of fraud, waste and abuse in the Medicare program. Moreover, the appeals process is fundamentally broken, which means that hospitals must wait three to five years and expend even more resources just to recover money that they never should have had to repay in the first place.

CMS action is needed now to address all of these serious concerns. During our meeting, we made several specific suggestions to improve the accuracy and fairness of the OIG audits

¹ For example, the majority of claim denials in the Mount Sinai audit relate to "short stay" admissions prior to October 2013 (when the Medicare rules changed). The OIG reviewers ignored the physicians' judgment to admit the patients, concluding that the patients should have been treated as outpatients under observation. Mount Sinai appealed numerous identical "short stay" denials from Recovery Audit Contractor (RAC) reviews and prevailed at the Administrative Law Judge (ALJ) stage in approximately 85 percent of these cases. The hospital has every reason to believe that this same category of denials in the OIG audit will be reversed on appeal. Similarly, with respect to the recent OIG audits for the two hospital systems represented at our meeting, at the first level of appeal alone, the Medicare Administrative Contractor (MAC) already has reversed 11 of the 29 denials appealed by Mount Sinai Health System and 10 of 41 denials appealed by Allina Health. The first level of appeal typically results in relatively few reversals, and we expect many more of the claims to be reversed on further appeal.

² As a related matter, the OIG also errs by routinely including in its audit reports a recommendation that the hospital "exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having being made in accordance with this recommendation." Among other things, the recommendation is premature for the same reason that extrapolation is premature: The hospital cannot determine whether it may have received "similar overpayments" outside the audit period if the hospital is in the process of appealing whether there was any overpayment in the first place.

³ Extrapolation in cases involving a low error rate is particularly unjustified. For example, in the most recent audit report, the OIG identified only 12 of 100 claims as incorrectly billed, and the hospital agreed as to only 4 of 100 claims, yet the OIG extrapolated anyway. OIG, Medicare Compliance Review of Parkridge Medical Center, Inc., for 2014 and 2015, available at: <https://oig.hhs.gov/oas/reports/region4/41608048.pdf>.

through discrete and targeted action by CMS. We reiterate these suggestions below. We believe that taking these actions will have an immediate and positive effect for hospitals, patients and the Medicare program. We look forward to working with CMS to implement them as soon as possible.

1. Extrapolate only if there is a significant error rate.

After appeals are exhausted, CMS and its contractors should extrapolate from any remaining claims only if there is a significant error rate. Under the Social Security Act, CMS contractors may extrapolate from overpayment determinations only if there is a “sustained or high level of payment error” or if a documented educational intervention has failed to correct the payment error. This provision makes clear that Congress intended to limit extrapolation to cases where the level of error is extreme or the provider has failed demonstrably to improve despite educational efforts. We recognize that the OIG is not bound by this limitation, and neither we nor CMS can prevent the OIG from extrapolating in every case, even though we believe it is inaccurate and unfair to do so. However, we ask CMS to recognize Congress’s clear intent by declining to instruct contractors to issue extrapolated repayment demands unless there is a significant payment error after the hospital’s appeals are exhausted.

2. Delay extrapolation until the appeals process is complete.

CMS should not accept the OIG’s recommendation to extrapolate from audit findings until the hospital has exhausted its appeals of individual claims denied based on the audit. In many cases, hospitals succeed in having many or almost all of the individual claim denials reversed. Delaying extrapolation until the individual claim appeals are exhausted will ensure that CMS is looking at an accurate error rate when it decides whether it is appropriate to extrapolate. It also will avoid the unnecessary reputational harm that hospitals suffer when an extrapolated repayment demand is published in the media and is never corrected, even after the hospital significantly reduces the amount of the demand through its appeals. Finally, delaying extrapolation will save the government the time and resources needed to recalculate the repayment amount after each level of appeal as more claim denials are reversed and refund money that was improperly recouped as a result of the inflated error rate.

We understand that delaying extrapolation until after appeals are exhausted may require CMS and the hospital to agree in advance on how and when CMS would proceed to consider whether extrapolation is appropriate, which may include a limited stipulation by the hospital that it will not object to a later extrapolated repayment based on timeliness. We would be happy to work with CMS to determine a fair and effective process that allows extrapolation to occur based on an accurate error rate that is legally and statistically significant.

3. Allow rebilling of denied inpatient claims regardless of the usual timely filing period.

In cases where CMS accepts the OIG’s determination that hospital services were improperly billed as Part A inpatient claims, we believe that equity requires CMS to allow hospitals to bill under Part B for all covered care and services that were provided (including observation services), regardless of

the expiration of the one-year claim filing deadline. By revising its policies to allow rebilling of certain services denied as inpatient claims in a Recovery Audit Contractor (RAC) audit,⁴ CMS already has recognized that it would be unfair to deny hospitals any payment for covered and legitimately provided services. But, as a matter of basic fairness, rebilling should be allowed for *all* covered services that the hospital provided. If changing this Medicare policy would require involvement of individuals in another CMS office or center, then we would appreciate your raising this issue with those individuals. We would be happy to participate in a discussion with relevant staff about how such rebilling could be accomplished.

4. Provide feedback to the OIG to facilitate issuance of an amended audit report and improvements in audits.

The OIG's findings frequently are overturned on appeal to a Medicare Administrative Contractor (MAC) or an Administrative Law Judge (ALJ), often with significant effects on the amount of the MAC's repayment demand. We do not see any reason why errors that have been corrected by a MAC or ALJ should remain uncorrected in the public audit report, and we ask CMS to provide the OIG with information on the disposition of claim appeals that flow from OIG audits and guidance on the underlying Medicare policies. Providing this feedback loop would allow the OIG to develop a process for issuing an amended audit report acknowledging that the reversed claims were correctly billed and prevent the OIG from making the same errors in future audits.

5. Review and address legal issues raised by hospitals before an audit is performed or before a repayment demand is issued.

We do not believe hospital or government resources are well spent on appeals of legal mistakes by the OIG that could be avoided or corrected before a repayment demand is issued. We respectfully ask CMS to review and address legal arguments raised by hospitals, rather than simply accepting the OIG's interpretation of the law and issuing a demand letter based on that interpretation. For example, in the hospital audits discussed at our meeting, the OIG misread or misapplied CMS rules on manufacturer credits for replacement devices and the use of modifier 59 to bill for clearly distinct procedures. Each of these errors now has been corrected on appeal, at least in part, but hospitals should not have to expend the time and resources – and the government should not waste the time and resources – to resolve such appeals. By taking a closer look at legal issues before a repayment demand is issued, CMS can avoid wasted resources and ensure uniform and accurate application of its own rules.

We also urge CMS and the OIG to consult on the categories of claims to be audited and the correct interpretation of Medicare rules *before* the OIG conducts an audit. Although we recognize that the OIG has ultimate authority to decide what to audit, we believe that the OIG's meaningful consultation with CMS before performing an audit would significantly reduce unnecessary and costly appeals. Moreover, it would help focus payment review activities on areas more prone to fraud, waste and abuse, rather than gray areas in the law where even the most careful providers are likely to make mistakes. We were encouraged to see that CMS plans to take a more targeted

⁴ CMS Ruling 1455-R (Mar. 13, 2013).

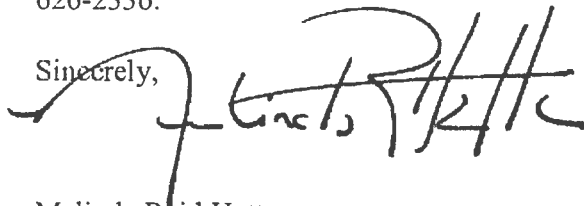
Ms. Jennifer Main
October 2, 2017
Page 5 of 5

approach to audits of physician payment and we hope that CMS will take a similar approach to hospital payment review, including by declining to accept OIG audit findings based on legal interpretations on which CMS has not been adequately consulted.

* * *

Thank you for your attention to this important matter. The AHA believes it is critical that CMS take action to improve implementation of the OIG audits for the benefit of hospitals, patients and the Medicare program, and we stand ready to work with you to carry out the improvements suggested above and any others that you may wish to discuss. If we can provide further information or if you would like to discuss any of these matters further, please contact me at mhatton@aha.org or (202) 626-2336.

Sincerely,

A handwritten signature in black ink, appearing to read "Melinda Reid Hatton". The signature is written in a cursive style with a large, stylized initial "M".

Melinda Reid Hatton
General Counsel

cc:

Sherri McQueen, Director, Financial Services Group, OFM
Nanette Foster Reilly, Consortium Administrator for Financial Management and Fee for Service Operations
Jerry Andersen, Associate Regional Administrator, Audit Management Division, FMFFSO
Barbara Veno, Associate Regional Administrator, Boston Division of FMFFSO
Wendell Cosgrove, Branch Manager, Boston Medicare Financial Management Branch
George Mills, Deputy Director, Center for Program Integrity
Megan Tinker, Senior Advisor for Legal Review, OCIG



**American Hospital
Association**

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

November 20, 2014

Ms. Gloria Jarmon
Deputy Inspector General for Audit Services
Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue S.W.
Washington, D.C. 20201

Dear Ms. Jarmon:

Thank you for meeting with the American Hospital Association (AHA) last month to discuss our concerns about the increasing number of “hospital compliance reviews” performed by the Office of Inspector General (OIG) Office of Audit Services in which the OIG has extrapolated audit findings to estimate Medicare overpayments to the hospitals. We are truly dismayed to see that despite the numerous legal defects that we identified in these audits, the OIG has proceeded to issue at least four new audit reports using extrapolation in the last month that include many of the same flaws.¹

As we explained during our meeting, we see several substantial legal problems with the extrapolated overpayment amounts. These include:

- Using extrapolation in audits reviewing short inpatient stays, despite acknowledgement by the Centers for Medicare & Medicaid Services (CMS) that its guidance on the criteria for an inpatient admission has been woefully inadequate;
- Artificially inflating the estimated overpayment amounts by not offsetting the amount of Part B payment to which the OIG acknowledges the hospital may be entitled for inpatient stays that the OIG concludes should have been outpatient encounters;
- Using extrapolation without a clear process for hospitals to challenge the OIG’s sampling and extrapolation methodology through the claim appeal process;

¹ These include: Medicare Compliance Review of Methodist Healthcare-Memphis Hospitals for the Period January 1, 2011 Through June 30, 2012 (Oct. 2014); Medicare Compliance Review of Hackensack University Medical Center for the Period April 1, 2011 Through September 30, 2012, No. A-02-13-01017 (Oct. 2014); Medicare Compliance Review of Mission Hospital for the Period January 1, 2011 Through December 31, 2012, No. A-04-14-03077 (Oct. 2014); Medicare Compliance Review of Orlando Health for the Period January 1, 2011 Through June 30, 2012, No. A-04-13-07042 (Sept. 2014).



