

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HOSPITAL PROVIDER
COMPLIANCE AUDIT:
STATEN ISLAND UNIVERSITY
HOSPITAL**

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Office of Inspector General

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Report in Brief

Date: June 2021

Report No. A-02-18-01025

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



Why OIG Did This Audit

This audit is part of a series of hospital compliance audits. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2017, Medicare paid hospitals \$206 billion, which represents 55 percent of all fee-for-service payments; accordingly, it is important to ensure that hospital payments comply with requirements.

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

How OIG Did This Audit

Our audit covered about \$43.1 million in Medicare payments to the Hospital for 2,718 claims that were potentially at risk for billing errors. We selected for audit a stratified random sample of 90 inpatient and 10 outpatient claims with payments totaling \$2.1 million for our 2-year audit period (calendar years 2016 and 2017).

We focused our audit on the risk areas that we identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted records associated with them to a medical review contractor.

Medicare Hospital Provider Compliance Audit: Staten Island University Hospital

What OIG Found

The Hospital complied with Medicare billing requirements for 63 of the 100 inpatient and outpatient claims we audited. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 37 claims, resulting in overpayments of \$830,291 for the audit period. Specifically, 34 inpatient claims and 3 outpatient claims had billing errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of nearly \$11.8 million for the audit period. As of the publication of this report, this amount included claims outside of the Medicare 4-year claim-reopening period.

What OIG Recommends and Hospital Comments

We recommend that the Hospital refund to the Medicare contractor the portion of the nearly \$11.8 million in estimated overpayments for the audit period for the claims that it incorrectly billed that are within the reopening period; exercise reasonable diligence to identify, report, and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements. The detailed recommendations are listed in the body of the report.

In written comments on our draft report, the Hospital, through its attorney, did not expressly indicate concurrence or nonconcurrence with our recommendations. The Hospital stated that it believes it has rigorous internal controls and a systematized, highly developed team approach to review inpatient rehabilitation facility admissions. Additionally, the Hospital disagreed with all but 2 of the 37 claims for which we determined that the Hospital did not fully comply with Medicare billing requirements.

After review and consideration of the Hospital's comments, we maintain that our findings and recommendations are valid. We obtained an independent medical review contractor to determine the medical necessity for all claims in our sample. Our contractor considered all applicable Medicare requirements and beneficiaries' medical records in making its determinations.

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INTRODUCTION

WHY WE DID THIS AUDIT

This audit is part of a series of hospital compliance audits. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2017, Medicare paid hospitals \$206 billion, which represents 55 percent of all fee-for-service payments; accordingly, it is important to ensure that hospital payments comply with requirements.

OBJECTIVE

Our objective was to determine whether Staten Island University Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims from January 1, 2016, through December 31, 2017.

BACKGROUND

The Medicare Program

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

Hospital Inpatient Prospective Payment System

Under the inpatient prospective payment system (IPPS), CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Inpatient Rehabilitation Facility Prospective Payment System

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for inpatient rehabilitation facilities. CMS implemented the payment system for cost-reporting periods

beginning on or after January 1, 2002. Under the payment system, CMS established a Federal prospective payment rate for each of the distinct case-mix groups (CMGs). The assignment to a CMG is based on the beneficiary's clinical characteristics and expected resource needs.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.¹ The HCPCS includes the American Medical Association's Current Procedural Terminology (CPT) codes for physician services and CMS-developed codes for certain nonphysician services.² All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

Previous Office of Inspector General (OIG) audits at other hospitals identified types of claims at risk for noncompliance. Out of the areas identified as being at risk, we focused our audit on the following:

- IRF claims,
- inpatient claims billed with Comprehensive Error Rate Testing (CERT) high-error rate DRG codes,³
- inpatient claims billed with high-severity-level DRG codes,
- inpatient mechanical ventilation claims,
- outpatient claims paid in excess of \$25,000,
- outpatient claims paid in excess of charges,

¹ The health care industry uses HCPCS codes to standardize coding for medical procedures, services, products, and supplies.

² 45 CFR § 162.1002(c)(1); *The Medicare Claims Processing Manual*, Publication No. 100-04 (the Manual), chapter 4, § 20.1.

³ CMS calculates the Medicare Fee-for-Service improper payment rate through the CERT program. Each year, CERT evaluates a statistically valid stratified random sample of claims to determine whether they were paid properly under Medicare coverage, coding, and billing rules. Based on our analysis of CERT data, we have identified 10 DRGs that are most at risk for billing errors: 149, 312, 313, 518, 519, 520, 742, 743, 947, and 948.

- outpatient bypass modifier claims,
- outpatient surgeries billed with units greater than one,
- outpatient skilled nursing facility (SNF) consolidated billing, and
- outpatient billing for dental services.

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.” We reviewed these risk areas as part of this audit.⁴

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§§ 1815(a) and 1833(e)).

Federal regulations state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

Claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)). The *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23, § 20.3).⁵

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or

⁴ For purposes of selecting claims for medical review, CMS instructs its Medicare contractors to follow the “two-midnight presumption” in order not to focus their medical review efforts on stays spanning two or more midnights after formal inpatient admission in the absence of evidence of systemic gaming, abuse, or delays in the provision of care (Medicare Program Integrity Manual, chapter 6, § 6.5.2). We are not constrained by the two-midnight presumption in selecting claims for medical review.

