DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

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Melinda Reid Hatton
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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:
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