- Misapplying or misinterpreting Medicare requirements, including inventing a requirement for a physician order as a condition of payment as well as rules for canceled surgeries that are directly contrary to more recent guidance from CMS.

As we also discussed during our meeting, we are aware of at least one hospital that successfully overturned almost the *entire* overpayment amount at the first level appeal and is seeking payment for the remaining claims through the administrative appeal process. This is additional proof that these audits are wasting resources—both for the government and for hospitals. Hospitals should not be forced to pursue the lengthy and expensive claim-by-claim appeal process—especially given the multi-year delay at the already inundated Administrative Law Judge (ALJ) level—to correct errors made by the OIG. Moreover, the headlines associated with the grossly overstated overpayment estimates misrepresent hospitals' compliance with Medicare requirements to the public. We therefore reiterate our request that these audits and issuance of any new reports be halted immediately.

1. The OIG Audit Results Significantly Overstate the Overpayment Amounts.

All of the audits involving extrapolation—including the four audit reports published within the last month—reviewed claims for short inpatient stays. Despite the fact that CMS has acknowledged that it has not provided clear guidance to physicians and hospitals regarding when an inpatient admission is “reasonable and necessary” and has since attempted to clarify that standard through rulemaking, the OIG auditors have insisted on reviewing claims for short inpatient stays. The OIG's findings that large numbers of the reviewed claims should not have been paid under Medicare Part A account for the vast majority of the dollars the OIG alleges were actually paid in error, and thus are the major driver of the estimated overpayments. For example, in the audit report published in October for Mission Hospital, 26 of the 28 inpatient claims that the OIG alleged were paid in error involved short inpatient stays, representing \$97,540 of the \$121,594 in alleged actual overpayments for sampled inpatient and outpatient claims. Thus very nearly the *entire* \$443,183 extrapolated amount is attributable to the OIG's findings on short inpatient stays.

Even setting aside the fact that the OIG's singular focus on short inpatient stays is unnecessary and duplicative of the Recovery Audit Contractor (RAC) activities and other audits, the OIG's almost exclusive reliance on short inpatient stays to generate multi-million-dollar estimated overpayments also unfairly prejudices hospitals for at least three reasons.

First, many of the OIG's allegations that sampled claims for short inpatient stays should not have been paid under Part A will be overturned on appeal. For example, we are aware of two hospitals that successfully overturned the majority of the OIG's findings on the reviewed short inpatient stay claims at the first and second levels of the appeals process, and are still pursuing appeals of the remaining claims. In comments on the OIG's audit reports, many hospitals, like Mission Hospital and the Methodist Healthcare-Memphis Hospitals, said that they intend to appeal the majority of the short inpatient stays denials. Other hospitals, however, including most recently both Hackensack University and Orlando Health, have elected not to appeal the OIG's findings on the sampled claims. Instead, they have tried to challenge the sampling and

extrapolation methodologies used by the OIG through the claim appeals process, even though there are no clear procedures for doing so, especially at the lower levels of appeal. Even if hospitals were successful in overturning the OIG's findings on particular claims or its extrapolation methodology, the appeals process is costly and time-consuming and thus a waste of scarce hospital resources.

Second, as explained in our letter dated June 2, 2014, even in cases in which the Medicare claims adjudicator, (i.e., MAC, Qualified Independent Contractor (QIC), or ALJ), agrees with the OIG that a particular inpatient admission was not "reasonable and necessary," Section 1879 of the Social Security Act (SSA) provides that the hospital is nonetheless entitled to receive Part A payment in cases in which the hospital and the Medicare beneficiary "did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A."² In such cases, no overpayment exists.

Third, even if a Medicare claims adjudicator agrees that a particular patient should have been treated on an outpatient rather than inpatient basis, the Part A overpayment should be offset by the amount of Part B payment that the hospital is entitled to receive on that claim. In those cases, offsetting the Part B payment amount will dramatically reduce not only the amount of the actual overpayment, but also the extrapolated amount. The OIG has acknowledged as much in all of its audits involving extrapolation based on samples of claims for short inpatient stays, but has disclaimed any responsibility for ensuring that the estimated overpayment accurately reflects those amounts.

During our meeting, you suggested that the OIG could not offset Part A overpayments by Part B payment amounts because the Inspector General Act of 1978, which established the OIG in the Department of Health and Human Services, prohibits the Secretary from transferring "program operating responsibilities" to the Inspector General. But nothing about offsetting Part A overpayments by Part B payments would entail the OIG exercising program operating responsibilities: CMS has changed its policy and now agrees that hospitals can be paid under Part B where a Part A stay is denied because the beneficiary could have been treated on an outpatient basis. Thus, in offsetting Part A overpayments by payments under Part B, the OIG would be engaged in its usual application of Medicare rules to the claims being audited. Moreover, the prohibition on the Secretary delegating her authority to the OIG is hardly an excuse for publishing estimated overpayment amounts that the OIG knows are incorrect. The OIG's publication of artificially inflated overpayment estimates is especially inexcusable in light of the fact that in many cases, the MACs simply have recouped the full, incorrect, extrapolated amount and the overwhelming backlog of Medicare claim appeals means that it may take hospitals years to correct those mistakes. And in the meantime, hospitals have suffered financial harm by having to repay the MACs as well as damage to their reputations through unfair portrayals in news reports.³ And all of this is based on the OIG's *overstated* estimated overpayments.

² SSA § 1879(a).

³ See, e.g., Scott Powers, *Audit: Orlando Health Overbilled Medicare By \$1.45 Million*, Orlando Sentinel (Oct. 6, 2014), <http://www.orlandosentinel.com/health/os-feds-say-orlando-health-overbilled-medicare-20141006-story.html> (last visited Nov. 17, 2014).

We applaud the OIG for stating that it is not currently reviewing short inpatient stays under the two-midnights rule and that it does not intend to do so for the same period that the RACs are prohibited from reviewing such claims. We think that the OIG should similarly discontinue reviews of short inpatient stays under the former criteria. It seems to be the worst kind of government “gotcha” for the OIG to continue to apply old rules that the OIG knows CMS has since abandoned because they were unclear. We therefore strongly urge the OIG to stop reviewing short inpatient stays under the pre-two-midnights criteria and to stop extrapolating those results.

2. The OIG’s Extrapolated Overpayments Continue to Be Based on Misinterpretations of Numerous Medicare Rules and Policies.

As noted above, in declining to offset Part A overpayments by Part B payments, you emphasized limitations on the OIG’s authority regarding “program operating responsibilities.” At the same time, however, in carrying out its audits, the OIG has invented Medicare requirements where they do not exist.

a. The OIG Invented a Physician Order Requirement.

As we discussed during our meeting, until October 1, 2013, CMS never required a physician order for a short-term, acute care inpatient admission as a condition of Medicare Part A payment.⁴ Thus, the OIG’s findings that Part A claims should not have been paid because “the medical records did not contain a valid order signed by a physician” are incorrect. No such requirement existed during the time period relevant to the audited claims.

Effective October 1, 2013, CMS amended its regulations to add a brand new section related to “admissions” that requires that “[a] physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A,” that the order “must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient’s hospital course, medical

⁴ As the AHA has explained repeatedly to CMS and the OIG, the requirement is unlawful because it is contrary to the plain language of the Medicare statute, which requires such an order only for inpatient hospital services “which are furnished *over a period of time.*” SSA § 1814(a)(3) (emphasis added). Congress explicitly amended the Medicare statute in 1967 to eliminate the requirement that a physician order appear in the medical record in every case. *See* Pub. L. No. 90-248, § 126(a), 81 Stat. 821, 846; H.R. Rep. No. 90-544, at 38, 149 (1967); S. Rep. No. 90-744, at 239 (1967). That forecloses CMS from imposing a physician order requirement as a condition of Part A payment in short-term, acute care stays, whether it purports to do so under §1814(a)(3) or, as in the revised regulation that CMS issued on October 31, 2014, under its general rulemaking authority under § 1871 of the Act.

plan of care, and current condition,” and that the order be “furnished at or before the time of the inpatient admission.”⁵

The wording of the newly added section speaks for itself. Nevertheless, at our meeting, you asked us to confirm that there was no requirement for a physician order as a condition of payment before CMS added it in October 2013.