⁵ “Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS)” 42 CFR § 419.2(a). Moreover, claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)).

(2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.⁶

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.⁷

Staten Island University Hospital

The Hospital is a 668-bed hospital located in Staten Island, New York. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately \$335 million for 18,293 inpatient and 199,569 outpatient claims from January 1, 2016, through December 31, 2017 (audit period).

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$43,095,755 in Medicare payments to the Hospital for 2,718 claims that were potentially at risk for billing errors. We selected for audit a stratified random sample of 100 claims (90 inpatient and 10 outpatient) with payments totaling \$2,108,697. Medicare paid these 100 claims during our audit period.⁸

We focused our audit on the risk areas identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted all claims to an independent medical review contractor to determine whether the claim was supported by the medical record and met Medicare requirements. This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

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

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

⁶ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

⁷ 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, Provider Reimbursement Manual—Part 1, Pub. No. 15-1, § 2931.2; and 81 Fed. Reg. at 7670.

⁸ This audit period reflects the most recent data available at the start of this audit.

FINDINGS

The Hospital complied with Medicare billing requirements for 63 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 37 claims, resulting in overpayments of \$830,291 for the audit period. Specifically, 34 inpatient claims had billing errors, resulting in overpayments of \$830,065 and 3 outpatient claims had billing errors, resulting in overpayments of \$226. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$11,761,274 for the audit period.⁹ As of the publication of this report, this amount included claims outside of the 4-year claim reopening period.

See Appendix B for our statistical sampling methodology, Appendix C for our sample results and estimates, and Appendix D for results of audit by risk area.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 34 of the 90 inpatient claims that we reviewed. These errors resulted in overpayments of \$830,065.

Incorrectly Billed Inpatient Rehabilitation Facility Claims

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

For an IRF claim to be considered reasonable and necessary, Federal regulations require that there be a reasonable expectation that, at the time of admission, the patient (1) requires the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; and (4) requires physician supervision by a rehabilitation physician (42 CFR § 412.622(a)(3)(i-iv)).

Federal regulations require that the patient’s medical record must contain certain documentation to ensure that the IRF coverage requirements are met. The record must include (1) a comprehensive preadmission screening that is completed within the 48 hours preceding the admission; (2) a post-admission physician evaluation that is completed within 24 hours of

⁹ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

admission and documents the patient's status on admission to the IRF, and includes a comparison with the information in the preadmission screening; and (3) an individualized overall plan of care that is completed within 4 days of admission to the IRF (42 CFR § 412.622(a)(4)(i-iii)).

According to Federal regulations, the patient must require an interdisciplinary team approach to care, as evidenced by documentation in the medical record of weekly interdisciplinary team meetings. The meetings must be led by a rehabilitation physician, and further consist of a registered nurse, a social worker or case manager, and a licensed or certified therapist from each therapy discipline involved in treating the patient (42 CFR § 412.622(a)(5)(A)).¹⁰

For 29 of the 90 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation. The Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet medical necessity requirements. IRF services for these beneficiaries were not reasonable and necessary because the beneficiaries (1) did not require the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally did not require and could not reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) were not sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; or (4) did not require supervision by a rehabilitation physician. The Hospital did not provide a cause for these errors because its officials contended that these claims met Medicare requirements.

As a result of these errors, the Hospital received overpayments of \$797,244.

Incorrectly Billed as Inpatient

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1815(a)).

A payment for services furnished to an individual may be made only to providers of services that are eligible and only if, “with respect to inpatient hospital services . . . , which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual’s medical treatment . . .” (the Act, § 1814(a)(3)). Federal regulations require an order for inpatient admission by a physician or other qualified provider at or before the time of the inpatient admission (42 CFR § 412.3(a)-(c)).

¹⁰ 42 CFR § 412.622(a)(5)(A) was redesignated as § 412.622(a)(5)(i) and amended effective October 1, 2018, to provide that the rehabilitation physician may lead the interdisciplinary team meeting remotely (83 Fed. Reg. 38514, 38573 (Aug. 6, 2018)).

In addition, the regulations provide that an inpatient admission, and subsequent payment under Medicare Part A, is generally appropriate if the ordering physician expects the patient to require care for a period of time that crosses two midnights (42 CFR § 412.3(d)(1)).

Furthermore, the regulations provide that the expectation of the physician “should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration” (42 CFR § 412.3(d)(1)(i)).

For 5 of the 90 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status that should have been billed as outpatient or outpatient with observation. Specifically, the medical records did not support the necessity for inpatient hospital services. Hospital officials did not provide a cause for these errors because they generally contended that the claims met Medicare requirements.

As a result of these errors, the Hospital received overpayments of \$32,821.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 3 of the 10 outpatient claims that we reviewed. These errors resulted in overpayments of \$226.

Incorrectly Billed Modifiers

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§§ 1815(a) and 1833(e)). Claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)). Acute care hospitals are required to report HCPCS codes, of which CPT codes are a subset, on outpatient claims (the Manual, chapter 4, § 20.1),¹¹ and providers are required to complete claims accurately so that Medicare contractors may process them correctly and promptly (the Manual, chapter 1, § 80.3.2.2).

