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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.
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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 declaimed 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.

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[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

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[5] *See* 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:

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[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

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[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.

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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 provider further information, please contact me at mhatton@aha.org or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President and General Counsel

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[20] *Medicare Could Save Millions By Strengthening Billing Requirements for Canceled Elective Surgeries*, *supra* note 19, at 8-9.
[21] *Id.* at 16.