Tellingly, in the preamble to the proposed rule, CMS did not attempt to—and in any event could not—point to any existing provision in the Medicare conditions of payment regulations that requires a physician order for inpatient admission. The only regulations to which CMS could turn were the Medicare conditions of *participation* (CoPs) for hospitals. CMS described at length the general standards for the hospital to maintain “medical records” and for the hospital’s governing body to ensure that Medicare patients are admitted to the hospital only on recommendation of a licensed practitioner.⁶ But of course, Medicare conditions of *participation* and conditions for *payment* are not the same thing; they are distinct legal requirements that carry with them different consequences for non-compliance. Hospitals work hard to comply with the CoPs and to include “orders” for care in their patients’ medical records, but under the CoPs, a missing physician order does not provide a basis for denying Medicare payment. Instead, hospital compliance with the CoPs is assessed through surveys,⁷ and if a hospital is deficient with respect to a standard, it typically must enter into a corrective action plan and achieve compliance within a “reasonable” period of time.⁸ In contrast, by making the physician order a condition of *payment*, CMS created a new legal obligation that directly affects a hospital’s reimbursement under Medicare Part A for each patient stay.⁹

As further evidence that the physician order requirement is new, CMS explained that, unlike in the CoPs, which “allow for inpatient orders to be given verbally in person or over the telephone as well as through the use of preprinted and electronic standing orders, order sets, and protocols,” the proposed rule would require the physician order to be present in the medical record in order for the hospital to be paid under Part A.¹⁰ In responding to comments in the final

⁵See 78 Fed. Reg. 50,495, 50,939–43, 50,965 (Aug. 19, 2013) (codified at 42 C.F.R. § 412.3(a)). CMS also amended its “Conditions for Medicare Payment” regulation specifying the requirements for inpatient services to add a new physician certification requirement for every inpatient admission occurring on or after October 1, 2013. See 78 Fed. Reg. at 50,940, 50,941 (codified at 42 C.F.R. § 424.13(a)). But CMS has subsequently amended its regulations again, dropping the requirement for a physician certification except for hospital stays that last 20 inpatient days or more and cost outlier cases. 79 Fed. Reg. 66,770, 66,998 (Nov. 10, 2014). CMS cited the administrative burden of requiring a separate certification for all inpatient admissions. *Id.*

⁶ 78 Fed. Reg. at 27,646 (proposed) (citing 42 C.F.R. § 482.24(c) and § 482.12(c)); *id.* at 50,940 (final).

⁷ 42 C.F.R. § 482.1; *id.* §§ 488.3, .20, .26.

⁸ *Id.* § 488.28.

⁹ See 42 C.F.R. § 424.13.

¹⁰ 78 Fed. Reg., 27,646-47.

rule, CMS confirmed that verbal orders would not meet the conditions for Part A payment.¹¹ CMS's discussion of verbal orders in the preamble demonstrates in two respects that the physician order requirement is new. First, CMS emphasized the need to take "additional time" to develop the requirements for verbal orders for inpatient admission using its subregulatory guidance, which is consistent with the requirement being new and distinct from existing requirements under the CoPs.¹² Second, CMS explained that it would consider "and potentially coordinate the CoP and payment rules," again illustrating that the new physician order requirements are not the same as existing requirements.¹³

In the final rule, CMS also added a requirement for the timing of the physician order, specifying that it "must be furnished at or before the time of the inpatient admission," and revised the proposed qualifications for the physician or other "qualified and licensed practitioner who has admitting privileges at the hospital" who may sign the physician order for inpatient admission.¹⁴ CMS has since issued multiple subregulatory guidance documents regarding the technical requirements for the physician order.¹⁵ The fact that CMS added more detailed specifications in the final rule, and has further elaborated on those specifications in subregulatory guidance, confirms that the physician order requirement is new.

In sum, CMS explicitly codified a new regulation to require a physician order for inpatient admission as a condition of Part A payment, engaged in lengthy discussion in the preamble about the distinct technical requirements for such an order as compared to the orders required under the CoPs, and further developed the specifications for the physician order in subregulatory guidance issued over the course of many months. These facts make clear that no such requirement existed before October 1, 2013. Thus, when the OIG found in several of its audits that one or more of the hospital's inpatient claims was paid in error because the patient's medical record did not contain "a valid order signed by a physician" for inpatient admission, it simply invented that requirement. Those findings were incorrect and the hospitals should not have been required to refund either the actual Part A payment or any portion of the extrapolated amount attributed to those claims.

b. The OIG Must Not Ignore CMS Policy on Canceled Surgeries.

The physician order requirement is not the only example of the OIG disregarding the Medicare requirements and substituting its own policies when auditing hospital claims. In at least one of the audit reports published in the last month, the OIG has turned to another issue:

¹¹ *Id.* at 50,941.

¹² *Id.* ("We intend to further discuss and develop our requirements regarding verbal orders for inpatient admission in our subregulatory guidance. The CoPs regarding verbal orders were carefully developed over a period of time, and we believe we should take additional time to consider and potentially coordinate the CoP and payment rules.")

¹³ *Id.*

¹⁴ *Id.* at 50,941-42.

¹⁵ See CMS, Hospital Center, <http://cms.gov/center/provider-type/hospital-center.html> (last visited Nov. 13, 2014).

Medicare Part A payment to hospitals for scheduled surgical procedures that are canceled after the beneficiary is admitted. In the audit report for Orlando Health published at the end of the September, inpatient claims with canceled surgeries represented the second largest dollar amount of actual Part A payments that the OIG alleged were made in error, and thus also substantially increased the extrapolated amount. We understand from our meeting that the OIG intends to continue to review payments for canceled surgeries under the two-midnights rule.

But the OIG has no basis for doing so. Indeed, any OIG finding that Part A payment should not be made in such cases would directly contradict CMS's guidance. And, as you rightly noted, CMS, not the OIG, has program operating responsibilities for Medicare. Tellingly, in the Orlando Health audit report, the OIG did not identify any Medicare regulation or guidance to support its findings that inpatient claims with canceled surgeries were paid in error. In fact, the OIG did not discuss its findings for that category of claims at all. That omission is not surprising in light of the report published by the OIG last year on this issue, in which the OIG concluded that there was no specific guidance from CMS for billing claims for canceled surgeries and urged CMS to strengthen its guidance.¹⁶ CMS responded to that recommendation by citing its then-proposed two-midnights rule, noting that “[w]hile the proposed rule does not specifically mention canceled inpatient procedures, we can address this circumstance in our responses to comments in the final rule.”¹⁷ And in subregulatory guidance implementing the two-midnights rule, CMS has confirmed that in cases in which a physician reasonably expected the beneficiary to require a hospital stay for two or more midnights at the time of the inpatient order and formal admission, but the surgery is canceled after the inpatient admission, the admission is generally appropriate for payment under Medicare Part A.¹⁸ Therefore, the OIG should not pursue this issue in its audits under the two-midnights standard.

c. The OIG Should Follow Medicare Time Limits on the Review and Denial of Paid Claims.

As explained in detail in our June 2, 2014 letter, the Medicare statute and regulations impose time limits on finding hospitals liable for overpayments or reopening and reviewing paid claims unless there is actual evidence of “fault.”¹⁹ The OIG is well aware of those limits. Indeed, in its recommendations to CMS in the report discussed above regarding canceled surgeries, the OIG acknowledged that CMS can adjust the sampled claims only “to the extent allowed under

¹⁶ U.S. Dep’t of Health & Human Servs., Office of Inspector General, *Medicare Could Save Millions By Strengthening Billing Requirements for Canceled Elective Surgeries*, No. A-01-12-00509 (Aug. 2013), at 8, available at <https://oig.hhs.gov/oas/reports/region1/11200509.pdf>.

¹⁷ *Id.* at 16.

¹⁸ CMS, *Frequently Asked Questions, 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013*, at 16 (Mar. 12, 2014), available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Questions_andAnswersRelatingtoPatientStatusReviewsforPosting_31214.pdf.

¹⁹ SSA § 1870(c) (2012); 42 C.F.R. § 405.980(b).

the law” and recover overpayments “to the extent feasible and allowed under the law.”²⁰ CMS responded, as it often does, by identifying the claims that cannot be reopened and for which overpayments cannot be collected because the claims are beyond the four year claims reopening period.²¹ But in its earlier Medicare Compliance Reviews of hospitals, the OIG refused to adjust its estimated overpayments to reflect the claims that CMS is prohibited from recovering under these rules, and instead recommended that hospitals refund the full extrapolated overpayment to CMS. We are pleased that in the four most recent hospital compliance audits the OIG did not review claims beyond the four year reopening period or state that the hospitals may be liable for overpayments identified beyond the three year statutory period for recovering overpayments where the provider is “without fault.” We encourage the OIG to adhere to Medicare’s reopening and overpayment recovery rules in any future audits.

* * *

Thank you for your attention to this matter. The AHA continues to urge you to halt these reviews and the resulting demands for our nation’s hospitals to repay improperly extrapolated amounts of Medicare reimbursement. If we can provide further information, please contact me at mhatton@aha.org or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President and General Counsel

cc: Daniel Levinson
Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue S.W.
Washington, D.C. 20201

Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Deborah Taylor
Director and Chief Financial Officer
Office of Financial Management
Centers for Medicare & Medicaid Services
7500 Security Blvd., MS C3-01-24
Baltimore, MD 21244

²⁰ *Medicare Could Save Millions By Strengthening Billing Requirements for Canceled Elective Surgeries*, *supra* note 19, at 8-9.

²¹ *Id.* at 16.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20001



JAN 15 2015

Melinda Reid Hatton
Senior Vice President and General Counsel
800 10th Street, NW
Two City Center, Suite 400
Washington, DC 20001

Dear Ms. Hatton:

I am writing in response to your letter of November 20, 2014, regarding our hospital compliance reviews. We value the input we have received from you and others in the hospital industry on these issues and appreciate the opportunity to address the concerns that you have raised.

Background

The Department of Health and Human Services (Department or HHS), Office of Inspector General (OIG), has long been committed to working with the hospital and provider community to provide education and training to improve compliance with Medicare laws and regulations. The goal of this work is to protect the integrity of HHS programs and the health and welfare of program beneficiaries. To this end, we have pursued a multi-disciplinary strategy to promote compliance that includes, for example, audits and other retrospective reviews, education, and guidance products to aid providers in upfront voluntary compliance efforts. Our guidance products include compliance program guidance and advisory opinions, as well as a collection of educational materials available on our Web site at <http://oig.hhs.gov/compliance/provider-compliance-training/index.asp#materials>. Through public comments, roundtables, and other mechanisms, we solicit industry input about our compliance and education tools and consider feedback from a range of public and private stakeholders.

Our hospital compliance reviews are part of a broad commitment to promoting greater compliance by hospitals and health systems. Using OIG's extensive experience in hospital audits, investigations, and inspections, we identify areas at risk for noncompliance with Medicare billing requirements. We use the results of our data mining and analysis to identify hospitals that appear to be at risk for noncompliance. All of our audits are conducted in accordance with generally accepted government auditing standards, which require that audits be planned and performed so as to obtain sufficient, appropriate evidence providing a reasonable basis for OIG findings and conclusions. For every hospital compliance review that we undertake, we work closely with the Centers for Medicare & Medicaid Services (CMS), our legal counsel, and the audited entity. We make every effort to ensure that we apply criteria accurately. Because every hospital is unique, the data-driven reviews are tailored to identify and review each individual hospital's specific areas of risk.