“The ‘59’ modifier is used to indicate a distinct procedural service. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)” (the Manual, chapter 23, § 20.9.1.1(B)).¹²

¹¹ “Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS)” (42 CFR § 419.2(a)).

¹² This manual provision was revised after our audit period by Change Request 10868, dated Dec. 28, 2018, and effective Jan. 30, 2019.

Effective January 1, 2015, CMS established four new HCPCS modifiers to define subsets of the “59” modifier. The four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services are: Modifier XE-Separate Encounter, Modifier XS-Separate Structure, Modifier XP-Separate Practitioner, and Modifier XU-Unusual Non-Overlapping Service. CMS will continue to recognize the “59” modifier, but providers should use one of the more descriptive modifiers when it is appropriate (CMS’s Pub. No. 100-20, One-Time Notification, Transmittal 1422, Change Request 8863, dated Aug. 15, 2014).

For 3 of 10 selected outpatient claims, the Hospital incorrectly billed Medicare Part B for a HCPCS code appended with the “XU” modifier that was not separate from other services or procedures billed on the same claim. Hospital officials did not provide a cause for these errors because they generally contended that the claims met Medicare requirements.

As a result of these errors, the Hospital received an overpayment of \$226.

OVERALL ESTIMATE OF OVERPAYMENTS

The combined overpayments on the 37 sampled claims that did not fully comply with Medicare billing requirements totaled \$830,291. On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$11,761,274 for the audit period. As of the publication of this report, this amount included claims outside of the Medicare 4-year claim-reopening period.

RECOMMENDATIONS

We recommend that Staten Island University Hospital:

- refund to the Medicare contractor the portion of the \$11,761,274 in estimated overpayments for the audit period for claims that it incorrectly billed that are within the 4-year reopening period;¹³
- based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule¹⁴ and identify any of those

¹³ OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a Medicare administrative contractor or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

¹⁴ This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

returned overpayments as having been made in accordance with this recommendation;
and

- strengthen controls to ensure that:
 - all IRF beneficiaries meet Medicare criteria for acute inpatient rehabilitation,
 - all inpatient beneficiaries meet Medicare requirements for inpatient hospital services,
 - the use of bypass modifiers is supported in the medical records, and staff are properly trained.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital, through its attorney, did not expressly indicate concurrence or nonconcurrence with our recommendations. The Hospital stated that it believes it has rigorous internal controls and a systematized, highly developed team approach to review IRF admissions. Additionally, the Hospital disagreed with all but 2 of the 37 claims for which we determined that the Hospital did not fully comply with Medicare billing requirements. We summarized the Hospital's objections below. After review and consideration of the Hospital's comments, we maintain that our findings and recommendations are valid.

HOSPITAL COMMENTS

The Hospital contended that our independent medical review contractor misconstrued Medicare requirements for coverage and/or overlooked important facets of care in patients' medical records. Specifically, the Hospital stated that the contractor denied IRF claims when there was substantial documentary evidence to support the reasonable expectation that IRF care was medically necessary. The Hospital also stated that the contractor repeatedly ignored documentation that supported the reasonable judgment of the beneficiary's admitting physician. Further, the Hospital stated that CMS expects deference be given to the judgment of the admitting physician in the CY 2010 IRF PPS Final Rule. Moreover, the contractor denied a number of claims, at least in part, on the grounds that the beneficiary did not receive speech language therapy. According to the Hospital, the Medicare standard for IRF admission does not require that an IRF patient receive speech language therapy. The Hospital also stated that the contractor denied claims because they did not meet the requirement set forth in 42 CFR § 412.622(a)(5) that the patient require an interdisciplinary approach to care. The Hospital stated that, for these cases, it provided documentation of weekly interdisciplinary team conferences led by a rehabilitation physician.

Regarding the five inpatient claims for which we determined that the Hospital did not meet Medicare criteria for inpatient status and should have billed as outpatient or outpatient with

observation,¹⁵ the Hospital stated that its physician reviewers confirmed that, in accordance with the Hospital's internal controls, inpatient admission was medically necessary for four of the claims. The Hospital stated that, for each claim, diagnostic testing could only be performed in an inpatient setting and there was a risk of harm to the beneficiary if they were discharged. According to the Hospital, our independent medical review contractor consistently denied inpatient claims when there was substantial documentary evidence to support the admitting physician's expectation that inpatient admission was medically necessary. The Hospital further alleged that the contractor often ignored patient-specific characteristics and comorbidities that made discharge within two midnights likely to be unsafe for the beneficiary.

Finally, the Hospital stated that it requested that we make our independent medical review contractor available to hear directly from the Hospital but were denied the opportunity. Therefore, the Hospital provided case-by-case explanations for each claim for which it disagreed with our determination.

The Hospital's written comments, which summarized its position on our findings, conclusions, and recommendations are included as Appendix E.¹⁶

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, including the case-by-case explanations, and based on the conclusions of our independent medical review contractor, we maintain that our findings and recommendations are valid. We obtained an independent medical review contractor to determine the medical necessity for all claims in our sample. Our contractor considered all applicable Medicare requirements and beneficiaries' medical records in making their determinations. This included determining whether the Hospital's documentation supported a reasonable expectation, at the time of admission, that the patient met Medicare criteria for an IRF admission.