OIG's continued review of Medicare Part A payments, which according to the Congressional Budget Office comprise about 24 percent of all Medicare payments, is essential to ensure proper expenditures of Federal funds. The Department's 2014 *Agency Financial Report* estimated improper payments in the Medicare fee-for-service program of \$42.7 billion, which represents an 11.8-percent improper payment rate. A contributing factor cited by the Department for these improper payments is medical necessity errors for inpatient hospital claims, such as short-stay claims, that were determined to not be reasonable and necessary in an inpatient setting.

Response to American Hospital Association Concerns About Hospital Reviews

Your letter raised four main areas of concern about our application of Medicare rules and policies: (1) the need for a physician order, (2) the treatment of canceled surgeries, (3) the rebilling of Medicare Part A claims under Part B, and (4) the review of claims beyond the statute of limitations. We address each of these concerns below. For the reasons noted, we respectfully disagree with the American Hospital Association's (AHA) legal conclusions and characterizations.

The first concern focuses on the requirements that an inpatient admission be documented by a physician's written certification (also called an order) as to the medical necessity of the admission. OIG's application of a physician-order requirement is supported by legal authority, and OIG applied the requirement only after extensive consultations with CMS. The CMS regulation in effect during our audit periods stated that Medicare paid for inpatient hospital services only if a physician certified and recertified the reasons for continued hospitalization.¹ In its 2013 regulations regarding the physician certification requirement, CMS thoroughly discussed the history of this issue and repeatedly described the physician-order requirement as a "longstanding policy" rather than as a new requirement.² Accordingly, for all the claims reviewed in our hospital compliance reviews, CMS required hospitals to have a physician order authorizing the inpatient admission to properly bill for Medicare Part A services.

The second concern raised by your letter involves Medicare reimbursement for an inpatient stay for a canceled surgery. Medicare requires that a service must be reasonable and necessary to be payable.³ During our audit periods, CMS implemented this requirement for hospitals by requiring that the admitting physician have an expectation that the patient would require a stay of 24 hours or more.⁴ In addition, Medicare policy states that the admitted beneficiary "must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must

¹ 42 CFR § 424.13(a)(1)(i) (2012).

² See CMS's discussion in Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, 78 Fed. Reg. 50496, 50938-50942 (Aug. 19, 2013), in which CMS states, among other things, that "our longstanding policy, as reflected in our regulations and other guidance, has been that a physician order is required for all inpatient hospital admissions, regardless of the length of stay. We believe that this policy is a legally supportable interpretation of [the Social Security Act]."

³ Social Security Act § 1862(a)(1)(A).

⁴ Medicare Benefits Policy Manual, Pub. 100-02, ch. 1, §10.

receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.”⁵ In our audit work, we found examples of canceled surgeries billed by hospitals to Medicare as inpatient stays in which a patient was admitted for a scheduled non-emergency procedure but: (1) a surgery room had been overbooked or was not available or (2) a preoperative exam before admission showed the patient no longer qualified for the procedure. Such admissions are not reasonable and necessary for the treatment of illness or injury.

The third concern pertains to offsetting (or “rebilling”) Medicare Part A overpayments with amounts that may be payable under Medicare Part B. We recognize in a footnote in our hospital compliance reviews that Medicare Part B rebilling may affect the final overpayment amount. However, CMS is ultimately responsible for administering Medicare and contracts with Medicare administrative contractors to process and pay claims. OIG cannot judge the value or allowability of Part B claims that have yet to be submitted. Consequently, providing an offset to the Part A overpayment with Part B reimbursement figures is not within the scope of these OIG reviews. However, OIG has assured hospitals that we would work with CMS to determine the offset Part A overpayments should CMS determine the Part B offset is a viable option.

AHA’s fourth concern relates to OIG’s review of claims outside of the 4-year claims-reopening period. CMS allows for reopening of claims at any time provided that there is reliable evidence that the initial determination was procured by fraud or similar fault.⁶ While some of our reviews include claims beyond the reopening period, OIG ultimately recognizes CMS as the cognizant Federal agency that has the authority to decide how to resolve these claims.

Your letter also expressed concern with our use of extrapolation in generating overpayment estimates. Each hospital review is unique; the sampling method used in each review may vary because of different risk factors. As we did more hospital compliance audits, we began the use of statistical sampling to draw conclusions about a larger portion of the hospital’s claims. The use of statistical sampling in Medicare is well established and has repeatedly been upheld on administrative appeal within the Department and by Federal courts. These hospital reviews determine whether Medicare claims have been submitted in accordance with laws and regulations and if the services were reasonable and necessary. One purpose of OIG’s oversight is to identify as accurately as possible the amount of overpayments received by a provider, so that those can be returned to the Medicare Trust Fund. Determining the overpayment through sampling and extrapolation, rather than reviewing each claim, is both economical and in the best interest of the provider and the Government. OIG uses a conservative method under which overpayment estimates will almost always be lower than the estimates that would result from reviewing every claim.

Conclusion

Our hospital compliance review work reflects our commitment to applying Medicare requirements correctly and, when appropriate, using a statistically valid methodology to estimate overpayments. We have solicited provider input about this work and incorporated feedback, as

⁵ Medicare Program Integrity Manual, Pub. 100-08, ch. 6, § 6.5.2.

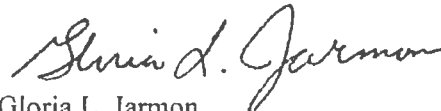
⁶ 42 CFR § 405.980(b).

appropriate. The reviews have served an important role in highlighting vulnerabilities in hospital billing and returning improper payments to the Medicare Trust Fund. Additionally, these reviews are a critical component of educating providers about how to identify and remediate risk areas in billing Medicare. It is our hope that hospitals, including hospital compliance departments, will use the results of our reviews to reduce the number of billing errors in the future and to otherwise strengthen the culture of compliance at their facilities.

OIG is committed to continuing its oversight of Medicare, including hospital payments, to reduce fraud, waste, and abuse. Currently, OIG has a number of reviews in progress that include the review of compliance with short-stay requirements. These reviews assess claims submitted before the implementation of the two-midnight inpatient admission requirements effective October 1, 2013. We are completing our review of these claims for adherence to the rules that governed hospital billing at the time the services were provided. The criteria we are using in these reviews are sound. Notwithstanding, we acknowledge the dynamic landscape surrounding inpatient short stays. As a result, we have voluntarily suspended reviews of inpatient short stay claims after October 1, 2013, consistent with the moratorium placed on the recovery audit contractors. We will continue to evaluate this important issue and adjust our work accordingly.

We appreciate the opportunity to respond to the concerns that you raised in your November 20, 2014 letter, and the informative and helpful discussions we have had with representatives of your organization on these topics. We look forward to continuing productive dialogue regarding these important Medicare oversight issues.

Sincerely,



Gloria L. Jarmon
Deputy Inspector General for Audit Services

cc:
Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

Deborah Taylor
Director and Chief Financial Officer
Office of Financial Management
Centers for Medicare & Medicaid Services



**American Hospital
Association**

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

August 21, 2014

Ms. Sylvia Burwell
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Suite 120F
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

On June 2nd, I sent the attached letter to Secretary Sebelius expressing serious concerns about OIG audits that have used extrapolation to estimate Medicare overpayments, which CMS contractors have then sought to recover from hospitals. We asked that these practices be halted immediately and were hopeful that they had been. Last month, however, the OIG issued another audit report using extrapolation to determine the estimated Medicare overpayment to a hospital system. And, in this new audit as in the prior ones, the OIG misconstrued and misapplied numerous Medicare regulations and policies. For example, the OIG found that a number of the hospitals' inpatient claims were paid in error because the patient's medical record did not contain an admission order signed by a physician. But as we previously pointed out, until October 1, 2013, CMS never required a physician order for a short-term, acute care inpatient admission as a condition of Medicare Part A payment, and the claims that were audited predated 2013. Similarly, the OIG's recent audit report artificially inflated the hospital system's estimated Medicare overpayment substantially by failing to offset Part A overpayments on individual claims by the amount of Part B payment that the hospitals are entitled to receive.

As noted in my initial letter, the OIG's approach grossly exaggerates estimated Medicare overpayments, leads to excessive recoveries by Medicare contractors, and otherwise prejudices and burdens hospitals.



Ms. Sylvia Burwell
August 21, 2014
Page 2 of 2

We would appreciate your prompt attention to this matter and look forward to receiving your response.

Sincerely,

/s/

Rick Pollack
Executive Vice President
American Hospital Association

Attachment

cc: Daniel Levinson
Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue S.W.
Washington, D.C. 20201

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

SEP - 3 2014

Mr. Rick Pollack
Executive Vice President
American Hospital Association
325 Seventh Street, NW, Suite 700
Washington, DC 20004

Dear Mr. Pollack:

Thank you for your letter in which you expressed concerns with the Department of Health and Human Services Office of Inspector General's (OIG) use of extrapolation in its Medicare hospital compliance reviews. You asked that these reviews, and the collection of related overpayments, be halted immediately. I appreciate hearing from you on this issue and understand your concerns about the process.

The Centers for Medicare & Medicaid Services (CMS) and the OIG perform numerous audits to safeguard the Medicare Trust Funds. The OIG works closely with CMS and its contractors to avoid duplication in their audits and ensure that multiple agencies do not review the same claims. The OIG uses statistical sampling and extrapolation in their review processes when a claim-by-claim audit is impossible, cost-prohibitive, or unreasonable. When OIG uses statistical sampling, the process is well documented to ensure the results are statistically valid.