Contrary to the Hospital's assertion, it is not CMS's policy that in the IRF setting post-payment medical reviewers must give deference to admission decisions of treating physicians. For the FY 2010 IRF PPS Final Rule, CMS had proposed to strengthen the requirement for a comprehensive

¹⁵ In multiple places, the Hospital indicates that OIG denied 6 inpatient beneficiary stays and a total of 35 inpatient claims. However, in our draft report findings, we indicated that we determined that 5 claims for inpatient beneficiary stays did not meet Medicare criteria for inpatient status and that a total of 34 inpatient claims had billing errors. Although we identified a claim for which the associated beneficiary stayed at the hospital for less than two midnights to be unallowable in an Other Matters section, we did not include this claim and estimated dollar amount in our overall estimate of overpayments or in our recommended recovery.

¹⁶ The Hospital attached case-by-case explanations to its comments. We did not include the explanations in Appendix E because they were voluminous and contained personally identifiable information. While the explanations have not been included as part of our final report, we considered them in preparing our final report and will provide the Hospital's comments in their entirety to CMS.

preadmission screening.¹⁷ In responding to a comment on the Proposed Rule that expressed concern that acute care hospital staff are not trained to perform a preadmission screening and that such screening should be performed by the rehabilitation physician in the IRF, CMS stated,

As we are placing more weight on the rehabilitation physician's decision to admit the patient to the IRF, we believe that it is important to require that the rehabilitation physician document the reasoning behind this decision, to enable medical reviewers to understand the rationale for the decision. We realize that this level of detail may exceed what some IRFs may have included in the patient's medical record in the past, but we believe that it will benefit both the IRFs and the Medicare contractors who are reviewing IRF claims to have the rationale for the reasoning behind the admission decision recorded in each patient's medical record.¹⁸

It is clear when the Hospital's abridged quote is put into context that CMS did not say that post-payment medical reviewers must show deference to admission decisions made by IRF treating physicians. Indeed, CMS said that IRF physicians must document their reasoning for admitting an IRF patient so that post-payment medical reviewers could perform medical review of IRF claims.

Contrary to the Hospital's assertion, our medical review contractor did not deny claims on the grounds that the beneficiary did not receive speech language therapy.¹⁹ Regarding the Hospital's comments concerning claims that did not require an interdisciplinary approach to care, we note that we did not disallow any claims for this reason. Rather, we questioned IRF services for beneficiaries that were not reasonable and necessary because the beneficiaries (1) did not require the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally did not require and could not reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) were not sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; or (4) did not require supervision by a rehabilitation physician.

We also maintain that our medical review contractor reviewed all documentary evidence in making its determination that, for five inpatient claims, the medical records did not support the necessity for inpatient hospital services.

¹⁷ 74 Fed. Reg. at 39790-39798.

¹⁸ 74 Fed. Reg. at 39791. CMS also stated, "We agree that the assessment would best be performed by the rehabilitation physician or IRF clinical staff designated by the rehabilitation physician. We believe that the commenter may have misunderstood our proposal in that we do not expect the acute care hospital staff to be performing the preadmission screenings for the IRF." Ibid.

¹⁹ We previously informed the Hospital that the lack of speech language therapy services did not constitute the reason for the denial of a claim. If these services were ordered, the medical review contractor reviewed whether they were medically necessary. If these services were not ordered, the contractor simply noted this.

Finally, our contract with the independent medical reviewer does not allow for direct interaction between them and the Hospital; however, we ensured that the contractor reviewed the medical records submitted by the Hospital to make an informed decision.

OTHER MATTERS: INCORRECTLY BILLED INPATIENT SHORT STAYS

Of the 90 inpatient claims in our sample, the Hospital incorrectly billed Medicare Part A for 1 beneficiary stay of less than 2 midnights (known as “inpatient short stay”), which it should have billed as outpatient or outpatient with observation. Because the medical records did not support the necessity for inpatient hospital services, the services should have been provided at a more appropriate level of care. As a result of these errors, the Hospital received overpayments totaling \$6,458.

We did not review any of the claims in our sample because they were inpatient short stays; instead, we reviewed them because they fell into one of the high-risk categories discussed in the background section of this report. We voluntarily suspended audits of inpatient short stay claims after October 1, 2013, and the suspension was in effect while we were performing this audit.²⁰ Therefore, we are not including the number and estimated dollar amount of this error in our overall estimate of overpayments or in our repayment recommendation.

²⁰ In November 2020, OIG added a new Work Plan item, a plan to audit hospital inpatient claims after the implementation of and revisions to the Two-Midnight Rule to determine whether inpatient claims with short lengths of stay were incorrectly billed as inpatient and should have been billed as outpatient or outpatient with observation (W-00-20-35857). As part of this Work Plan item, OIG announced, “While OIG previously stated that it would not audit short stays after October 1, 2013, this serves as notification that the OIG will begin auditing short stay claims again, and when appropriate, recommend overpayment collections.”

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$43,095,755 in Medicare payments to the Hospital for 2,718 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (90 inpatient and 10 outpatient) with payments totaling \$2,108,697. Medicare paid these 100 claims from January 1, 2016, through December 31, 2017 (audit period).

We focused our audit on the risk areas identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and submitted all claims to an independent medical review contractor to determine whether the claims were supported by the medical records and met Medicare requirements.

We limited our review of the Hospital's internal controls to those applicable to the inpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the NCH data, but we did not assess the completeness of the file.