Audits are a critical part of OIG's oversight responsibilities and are conducted in accordance with generally accepted government auditing standards. These standards require that audits obtain sufficient evidence to provide a firm basis for the OIG's findings and conclusions. When the Medicare contractor issues an overpayment determination, the provider/supplier is given the opportunity to appeal if it disagrees with the contractor's determination.

The OIG and CMS are available to discuss specific concerns you have related to these audits. Please feel free to contact Deborah Taylor at CMS on 410-786-2085 or Gloria Jarmon at OIG on 202-619-3155 to schedule a meeting about the American Hospital Association's specific issues. You should also feel free to contact me about this or any other issue of mutual concern. Thank you for your continued interest in the Medicare program.

Sincerely,

A handwritten signature in cursive script that reads "Sylvia M. Burwell".

Sylvia M. Burwell



**American Hospital
Association**

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

June 2, 2014

Ms. Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Suite 120F
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) wishes to express serious concerns about an increasing number of “hospital compliance reviews” performed by the Office of Inspector General (OIG) Office of Audit Services in which the OIG has extrapolated audit findings to estimate Medicare overpayments to the hospitals and the hospitals’ Medicare Administrative Contractors (MACs) have sought to recover the extrapolated overpayment amounts.¹ We respectfully request that these practices be halted without delay for the following reasons.

First, these OIG audits are entirely redundant to the Medicare Recovery Audit Contractor (RAC) reviews that have burdened hospitals for many years now. The OIG reviews have

¹The hospital Medicare Compliance Reviews that prompted this letter include the following: Princeton Baptist Medical Center for Calendar Years 2010 and 2011, No. A-04-12-00084, (Apr. 2014); Duke University Hospital for the Period January 1, 2011 Through September 30, 2013, No. A-04-13-04012 (Apr. 2014); Christus St. Frances Cabrini Hospital for the Period January 1, 2010 Through June 30, 2012, No. A-06-00019 (Feb. 2014); Christus Hospital St. Elizabeth for the Period January 1, 2010 Through June 30, 2012, No. A-06-00020 (Feb. 2014); Christus Santa Rosa Hospital for the Period January 1, 2010 Through June 30, 2012, No. A-06-00068 (Feb. 2014); Medical University of South Carolina for the Period January 1, 2011 Through June 30, 2012, No. A-04-13-03075 (Jan. 2014); St. Vincent’s Medical Center for Calendar Years 2009 and 2010, No. A-04-12-08013 (Dec. 2013); JFK Medical Center for Calendar Years 2009 and 2010, No. A-04-12-07032 (Nov. 2013); University of Miami Hospital, No. A-04-12-07033 (Sept. 2013); and Saint Thomas Hospital for Calendar Years 2009 and 2010, No. A-04-12-03071 (May 2013). We understand that the OIG continues to use extrapolation for other hospitals as well, although those audit reports have not yet been posted on the OIG website.



focused on the same types of claims—such as short inpatient stays—that have been under scrutiny by the Medicare RACs for quite some time.

Second, the OIG's audit findings and estimated overpayments are incorrect; the OIG misconstrued and misapplied numerous Medicare regulations and policies and then exacerbated its erroneous findings by using flawed sampling and extrapolation methods to estimate an overpayment amount.

Third, even the OIG acknowledges that its estimated overpayments significantly overstate the amounts at issue for these hospitals. The OIG is publishing these audits containing inflated overpayments and forwarding them to the Centers for Medicare & Medicaid Services (CMS) for recoupment without crediting hospitals for Part B payments for the care provided during an inpatient stay that the OIG concluded should have been provided on an outpatient basis. This approach wrongfully inflates the extrapolated overpayments, leads to excessive recoveries by the MACs, and otherwise prejudices these hospitals.

Finally, CMS has allowed or may even have instructed its MACs to recoup the OIG's estimated overpayment amounts in violation of the statutory limits on MACs' use of extrapolation and without following any of the Medicare rules or procedures for doing so or affording the hospitals the statutory and regulatory protections to which they are entitled. The Kafkaesque burden of imposing duplicative audits on hospitals and recouping payments from them without correcting the OIG's manifold and glaring errors is abusive and unfair to hospitals and a waste of government resources.

1. The OIG Audits Waste HHS Resources and Are Unduly Burdensome to Hospitals.

Despite being tasked with oversight to prevent waste and abuse in the Medicare program, the OIG itself appears to be wasting its time and resources by conducting audits of hospital claims that are completely redundant to RAC reviews. CMS implemented the permanent, nationwide RAC program in late 2009, and in CMS's view, the program has been a "success" in terms of reducing improper Medicare payments under Medicare Parts A and B.² In particular, RACs have focused their reviews on Part A claims for short inpatient stays where, according to the RACs, the patient should have been treated on an outpatient basis. Despite these ongoing, well-publicized and quite controversial RAC reviews, the OIG inexplicably has decided to review the same types of claims. All ten of the OIG audits listed above focused on short inpatient stays, and specifically whether the patient's medical record adequately documented that the inpatient admission was "reasonable and necessary." In fact, in several cases, the OIG admitted that it had inadvertently audited the very same claims that already had been reviewed by a RAC. Moreover, in all ten audits the OIG felt the need to retain a medical review contractor

²CMS, Implementation of Recovery Auditing at the Centers for Medicare & Medicaid Services, FY 2010 Report to Congress 14, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY2010ReportCongress.pdf>.

to review claims for “medical necessity,” squandering even more resources. More than half of the time, the OIG used the medical review staff of *CMS’s own Medicare review contractors* to perform the same “medical necessity” review that those contractors would have performed in the first place. In the other four audits, the OIG hired an independent contractor to conduct the review. And in at least one case, the OIG used an independent contractor to perform a second, additional medical review after receiving the hospital’s comments to the OIG’s draft report, and the second reviewer found fewer errors than the first.

The fact that different contractors attempting to apply the same standard for inpatient admission reach different results shows that CMS’s guidance in this area is woefully inadequate. CMS has acknowledged as much and undertook rulemaking last year in an attempt to clarify the standard. Given the lack of clear guidance, it is hardly fair for the Department to allow contractor after contractor to go after the same type of claims. The duplicative OIG audits are unnecessary and add to the already excessive burden imposed on hospitals by the RACs. Many of our member hospitals spend tens or hundreds of thousands of dollars managing the RAC review process. Surely the OIG has better use for its resources than re-reviewing the very same claims that are being reviewed by one or more Medicare contractors.

2. The OIG’s Extrapolated Overpayments Are Based on Misinterpretations of Numerous Medicare Rules and Policies.

The OIG’s findings of estimated overpayments based on the sample of claims that it reviewed for each hospital are fundamentally flawed because in all cases, the OIG misinterpreted and/or misapplied Medicare requirements.

a. The OIG Invented a Physician Order Requirement That Did Not Exist.

For example, in several audits the OIG found that one or more of the hospital’s inpatient claims was paid in error because the patient’s medical record did not contain “a valid order signed by a physician” for inpatient admission. But from 1967—almost the beginning of the Medicare program—until October 1, 2013, CMS never required a physician order for a short-term, acute care inpatient admission as a condition of Medicare Part A payment. Indeed, effective October 1, 2013, CMS amended its regulations to add such a requirement for all inpatient admissions.³ In other words, the OIG invented a physician order requirement that

³See 78 Fed. Reg. 50,495, 50,939–43, 50,965 (Aug. 19, 2013) (codified at 42 C.F.R. §§ 412.3, 424.13). In any event, imposing such a physician order requirement as a condition of payment is unlawful because it is contrary to the plain language of the Medicare statute, which requires such an order only for inpatient hospital services “which are furnished *over a period of time.*” Social Security Act (SSA) § 1814(a)(3) (emphasis added). Congress explicitly amended the Medicare statute in 1967 to eliminate the requirement that a physician order appear in the medical record in every case. See Pub. L. No. 90-248, § 126(a), 81 Stat. 821, 846; H.R. Rep. No. 90-544, at 38, 149 (1967); S. Rep. No. 90-744, at 239 (1967).

simply did not exist during the time period relevant to the claims being audited and incorrectly denied claims on that basis.

b. The OIG Has Misconstrued the Statutory Time Limits on the Collection of Overpayments and Regulations Governing Review of Paid Claims.

i. The OIG Misinterpreted Section 1870 of the Social Security Act.

Many of the hospitals that were audited are not liable for the overpayments because they are deemed “without fault” under Section 1870 of the SSA. Section 1870 establishes a presumption that a hospital is “without fault” “in the absence of evidence to the contrary,” when the Secretary’s determination that there was an overpayment is made after the third year following the year in which the Part A payment was originally made.⁴ CMS has explained how its contractors should calculate this time frame in its Medicare Financial Management Manual, which makes clear that “only the year of payment and the year it was found to be an overpayment enter into the determination” for purposes of Section 1870(b).⁵ In other words, for payments made on any date in 2009, the third calendar year thereafter is 2012. The presumption that the provider is without fault attaches to any overpayment discovered after December 31, 2012. To overcome the presumption, there must be actual evidence of “fault” on the part of the provider.

Four of the OIG’s audits involved claims for which the original year of payment was 2009—i.e., more than three years before the OIG published its reports and the MACs sought to recover the amounts identified in those reports in 2013.⁶ In addition, in four of the OIG’s audits published in 2014, the OIG reviewed claims with dates of service in 2010 (as well as in later

⁴The American Taxpayer Relief Act of 2012, Pub. L. No. 112-240 § 638(a), 126 Stat. 2357, extended this time limitation from the third year after the claim was initially paid to the fifth year after payment was made. That change took effect January 2, 2013. *Id.* § 638(b). Absent an express statement from Congress that the provision applies retroactively, the three-year time frame continues to apply to all of the claims audited by the OIG in all but one of the audits identified in this letter. The Duke University Hospital audit reviewed claims for services furnished and paid for in 2013.

⁵Medicare Financial Management Manual Ch. 3 § 80.1.