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

We conducted our audit work from August 2018 through October 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claims data from CMS's NCH database for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 90 inpatient claims and 10 outpatient claims totaling \$2,108,697 for detailed review (Appendix B);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;

- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- used an independent medical review contractor to determine whether all claims complied with selected billing requirements;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample review to calculate the estimated Medicare overpayment to the Hospital (Appendix C); and
- discussed the results of our audit with Hospital officials.

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

According to CMS's NCH database, Medicare paid the Hospital \$335,950,233 for 18,293 inpatient and 199,569 outpatient claims during the audit period.

We obtained a database of claims from the NCH data totaling \$224,263,769 for 12,471 inpatient and 47,708 outpatient claims in 33 risk areas. From these 33 areas, we selected 10 consisting of 22,328 claims totaling \$89,976,313 for further review.

We performed data filtering and analysis of the claims within each of the 10 selected high-risk areas. The specific filtering and analysis steps performed varied depending on the Medicare issue but included such procedures as removing:

- \$0 paid claims,
- claims with certain discharge status and diagnosis codes,
- claims with specific diagnosis and HCPCS codes, and
- claims under review by the Recovery Audit Contractor as of July 16, 2018.

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: IRF Claims, Inpatient Claims Billed With CERT High Error Rate DRG Codes, Inpatient Claims Billed With High-Severity Level DRG Codes, Inpatient Mechanical Ventilation Claims, Outpatient Claims Paid in Excess of \$25,000, Outpatient Claims Paid in Excess of Charges, Outpatient Claims With Bypass Modifiers, Outpatient Surgeries Billed With Units Greater Than One, Outpatient SNF Consolidated Billing Claims, and Outpatient Billing for Dental Services. This resulted in a sample frame of 2,718 Medicare paid claims in 10 high-risk areas totaling \$43,095,755 from which we drew our sample (Table 1 next page).

Table 1: Selected Risk Areas

Medicare Risk Area	Frame Size	Value of Frame
IRF Claims	969	\$27,475,600
Inpatient Claims Billed with CERT high-error DRG codes	758	5,277,078
Inpatient Claims Billed with High-Severity Level DRGs	604	7,219,818
Inpatient Mechanical Ventilation Claims	17	738,947
Outpatient Claims Paid in Excess of \$25,000	61	2,091,644
Outpatient Claims Paid in Excess of Charges	5	25,813
Outpatient Claims with Bypass Modifiers	221	215,723
Outpatient Surgeries Billed with Units Greater than One	5	14,740
Outpatient SNF Consolidated Billing Claims	45	14,796
Outpatient Billing for Dental Services	33	21,596
Total	2,718	\$43,095,755

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We stratified the sampling frame into four strata on the basis of claim type and claim paid amount. Strata 1, 2 and 3 include risk areas 1 through 4 from Table 1 separated by paid amount;²¹ and stratum 4 includes all outpatient claims from risk areas 5 through 10 from Table 1. All claims were unduplicated, appearing in only one area and only once in the entire sampling frame.

We selected 100 claims for review as shown in Table 2 (next page).

²¹ Stratum 1 includes claims from all inpatient risk areas (risk areas 1 through 4 from table 1) with total payments less than \$13,444 (lower dollar claims); stratum 2 includes claims from all inpatient risk areas (risk areas 1 through 4 from table 1) with total payments greater than or equal to \$13,444 and less than \$31,670 (moderate dollar claims); stratum 3 includes claims from all inpatient risk areas (risk areas 1 through 4 from table 1) with total payments greater than or equal to \$31,670 (higher dollar claims).

Table 2: Claims by Stratum

Stratum	Claims Type	Frame Size (Claims)	Value of Frame	Sample Size
1	Inpatient Risk Areas Claims, Low Dollar Claims	1,166	\$8,550,570	20
2	Inpatient Risk Areas Claims, Moderate Dollar Claims	931	22,045,271	50
3	Inpatient Risk Areas Claims, High Dollar Claims	251	10,115,602	20
4	All Outpatient Risk Area Claims	370	2,384,312	10
	Total	2,718	\$43,095,755	100

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OIG/OAS) statistical software Random Number Generator.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims within strata 1 through 4. After generating the random numbers, we selected the corresponding claims in each stratum.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount overpaid to the provider for the claims listed in our sampling frame. To be conservative, we used the lower limit of the two-sided 90-percent confidence interval to estimate the amount of improper Medicare payments in our sampling frame during the audit period. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	1,166	\$8,550,570	20	\$ 147,467	5	\$32,821
2	931	22,045,271	50	1,163,316	22	529,824
3	251	10,115,602	20	757,190	7	267,420
4	370	2,384,312	10	40,725	3	226
Total	2,718	\$43,095,755	100	\$2,108,697²²	37	\$ 830,291

Table 4: Estimates of Overpayments for the Sampling Frame
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	\$15,143,279
Lower Limit	11,761,274
Upper Limit	18,525,285

²² Individual stratum values do not add up to the total amount due to rounding.