⁶*See, e.g.*, Medicare Compliance Review of St. Vincent’s Medical Center for Calendar Years 2009 and 2010 app. D at 5; Medicare Compliance Review of JFK Medical Center for Calendar Years 2009 and 2010 app. D at 3. The audits of Saint Thomas Hospital and the University of Miami Hospital also reviewed claims with dates of service in 2009 and 2010, but the OIG’s audit report did not specify the year in which those claims were originally paid. *See* Medicare Compliance Review of Saint Thomas Hospital for Calendar Years 2009 and 2010 app. A; Medicare Compliance Review of University of Miami Hospital app. A. Presumably, many of those claims were paid in 2009.

years), many of which likely were paid in 2010, more than three years before the OIG published its reports.⁷

The OIG provided no evidence to overcome the presumption that the hospitals acted “without fault” in any of these eight audit reports. In two of them, the OIG responded to the hospitals’ objections to the review of claims from 2009 with a conclusory assertion that the hospital was not “without fault” because it should have known Medicare policies or rules contained in the provider manuals or federal regulations.⁸ That would mean, in the OIG’s view, that every time there is an overpayment because a hospital incorrectly applied one of the thousands of Medicare manual provisions, the hospital is at fault and can be subject to audit and recovery of overpayments long after the fact. To accept the OIG’s view would nullify Congress’s recognition of hospitals’ need for finality and its express inclusion in the statute of language deeming providers to be “without fault” for overpayments that are discovered years later.

In addition, in the remaining six audits involving claims that were originally paid more than three years before the OIG published its reports, the OIG did not even acknowledge the Section 1870 presumption or make any assertion that the hospitals were not “without fault.”

ii. The OIG’s Findings Run Afoul of the Medicare Claim Reopening Rules.

In each of its audit reports, the OIG recommended that the hospital refund the full estimated overpayment to the Medicare program. But in at least four of the OIG audit reports, as noted above, the estimated overpayment was based on a sample containing claims for services furnished—and likely paid for—in 2009, *more than four years* before the OIG published its findings and CMS instructed its MACs to recoup those amounts from the hospitals. Too much time has passed for CMS to collect any payment from hospitals based on those claims.

The Medicare regulations prohibit MACs from reopening and revising “initial determinations” more than four years after the date of the initial determination, unless there is “reliable evidence . . . that the initial determination was procured by fraud or similar fault.”⁹ “Reliable evidence” means evidence that is “relevant, credible and material,” and “similar fault”

⁷See Medicare Compliance Review of Christus St. Frances Cabrini Hospital for the Period January 1, 2010 Through June 30, 2012, app. A; Medicare Compliance Review of Christus Hospital St. Elizabeth for the Period January 1, 2010 Through June 30, 2012 app. A; Medicare Compliance Review of Christus Santa Rosa Hospital for the Period January 1, 2010 Through June 30, 2012 app. A; Medicare Compliance Review of Princeton Baptist Medical Center for Calendar Years 2010 and 2011 app. A. Although the four audit reports do not specify the year in which the claims were originally paid, presumably many of them were paid in 2010.

⁸Medicare Compliance Review of St. Vincent’s Medical Center for Calendar Years 2009 and 2010 at 10; Medicare Compliance Review of JFK Medical Center for Calendar Years 2009 and 2010 at 7.

⁹42 C.F.R. § 405.980(b)(3).

means “to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled.”¹⁰

Although the OIG agreed that it was not alleging that these hospitals engaged in fraud, it nevertheless made an unfounded assertion in at least two audits that the hospital’s “improper billings” are sufficient to establish “similar fault.”¹¹ But CMS has explained that “[t]he similar fault provision is appropriately used where fraudulent behavior is suspected but law enforcement is not proceeding with recovery on the basis of fraud.”¹² There is no evidence of any “similar fault” on the part of any of the hospitals subject to these OIG compliance reviews, and the OIG cannot bootstrap its own findings that some claims were improperly paid as a replacement for “credible and material evidence” that the hospital acted with fraud or similar fault. And, as described in more detail below, it is especially disingenuous for the OIG to assert that the hospital acted with “similar fault” when the bulk of the claims that the OIG alleges were improperly billed involve short inpatient stays where CMS itself has acknowledged the standard has been difficult to apply and CMS’s own contractors and the medical review contractors hired by the OIG have reached opposite conclusions when they attempt to apply the standard to the very same claims.

Thus the OIG’s recommendations that hospitals refund estimated overpayments based on reviewed claims that are more than four years old directly contradict the Medicare claim reopening rules. The strict time limits for CMS’s contractors to reopen claims recognize that hospitals need some assurance of finality regarding the Medicare reimbursement that they received years before. Allowing a MAC to reopen any claim, regardless of the amount of time that has passed since the claim was paid, based only on an OIG finding that some claims were paid improperly, nullifies the fraud or “similar fault” limitation and renders those assurances meaningless.

c. The OIG Misapplied Section 1879 of the Social Security Act.

As noted above, a significant proportion of the claims that the OIG alleged were paid in error are claims in which, according to the OIG and its medical review contractor, “the level of care and services provided should have been billed as outpatient or outpatient with observation services.”¹³ In other words, in the OIG’s view, the inpatient admission was not “reasonable and necessary” as required by Section 1862(a)(1)(A) of the SSA, and as a result, the hospital received an overpayment equal to the entire amount of the Part A payment it received for those

¹⁰*Id.* § 405.902.

¹¹*See*, Medicare Compliance Review of JFK Medical Center for Calendar Years 2009 and 2010 at 7; Medicare Compliance Review of St. Vincent’s Medical Center for Calendar Years 2009 and 2010 at 10.

¹²70 Fed. Reg. 11,420, 11,450 (Mar. 8, 2005).

¹³*See, e.g.*, Medicare Compliance Review of St. Vincent’s Medical Center for Calendar Years 2009 and 2010 at 5.

services. But most of the claims that the OIG reviewed should not be treated as overpayments at all.

First, in nearly all of the OIG audits, the hospitals disputed many of the OIG's findings that the inpatient admission was not "reasonable and necessary," relying on the admitting physician's judgment, the information in the medical record, and the analysis performed by the hospital's own case management or utilization review teams, and informed the OIG that the hospital intended to appeal those claims through the Medicare claims appeals process. Although it is too soon to tell, we expect that the hospitals will be successful in overturning the vast majority of the Part A denials. Our member hospitals report that when they appeal the same type of Part A denials by the RACs, the RAC decisions have been overturned on appeal in favor of the admitting physician's judgment *more than two-thirds of the time*.¹⁴

Second, even in cases in which the Medicare claims adjudicator, (i.e., the MAC, the Qualified Independent Contractor (QIC), or an Administrative Law Judge (ALJ)), agrees with the OIG that a particular inpatient admission was not "reasonable and necessary," Section 1879 of the SSA provides that the hospital is nonetheless entitled to receive Part A payment in cases in which the hospital and the Medicare beneficiary "did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A."¹⁵ In such cases, no overpayment exists. In other words, Congress itself recognized that hospitals, physicians and other health care providers treating Medicare beneficiaries would be required to understand and apply many complex, detailed Medicare requirements and make difficult, fact-specific, judgments about whether a particular health care item or service was "reasonable and necessary" for a given beneficiary and that sometimes the hospital or health care practitioner might make a mistake. Congress concluded that in those cases, where the hospital and the Medicare beneficiary could not reasonably have been expected to know that payment would not be made for those items or services, a hospital should not be held liable for those amounts.

With respect to the decision whether to admit a beneficiary as an inpatient, physicians, hospitals, and even CMS's own contractors have experienced tremendous difficulty in applying CMS's longstanding guidance regarding the multiple factors that must be considered. In fact, CMS attempted to clarify the standard for inpatient admissions by adopting its new and troubling "two-midnights" rule for federal fiscal year 2014.¹⁶ Given the lack of clear guidance regarding when a patient should be admitted as an inpatient for purposes of payment under Part A, it would be unreasonable for CMS or its contractors to claim that in these cases, the hospital had reason to know that Part A payment would not be made. Therefore, under Section 1879, many of the claims that the OIG alleged were paid in error should not be treated as overpayments at all.

¹⁴AHA RACTrac Survey, 3rd Quarter 2013, at 55 (Nov. 21, 2013).

¹⁵SSA § 1879(a).

¹⁶78 Fed. Reg. at 50,908, 50,949, 50,965 (codified at 42 C.F.R. § 412.3(e)(1)).

d. The OIG Extrapolated Based on Amounts It Acknowledged Are Incorrect.

Even if a Medicare claims adjudicator agrees that a particular patient should have been treated on an outpatient, rather than inpatient, basis and that the hospital received a Part A overpayment for that patient, the OIG's estimated overpayments in these audits are artificially inflated because in many cases, that Part A overpayment should be offset by the amount of Part B payment that the hospital is entitled to receive on that claim. The Medicare statute requires CMS to pay for the reasonable and necessary services provided under Part B,¹⁷ and thus after a CMS contractor denies Part A payment on the ground that the beneficiary should have been treated as an outpatient, CMS allows a hospital to request payment under Part B for the services "that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient."¹⁸ The OIG itself acknowledged as much in a footnote. But then the OIG simply ignored that limitation and calculated overpayments for the entire Part A payment amount because the MAC has not yet adjudicated the requests for Part B payment. The OIG then extrapolated those overstated amounts to the entire universe of claims. That means the OIG took an overpayment amount that it admitted was *incorrect*—and multiplied it across the entire universe of claims—increasing the impact of the OIG's error. And CMS's contractors have attempted to collect that incorrect amount.

To make matters worse, because the MACs have been confused about how to process hospitals' requests for Part B payment and how to recalculate the estimated overpayment to reflect those Part B payments, the MACs simply have recouped the full, incorrect, extrapolated amount. As a result, at least one hospital has been forced to repay Medicare *twice* for the alleged Part A overpayments: once through the recoupment of the full extrapolated overpayment and then again for the specific Part A claims, which the MAC required as part of the process of requesting Part B payment. Moreover, to correct the overstated extrapolation amounts, hospitals have had to appeal the Part A denials, even in cases in which the hospital otherwise would concede that a particular patient should have been treated on an outpatient basis and request Part B payment for that beneficiary. Pursuing such needless appeals imposes a significant financial burden on the hospitals, and at the same time, means that CMS later may be responsible for increased interest payments when the hospitals eventually prevail in their appeals of these cases.