APPENDIX D: RESULTS OF AUDIT BY RISK AREA

Table 5: Sample Results by Risk Area

Risk Area	Selected Claims	Value of Selected Claims	Claims With Overpayments	Value of Overpayments
Inpatient Claims Billed With CERT high error rate DRG codes	16	\$156,143	3	\$15,479
IRF Claims	58	1,689,331	29	797,244
Inpatient Claims Billed With High-Severity Level DRG Codes	16	222,498	2	17,342
Inpatient Totals	90	\$2,067,972	34	\$830,065
Outpatient Claims with Bypass Modifiers	9	\$11,087	3	\$ 226
Outpatient Claims Paid in Excess of \$25,000	1	29,638	-	-
Outpatient Totals	10	\$40,725	3	\$ 226
Inpatient and Outpatient Totals	100	\$2,108,697	37	\$830,291

Notice: The table above illustrates the results of our audit by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX E: HOSPITAL COMMENTS



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April 29, 2021

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BY FEDEX AND E-MAIL (AKRAM.AL RUBAYAI@OIG.HHS.GOV)

Mr. Akram Alrubayai
Assistant Regional Inspector General
Office of Audit Services, Region II
Jacob K. Javitz Building
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New York, NY 10278

Re: **Staten Island University Hospital
Medicare Compliance Audit – Inpatient Rehabilitation Facility Claims
Report: A-02-18-01025**

Dear Akram:

I write on behalf of Staten Island University Hospital (SIUH). Thank you again for your continued willingness to engage in conversations with SIUH regarding the above-referenced audit, in which an OIG auditor determined that 35 of the 90 inpatient claims reviewed were did not fully comply with Medicare billing requirements.¹

As we have previously discussed, SIUH takes great pride in the care that it provides to its patients, as well as in its attention to compliance with all health care laws and regulations, including Medicare's regulatory and sub-regulatory coverage rules. As a result, following denial of 29 inpatient rehabilitation facility ("IRF") claims and six acute care hospital inpatient claims by OIG's claims reviewer, SIUH undertook a detailed and time-intensive review of all 35 denied claims.²

*

¹ The OIG draft Report No. A-02-18-01025, dated January 29, 2021 cites 34 instances of billing errors for inpatient claims. This number excludes inpatient case no. S1-09, which was denied by the OIG auditor as billed in error, but was excluded from OIG's overall estimate of overpayments. We dispute the OIG auditor's findings with respect to case no. S1-09 and, as a result, have included it in this letter.

² SIUH participated in an exit conference with OIG on December 21, 2020. SIUH requested that the claims reviewer be present at the exit conference, so as to allow for SIUH's clinicians to discuss the claims and supporting medical records at issue with the claims reviewer. SIUH believed that such a conversation would lead the claims reviewer to reconsider his/her determinations regarding the claims at issue. OIG declined SIUH's request to have the claims reviewer present, and noted that SIUH would be offered an opportunity to appeal the claims reviewer's findings, at which point SIUH could endeavor to correct any misunderstanding of law or fact that led to denial of the audited claims. OIG has also declined to provide SIUH with *any* information regarding the claims reviewer's medical background.

‡ Based on this review, SIUH has concluded that all 29 IRF claims and four of six inpatient claims at issue were properly billed and disputes the OIG auditor’s denial of 33 claims.

Notably, with the exception of one IRF claim, the OIG auditor did not find any claims to be unsupported due to documentation deficiencies.³ This means that, in all but one of the 35 denied cases, the clinical reviewer disagreed clinically with the admitting physician’s conclusions as to whether IRF or inpatient admission, respectively, was reasonable and necessary for the patient. In light of the strength of the documentation supporting the medical necessity of each of the denied claims and the reasonableness of the admitting physician’s expectation of each patient’s need for IRF or inpatient admission, together with the agency’s clear direction to defer to the admitting physician’s reasonable expectation, we submit that the OIG’s draft findings rest on a misconstruction of Medicare’s requirements for coverage and/or the oversight of an important facet of care in the patient’s full medical record.

As you know, we requested and were denied the opportunity to hear directly from the OIG auditor and to respond to his/her findings. We have, therefore, drafted case-by-case explanations (attached hereto) of why the patient’s medical record supports the medical necessity of care under 42 C.F.R. § 412.622 and 42 C.F.R. § 412.3, respectively. Additionally, we would like to take this opportunity to address errors of law and fact that were commonly made by the claims reviewer during the course of his/her review of the claims.

I. Analysis of Denied IRF Claims

SIUH uses a systematized, highly-developed team approach to consider and review IRF admissions. SIUH’s physician reviewers confirmed that, in accordance with SIUH’s rigorous internal controls related to IRF and inpatient admission (copies of which were provided to OIG), in each case, the patient’s combined medical complexity and medical fragility—the patient’s comorbidities combined with the patient’s need for expert and intensive rehabilitation therapy—made the patient an appropriate candidate for the services uniquely available in an IRF. In many cases, the patient had recently experienced post-surgical complications or worsening of comorbidities that required ongoing monitoring and treatment. In all cases, the IRF’s determination that IRF care was medically necessary for the patient was well documented in the patient’s medical record, including in the patient’s pre-admission screening and plan of care.