¹⁷See SSA § 1832(a).

¹⁸78 Fed. Reg. at 50,914, 50,968 (codified at 42 C.F.R. § 414.5). CMS purports to require hospitals to submit these requests for Part B payment within one year of the date of service, 42 C.F.R. § 414.5(c), which would effectively prevent hospitals from being able to request Part B payment in nearly all of these cases. Like the OIG in these ten audits, CMS's review contractors typically do not even begin their reviews until well after the one year time limit has expired. For this and other reasons, CMS's decision to apply the one year time limit in these circumstances is arbitrary and capricious and therefore unlawful under the Administrative Procedures Act.

3. Collecting Overpayments Based on the OIG Audit Findings Violates the Medicare Statute and CMS's Own Rules.

Given the multitude of errors in the OIG's audit findings—including the invention of a non-existent physician order requirement, the misinterpretation of Section 1870 of the SSA, the total disregard of the Medicare claims reopening rules, the misapplication of Section 1879 of the SSA, and the extrapolation of incorrect overpayment amounts—CMS should not permit its MACs to collect the OIG's estimated overpayments from the hospitals.¹⁹ But even if the OIG's audit findings were not so flawed, the MACs cannot recoup based on the OIG's extrapolated overpayments because that would violate the statutory limits on the use of extrapolation and CMS's own rules related to the recovery of alleged overpayments.

The Medicare statute prohibits the MACs from using extrapolation unless the Secretary determines that “there is a sustained or high level of payment error,” or “documented educational intervention has failed to correct the payment error.”²⁰ Neither the Secretary nor the MACs have made the requisite finding in any of these cases. Instead, CMS and its MACs are adopting the OIG's estimated extrapolated overpayment amount as the MAC's own and issuing a demand letter for those estimated amounts. That does not meet the statutory requirement. Even if the OIG is permitted to use extrapolation in audits, in these cases, the MAC effectively is using the OIG as a subcontractor in a manner that impermissibly does an end-run around the congressionally-imposed limits on the MAC's ability to use extrapolation and calls into question the independence of the OIG.

To be sure, a hospital can dispute the OIG's flawed audit findings and the overstated extrapolated overpayments through the normal claim appeals process. But it is especially unfair to impose that burden on hospitals given the two-year moratorium on assigning new claim appeals to administrative law judges adopted last year by the Office of Medicare Hearings and Appeals. As a result, it may take a hospital anywhere from three to five years to overturn the OIG's audit results.

In addition, while some hospitals have concluded that the time and expense associated with appealing the denied claims is not worth it, others have tried to pursue the rebuttal process or sought redeterminations by their MACs and reconsideration by the QIC. But all too often, where hospitals try to invoke their other administrative remedies, they have been similarly stymied. For example, in at least one case, even when the hospital filed a timely request for redetermination of some of the underlying claims, the MAC recouped the full extrapolated amount more than three weeks later. That is directly contrary to the requirements of Section 1893(f)(2) of the SSA, which prohibits the Secretary or “any [M]edicare contractor” from

¹⁹Not only are the OIG's findings for the claims that it actually reviewed incorrect, but also there appear to be significant flaws in the sampling procedures and extrapolation methodology that the OIG used. However, the OIG's published reports do not provide sufficient information for the AHA or its members to identify or respond to those deficiencies in more detail.

²⁰See SSA § 1893(f)(3).

recouping the overpayment until “the date the decision on the reconsideration [by the QIC] has been rendered,”²¹ and the Medicare regulations, which require a Medicare contractor to cease recoupment upon receipt of a valid request for redetermination.²² And where a hospital was able to win a partially favorable redetermination decision, there has been more than a six-month delay in the re-calculation of the reduced extrapolated amount, as the MAC referred the calculation back to the OIG. In the meantime, the MAC has not returned any of the recouped funds to the hospital. These are real-world examples of a process that has run amok, frustrating hospitals at every turn and costing them dearly in lost Medicare reimbursement and unnecessary administrative expenses.

* * *

Thank you for your immediate attention to this matter. I also have sent a copy of this letter to Inspector General Levinson and the AHA looks forward to working with you both to halt these reviews and the resulting demands for our nation’s hospitals to repay improperly extrapolated amounts of Medicare reimbursement. If we can provide further information, please contact Melinda Hatton, senior vice president and general counsel, at (202) 626-2336, or mhatton@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President
American Hospital Association

Cc: Daniel Levinson
Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue S.W.
Washington, D.C. 20201

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

²¹SSA § 1893(f)(2)(A).

²²42 C.F.R. § 405.379(a),(d).

May 15, 2014

Deborah Taylor
Director and Chief Financial Officer
Office of Financial Management
Centers for Medicare & Medicaid Services
7500 Security Blvd, MS C3-01-24
Baltimore, MD 21244

**Re: Medicare Administrative Contractors' Recovery of Extrapolated Overpayments
Estimated by the Office of Inspector General**

Dear Deb:

Thank you for meeting with the American Hospital Association (AHA) last week to discuss our concerns about the increasing number of hospital "Medicare Compliance Reviews" performed by the Office of Inspector General (OIG) Office of Audit Services. In many of those reviews, the OIG extrapolated its audit findings to estimate Medicare overpayments and the hospitals' Medicare Administrative Contractors (MACs) demanded repayment and recovered the extrapolated overpayment amounts.

As we explained during our meeting, we see several substantial legal problems with the MACs simply adopting the OIG's extrapolated overpayment amounts and the findings that underlie them. These include:

- Extrapolating the overpayment amount without determining that there is "a sustained and high level of payment error" or a "documented educational intervention [that] has failed to correct the payment error" as required by Section 1893(f) of the Social Security Act (SSA);
- Collecting an overpayment where there is no evidence of provider "fault" and the overpayment was determined more than three years after the year the claim was paid in violation of Section 1870 of the SSA;
- Reopening claims that were paid more than four years earlier where there was no provider fraud or similar fault in violation of the Medicare claim reopening rules.

MAC demands for repayment that essentially rubber stamp the OIG's audit findings also run afoul of other Medicare rules and, in some cases, have led to hospitals losing the procedural protections that Congress established for them in the Medicare statute.

1. Failure to Meet the Requirements for Extrapolating Overpayments.

Under the Medicare statute, MACs may not use extrapolation “unless the Secretary determines that—(A) there is a sustained and high level of payment error; or (B) documented educational intervention has failed to correct the payment error.” This language precludes the MACs from viewing the OIG's extrapolated overpayment amounts as their own and issuing demand letters for the estimated amounts. Neither the Secretary nor the MACs have made the requisite finding in any of these cases and adopting the OIG's estimated overpayments does not meet the statutory requirement. As a result, the MACs must either (1) limit their recoveries to the individual claims identified as paid in error by the OIG,¹ or (2) make their own, independent determination of a sustained and high level of payment error or documented failed educational intervention.

2. Violation of Section 1870 of the Social Security Act.

As you know, Section 1870 of the SSA establishes a presumption that the provider is “without fault” or is deemed without fault, “in the absence of evidence to the contrary,” when the Secretary's determination that there was an overpayment is made after the third year following the year in which the Part A payment was originally made.² CMS has explained how its contractors should calculate this time frame in its Medicare Financial Management Manual, which makes clear that “only the year of payment and the year it was found to be an overpayment enter into the determination” for purposes of Section 1870(b).³ In other words, for payments made on any date in 2009, the third calendar year thereafter is 2012. The presumption that the provider is without fault attaches to any overpayment discovered after December 31, 2012. To overcome the presumption, there must be actual evidence of “fault” on the part of the provider.

Four of the OIG's audits involved claims for which the original year of payment was 2009—i.e., more than three years before the OIG published its reports and the MACs sought to

¹ This assumes, of course, that the OIG correctly determined that the claims it reviewed contained errors, which is often not the case for the reasons outlined in this letter.

² The American Taxpayer Relief Act of 2012, Pub. L. No. 112-240 § 638(a), 126 Stat. 2357, extended this time limitation from the third year after the claim was initially paid to the fifth year after payment was made. That change took effect January 2, 2013. *Id.* § 638(b). Absent an express statement from Congress that the provision applies retroactively, the three-year time frame continues to apply to all of the claims audited by the OIG in the audits identified in this letter.

³ Medicare Financial Management Manual Ch. 3 § 80.1.

recover the amounts identified in those reports in 2013. According to CMS's own instructions, the MACs should not have demanded repayment unless there was some evidence to overcome the presumption that the hospital was without fault. For example:

- In the audit of St. Vincent's Medical Center, 27 of the 54 claims that the OIG identified as errors were originally paid in 2009.⁴
- In the audit of JFK Medical Center, 34 of the 70 claims that the OIG concluded were paid in error were originally paid in 2009.⁵

In addition, in the audit reports for three Christus hospitals published in February 2014, and the audit report for Princeton Baptist Medical Center published in April 2014, the OIG reviewed claims with dates of service in 2010 (as well as in later years). Again, although the OIG reports did not specify the year in which the reviewed claims were initially paid, many of the claims likely were paid in 2010, more than three years before the OIG published its reports.⁶ If that is the case, the MACs must not be allowed to recover those amounts unless there is actual evidence that the hospitals acted with "fault."

The OIG provided no evidence to overcome the presumption that the hospitals acted "without fault" in any of the above audit reports. In two of them, for St. Vincent's Medical Center and for JFK Medical Center, the OIG responded to the hospitals' objections to the review of claims from 2009 with a conclusory assertion that the hospital was not "without fault" because it should have known Medicare policies or rules contained in the provider manuals or federal regulations.⁷ Yet the OIG did not point to any evidence to support those assertions nor could it.

⁴ Medicare Compliance Review of St. Vincent's Medical Center for Calendar Years 2009 and 2010, No. A-04-12-08013, Appx. D at 5 (Dec. 2013).

⁵ Medicare Compliance Review of JFK Medical Center for Calendar Years 2009 and 2010, No. A-04-12-07032, Appx. D at 3 (Nov. 2013). The audits of Saint Thomas Hospital and the University of Miami Hospital also reviewed claims with dates of service in 2009 and 2010, but the OIG's audit report did not specify the year in which those claims were originally paid. *See* Medicare Compliance Review of Saint Thomas Hospital for Calendar Years 2009 and 2010, No. A-04-12-03071 (May 2013); Medicare Compliance Review of University of Miami Hospital, No. A-04-12-07033 (Sept. 2013). Presumably, some of those claims were paid in 2009, which means that the MACs should not have sought to recover those amounts in 2013.

⁶ *See* Medicare Compliance Review of Christus St. Frances Cabrini Hospital for the Period January 1, 2010 Through June 30, 2012, No. A-06-00019 (Feb. 2014); Medicare Compliance Review of Christus Hospital St. Elizabeth for the Period January 1, 2010 Through June 30, 2012, No. A-06-00020 (Feb. 2014); Medicare Compliance Review of Christus Santa Rosa Hospital for the Period January 1, 2010 Through June 30, 2012, No. A-06-00068 (Feb. 2014); Medicare Compliance Review of Princeton Baptist Medical Center for Calendar Years 2010 and 2011, No. A-04-12-00084, Appx. A (Apr. 2014).

⁷ Medicare Compliance Review of St. Vincent's Medical Center for Calendar Years 2009 and 2010, at 10; Medicare Compliance Review of JFK Medical Center for Calendar Years 2009 and 2010, at 7.

In the remaining six audits involving claims that were originally paid more than three years earlier, the OIG did not even acknowledge the Section 1870 presumption or make any assertion that the hospitals were not “without fault.”

If the MACs were to accept the OIG’s conclusory assertions and (often incorrect) findings that the audited claims were paid in error as “evidence” of fault, that would mean that every time there is an overpayment because a hospital incorrectly applied one of the thousands of Medicare manual provisions, the hospital is at fault and can be subject to audit and recovery of overpayments long after the fact. Taking that view effectively nullifies the presumption that Congress expressly adopted in Section 1870.

3. Violation of the Medicare Claim Reopening Rules.

The Medicare regulations also prohibit MACs from reopening and revising “initial determinations” more than four years after the date of the initial determination, unless there is “reliable evidence . . . that the initial determination was procured by fraud or similar fault.” 42 C.F.R. § 405.980(b)(3).

As noted above, at least eight of the OIG audits included reviews of claims for services that were provided more than four years before the OIG published its reports and the MACs would have had to reopen those claims to recover the alleged overpayments. For example, in the audit of St. Vincent’s Medical Center, more than half of the claims that the OIG concluded were paid in error were originally paid through “initial determinations” issued in 2009. The MAC issued a demand letter for the OIG’s estimated overpayment amount more than four years later, on December 20, 2013. Although the dates of the “initial determinations” in which the hospitals received payment for services furnished in 2009 are not included in the other OIG audit reports published in mid-to-late 2013, it is highly likely that many of the claims that the OIG concluded were paid in error were originally paid more than four years before the date the MACs issued demand letters for the overpayment amounts.⁸

In the same two examples noted above, for St. Vincent’s Medical Center and for JFK Medical Center, the OIG likewise summarily rejected hospitals’ objections to the OIG’s review of claims from 2009 on the basis of the Medicare reopening rules. Although the OIG agreed that it was not alleging that these hospitals engaged in fraud, it nevertheless made an unfounded assertion that the hospital’s “improper billings” are sufficient to establish “similar fault.”⁹ The OIG did not point to any other “reliable evidence” of fraud-like fault. Nor did the OIG point to

⁸ We do not know now whether the MACs have attempted to reopen the claims for the three Christus hospitals or Princeton Baptist Medical Center based on the OIG’s reports published earlier this year.

⁹ Medicare Compliance Review of St. Vincent’s Medical Center for Calendar Years 2009 and 2010, at 10; Medicare Compliance Review of JFK Medical Center for Calendar Years 2009 and 2010, at 7.

any evidence—or even suggest that there was “similar fault”—in any of the other six audits in which it reviewed claims that were more than four years old.¹⁰ Thus the MACs were not permitted to reopen any of those claims.

4. Misapplication of Other Medicare Rules.

The OIG also misapplied or misconstrued other Medicare requirements. For example, in three audits—those of St. Vincent’s Medical Center, Christus St. Elizabeth Hospital and Christus Santa Rosa Hospital—the OIG found that one or more of the hospital’s inpatient claims was paid in error because the patient’s medical record did not contain “a valid order signed by a physician” for inpatient admission. But from 1967—almost the beginning of the Medicare program—until October 1, 2013, CMS never required a physician order for a short-term, acute care inpatient admission as a condition of Medicare Part A payment. CMS amended its regulations to add such a requirement effective October 1, 2013.¹¹

5. Failure to Exclude Claims Reviewed by Recovery Audit Contractors from Claims Sample.

In two cases, the OIG acknowledged that it mistakenly included claims in its sample that had already been reviewed by a Medicare Recovery Audit Contractor (RAC). That illustrates that the OIG audits unnecessarily duplicate the audits performed by the RACs and add to the already excessive burden imposed on hospitals by the RAC audits. The hospitals were required to produce the very same medical records that they already had been required to turn over to the RACs. Not only did the OIG fail to acknowledge the unnecessary burden caused by the duplicative reviews, but also the OIG refused to accept responsibility for correcting its overpayment amount in at least one audit. The OIG responded to an objection by St. Vincent’s Medical Center by stating that it had “taken steps to exclude all claims in its sampling frame from future RAC review” and that the hospital “should tell CMS which claims in our sampling frame were previously adjusted as a result of a RAC review. CMS can then reduce the amount recommended the Hospital refund (\$3,248,566) by the amount already repaid as a result of any RAC review.”¹² We do not know whether these adjustments to the amounts to be recouped were made.

¹⁰ Medicare Compliance Review of Princeton Baptist Medical Center; Medicare Compliance Review of Christus St. Frances Cabrini Hospital; Medicare Compliance Review of Christus Hospital St. Elizabeth; Medicare Compliance Review of Christus Santa Rosa Hospital; Medicare Compliance Review of the University of Miami; Medicare Compliance Review of Saint Thomas Hospital.

¹¹ See 78 Fed. Reg. 50,495, 50,939–43, 50,965 (codified at 42 C.F.R. §§ 412.3, 424.13).

¹² Medicare Compliance Review of St. Vincent’s Medical Center, at 12.

6. Misapplication of Section 1879 of the SSA.

The extrapolated overpayment amount in all ten of the recently published OIG audit reports was based in large part on findings of claims errors that should not be considered overpayments at all under Section 1879 of the SSA. As we discussed, the OIG audits have focused on claims for inpatient stays in which, according to the OIG and its medical review contractor, “the level of care and services provided should have been billed as outpatient or outpatient with observation services.” In other words, in the OIG’s view, the inpatient admission was not “reasonable and necessary.” As a result, the entire amount of the Part A payment the hospital received was an overpayment.¹³

In each of the audits where the OIG concluded services should have been billed as outpatient rather than inpatient, the hospitals disputed the OIG’s conclusion for the majority of the claims. Given the lack of clear guidance regarding when a patient should be admitted as an inpatient for purposes of payment under Part A, it would be unreasonable for CMS or its contractors to claim that in these cases, the hospital had reason to know that Part A payment would not be made. Therefore, under Section 1879, many of the claims that the OIG alleged were paid in error should not be treated as overpayments at all.

7. MAC Process Issues.

We also wanted to provide you with information in response to some of the more technical questions you raised about the MACs’ involvement in these OIG audits. As we explained, several of the OIG’s audit reports, including the recently published report for Princeton Baptist Medical Center, say that the OIG used MAC medical review staff to perform the medical necessity reviews.¹⁴ In addition, we are aware of one instance in which the MAC recouped the full extrapolated overpayment after the hospital submitted a timely and valid request for redetermination. Saint Thomas Hospital filed a timely request for a redetermination on July 3, 2013, less than 30 days after it received the demand letter from the MAC, and yet the MAC recouped the entire estimated overpayment amount in a series of transactions on July 19, July 22 and July 23, 2013. The hospital received a partially favorable redetermination decision on October 21, 2013 and timely requested reconsideration on April 18, 2014. Our understanding is that the money has not been returned to the hospital.

¹³ For example, in auditing three Christus hospitals, the OIG reviewed claims solely for short inpatient stays. *See* Medicare Compliance Review of Christus St. Frances Cabrini Hospital; Medicare Compliance Review of Christus Hospital St. Elizabeth; Medicare Compliance Review of Christus Santa Rosa Hospital. Of the 300 claims that the OIG reviewed across the three hospitals, it concluded that 216 had been paid in error, including 205 cases in which care should have been provided on an outpatient basis. *Id.*

¹⁴ Medicare Compliance Review of Princeton Baptist Medical Center, at ii.

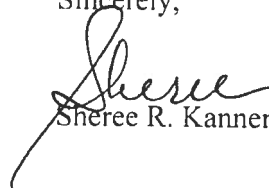
Finally, we note that hospitals are confused by the conflicting instructions and requests that they are receiving from the OIG and their MAC. For example, as discussed above, the OIG audits include claims already audited by the RACs. In addition, we are aware of at least one instance in which the CMS regional office appears to have allowed or instructed the MAC to issue a demand letter for the full estimated overpayment in the OIG's report, even though the hospital followed instructions from the OIG to submit to the CMS regional office a detailed statement objecting to the OIG's findings.

In sum, given the myriad problems with the OIG audits, we believe that the MACs should not issue demand letters at all based upon them. Indeed, the Medicare statute precludes the MACs from demanding repayment based on the OIG's extrapolated amounts. But if CMS takes a different view and instructs the MACs to issue demand letters, the CMS regional office and MACs should thoroughly review the audit findings to confirm that each of them is consistent with the Medicare rules before a demand letter is issued.

* * *

Please do not hesitate to contact us if there is any additional information that we can provide to help resolve these problems in a timely manner.

Sincerely,



Sheree R. Kanner

cc: George Mills
Charlotte Benson