A. Application of 42 C.F.R. § 412.622(a)(3)

With the exception of one claim for which supporting documentation has now been provided, the claims reviewer did not dispute that, in each case, the medical record contained all relevant and supporting documentation required under 42 C.F.R. § 412.622(a)(4). Rather, in each case, the

‡‡

³ SIUH inadvertently excluded a plan of care from its initial submission for case no. S3-05. That plan of care has since been provided to OIG.

claims reviewer concluded that IRF was not reasonable and necessary because the patient did not meet one or more of the IRF coverage criteria set forth at 42 C.F.R. § 412.622(a)(3). 42 C.F.R. § 412.622(a)(3) states, in relevant part:

In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation that the patient meets all of the following requirements at the time of the patient's admission to the IRF—

(i) . . . requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

(ii) . . . generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week. . .

(iii) . . . is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program that is described in paragraph (a)(3)(ii) of this section.

(iv) . . . requires physician supervision by a rehabilitation physician. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process . . .

42 C.F.R. § 412.622(a)(3) asks whether, at the time of admission, the IRF had the reasonable expectation that the patient met the criteria set forth at subsections (i) through (iv). The standard is not whether a *post-hoc* review reveals that care could have been provided in an alternative setting, nor whether the patient suffered from specific comorbidities or complications prior to or during their ICF stay. Rather, the standard for coverage of IRF services under 42 C.F.R. § 412.622(a)(3) is whether documentation supports the reasonableness of the IRF's expectation, at the time of admission, that, the patient: (i) required the active and ongoing intervention of multiple therapy disciplines, (ii) generally required and could reasonably be expected to participate in an intensive program or rehabilitation therapy, (iii) was sufficiently stable to participate in rehabilitation therapy, and (iv) required oversight of care by a rehabilitation physician, such as a physiatrist.

CMS has explained that, in creating a standard that turns on the reasonable expectation of the IRF, it recognizes “the importance of the professional judgment of a rehabilitation physician in the review of the preadmission screen at the time an admission decision is made.”⁴ CMS expects deference to be given to the judgment of the admitting physician, who is in the best position to assess the patient’s medical needs.⁵ The medical necessity of IRF services is, therefore, evaluated in terms of whether the preadmission screening and other documentation contained in the patient’s medical record supports the reasonableness of the IRF’s determination, at the time of admission, that IRF care was reasonable and necessary for the patient.⁶ Such a determination requires a highly individualized and context-dependent assessment of each patient’s specific needs and circumstances.⁷

Despite CMS’s well-defined expectations with respect to the medical necessity of IRF services, the claims reviewer consistently denied IRF claims when there was substantial documentary evidence to support the reasonableness of the IRF’s expectation that IRF care was medically necessary. In a number of cases, the claims reviewer denied a claim because, although the standards of 42 C.F.R. § 412.622(a)(3) had been met, the claims reviewer determined that it was possible for therapy to be provided in another setting. The claims reviewer also repeatedly ignored documentation that supported the reasonable judgment of the patient’s admitting physician, and instead substituted his/her own judgment as to whether the patient could have received less-than-intensive rehabilitation therapy or gone without supervision of care by a physiatrist. In doing so, the claims reviewer failed to give deference to the reasonable expectation of the IRF, as required by applicable regulation and guidance.

In a number of cases, moreover, the claims reviewer denied the claim, at least in part, on the grounds that the patient did not receive speech language therapy. The Medicare standard for IRF admission does not require that an IRF patient receive speech language pathology. The pertinent Medicare regulation, 42 C.F.R. § 412.622(a)(3)(i), requires that, at the time of a patient’s admission to an IRF, there must be a reasonable expectation that the patient “requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or

⁴ 74 Fed. Reg. 21051, 21070 (May 6, 2009).

⁵ 74 Fed. Reg. 39762, 39791 (Aug. 7, 2009) (“We believe that, in today’s clinical environment, licensed physicians with training and experience in rehabilitation are able to assess a patient prior to admission to an IRF and determine whether there is a reasonable expectation that the patient can participate in and benefit from treatment in an IRF.”).

⁶ 74 Fed. Reg. 21051, 21068 (May 6, 2009) (“We believe that a comprehensive preadmission screening process is the key factor in initially identifying appropriate candidates for IRF care.”); 74 Fed. Reg. 39762, 39791 (Aug. 7, 2009) (“As we are placing more weight on the rehabilitation physician’s decision to admit the patient to the IRF, we believe that it is important to require that the rehabilitation physician document the reasoning behind this decision, to enable medical reviewers to understand the rationale for the decision.”).

⁷ 74 Fed. Reg. 39762, 39796 (Aug. 7, 2009) (“our proposal refers only to our belief that a rehabilitation physician is that professional who is uniquely qualified to assess all aspects of the patient’s medical condition (with input from others as needed) and apply this knowledge to modify or advance the program of therapies that the patient is receiving in the IRF to provide for a desirable functional outcome.”).

occupational therapy (emphasis added).” 42 C.F.R. § 412.622(a)(3)(i) does not require that a patient receive speech language pathology services.

B. Factual Support for the Medical Necessity of IRF Care

SIUH’s detailed review of the claims at issue also revealed that the OIG auditor often misread and/or overlooked documentation in the patient’s medical record. Examples of common factual errors made by the claims reviewer include:

- ***Overlooking documented comorbidities and complications:*** The claims reviewer repeatedly stated that patients had no comorbidities or complications where complications and comorbidities were well documented in the patient’s medical record. On the basis of such misreading of the patient’s medical record, the claims reviewer often concluded that the patient did not require intensive therapy or did not require oversight of care by a physiatrist;
- ***Failing to consider the totality of the patient’s medical record:*** Where patients suffered from comorbidities that made sub-acute care inappropriate, the claims reviewer often ignored ample documentation of serious (and even life-threatening) comorbidities to conclude, on the basis of one diagnosis or functional limitation, taken in isolation, that the patient could have received care in a less intensive setting. In such cases, the OIG auditor failed to account for the patient’s level of medical fragility or complexity, which required the type of careful and specialized monitoring and care that is best provided in an IRF; and
- ***Ignoring the complexity of the patient’s rehabilitation needs:*** The OIG auditor denied claims on the basis that the patient purportedly was able to ambulate short distances or perform activities of daily living with minimal assistance. In such cases, the OIG auditor concluded that the patient did not require an intensive program of rehabilitation, without considering the complexity of the patient’s therapeutic needs. Specifically, the OIG auditor often overlooked the type of mixed cognitive-physical symptomatology that would require that intensive therapy be delivered by IRF clinicians, who have the specialized expertise necessary to address combined physical and cognitive functional deficits.

Additionally, in nearly all of the 29 denied claims, the OIG auditor found that the claim failed to meet the requirement of 42 C.F.R. § 412.622(a)(5) that an IRF patient “require an interdisciplinary approach to care, as evidenced by documentation in the patient’s medical record of weekly interdisciplinary meetings. . .” In each such case, the auditor’s finding was contradicted by record evidence. In all cases, medical records contained documentation of weekly interdisciplinary team conferences that were led by a rehabilitation physician with the appropriate staff present.

Finally, in a number of cases, the auditor asserted, without explanation, that the patient did not receive supervision of care by a rehabilitation physician. In all cases, however, the patient’s medical record contained documentation of at least five direct patient visits per week with a physiatrist, thus undermining the auditor’s claim.

II. Analysis of Denied Inpatient Claims

Following a rigorous review of all six denied inpatient claims, SIUH's physician reviewers confirmed that, in accordance with SIUH's internal controls, inpatient admission was medically necessary in four of the six denied cases. Specifically, in each case, documentation of the patient's need for diagnostic testing that could only be performed in an inpatient setting, combined with the patient's risk of harm if discharged, provided substantial support for the reasonableness of the admitting physician's expectation that the patient would require inpatient care that crossed two midnights.

A. Application of 2 C.F.R. § 412.3(d)(1)

Medicare regulations set forth what is commonly referred to as the "two-midnight" rule for Medicare coverage of inpatient admission. The regulation provides, in relevant part:

. . . an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights. . . The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

2 C.F.R. § 412.3(d)(1). CMS has further explained:

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

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

- *The availability of diagnostic procedures at the time when and at the location where the patient presents.*⁸

Recognizing that the admitting physician is in the best position to judge the patient's needs, CMS has articulated a highly-contextual standard for inpatient admission that turns on the reasonable expectation of the admitting physician. Such a standard requires an individualized assessment of each patient's unique needs and circumstances, and is, therefore, not well-suited to rigid rules-of-thumb that demand specific diagnosis or test results in order for inpatient admission to be considered medically necessary. This standard does not, moreover, demand that the patient actually remain in the hospital past two midnights. Rather, the relevant question is whether documentation contained in the patient's medical record supports the reasonable expectation of the admitting physician, at the time of admission, that the patient was likely to require inpatient care past two midnights.

B. Errors of Law and Fact made by the OIG Auditor.

Despite the clarity with which CMS has articulated the two-midnight rule, the OIG auditor consistently denied inpatient claims when there was substantial documentary evidence to support the admitting physician's expectation that inpatient admission was medically necessary. In denying these claims, the auditor ignored documentation of each patient's symptoms, comorbidities, medical needs, and/or individual circumstances that supported the reasonable expectation of the admitting physician that the patient would require an inpatient stay that spanned at least two midnights. In particular, the auditor often ignored patient-specific characteristics and comorbidities that made discharge within two midnights likely to be unsafe for the patient. In circumstances in which the patient's diagnosis was uncertain and symptoms or risks were acute, the auditor ignored documentation of the need for diagnostic testing that would likely span at least two midnights. With respect to all six cases, the OIG auditor substituted his/her judgement—without considering the patient's condition as a whole, and sometimes on the basis of as little as a single diagnostic laboratory test, in isolation—for that of the patient's admitting physician. In doing so, the auditor both misread the patient's medical record and misapplied CMS's requirements for coverage of inpatient care.

III. Conclusion

SIUH goes to great lengths to ensure that it claims reimbursement only for care that is medically necessary and allowed by law and governing regulations. It makes considered, evidenced-based clinical decisions based on a comprehensive pre-admission screening. SIUH has thoroughly reviewed the cases denied by the OIG in its preliminary review. All of the cases support the admitting physician's reasonable determination at the time of admission that the patients at issue

⁸ Centers for Medicare and Medicaid Services, Pub. No. 100-01, Medicare Benefit Policy Manual, Ch. 1, § 10 (Rev. Mar. 10, 2017), available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf>.

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required IRF or inpatient care, respectively. In all of the challenged cases, the OIG's preliminary findings fail to identify any evidence to show otherwise.

Thank you for your attention to this matter.

Sincerely,

/s/ Deborah Kantar Gardner

Attachments