American Hospital Association

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August 21, 2014

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

Dear Secretary Burwell:

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

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

AMERICAN HOSPITAL ASSOCIATION
NISI DOMINUS FRUSTRA
FOUNDED 1898

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

Sincerely,

/s/

Rick Pollack
Executive Vice President
American Hospital Association

Attachment

cc: Daniel Levinson
Inspector General
U.S. Department of Health and Human Services
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Marilyn B. Tavenner
Administrator
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June 2, 2014

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

Dear Secretary Sebelius:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Four of the OIG's audits involved claims for which the original year of payment was 2009—i.e., more than three years before the OIG published its reports and the MACs sought to recover the amounts identified in those reports in 2013.[6] In addition, in four of the OIG's audits published in 2014, the OIG reviewed claims with dates of service in 2010 (as well as in later

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

[5]Medicare Financial Management Manual Ch. 3 § 80.1.

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

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

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

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

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

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

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

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[7]*See* Medicare Compliance Review of Christus St. Frances Cabrini Hospital for the Period January 1, 2010 Through June 30, 2012, app. A; Medicare Compliance Review of Christus Hospital St. Elizabeth for the Period January 1, 2010 Through June 30, 2012 app. A; Medicare Compliance Review of Christus Santa Rosa Hospital for the Period January 1, 2010 Through June 30, 2012 app. A; Medicare Compliance Review of Princeton Baptist Medical Center for Calendar Years 2010 and 2011 app. A. Although the four audit reports do not specify the year in which the claims were originally paid, presumably many of them were paid in 2010.
[8]Medicare Compliance Review of St. Vincent's Medical Center for Calendar Years 2009 and 2010 at 10; Medicare Compliance Review of JFK Medical Center for Calendar Years 2009 and 2010 at 7.
[9]42 C.F.R. § 405.980(b)(3).

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

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

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

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

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

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[10] *Id.* § 405.902.
[11] *See,* Medicare Compliance Review of JFK Medical Center for Calendar Years 2009 and 2010 at 7; Medicare Compliance Review of St. Vincent's Medical Center for Calendar Years 2009 and 2010 at 10.
[12] 70 Fed. Reg. 11,420, 11,450 (Mar. 8, 2005).
[13] *See, e.g.*, Medicare Compliance Review of St. Vincent's Medical Center for Calendar Years 2009 and 2010 at 5.

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

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

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

With respect to the decision whether to admit a beneficiary as an inpatient, physicians, hospitals, and even CMS's own contractors have experienced tremendous difficulty in applying CMS's longstanding guidance regarding the multiple factors that must be considered. In fact, CMS attempted to clarify the standard for inpatient admissions by adopting its new and troubling "two-midnights" rule for federal fiscal year 2014.[16] Given the lack of clear guidance regarding when a patient should be admitted as an inpatient for purposes of payment under Part A, it would be unreasonable for CMS or its contractors to claim that in these cases, the hospital had reason to know that Part A payment would not be made. Therefore, under Section 1879, many of the claims that the OIG alleged were paid in error should not be treated as overpayments at all.

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[14]AHA RACTrac Survey, 3rd Quarter 2013, at 55 (Nov. 21, 2013).
[15]SSA § 1879(a).
[16]78 Fed. Reg. at 50,908, 50,949, 50,965 (codified at 42 C.F.R. § 412.3(e)(1)).

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

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

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

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[17] *See* SSA § 1832(a).

[18] 78 Fed. Reg. at 50,914, 50,968 (codified at 42 C.F.R. § 414.5). CMS purports to require hospitals to submit these requests for Part B payment within one year of the date of service, 42 C.F.R. § 414.5(c), which would effectively prevent hospitals from being able to request Part B payment in nearly all of these cases. Like the OIG in these ten audits, CMS's review contractors typically do not even begin their reviews until well after the one year time limit has expired. For this and other reasons, CMS's decision to apply the one year time limit in these circumstances is arbitrary and capricious and therefore unlawful under the Administrative Procedures Act.

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

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

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

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

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

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

[20]*See* SSA § 1893(f)(3).

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

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

Sincerely,

/s/

Rick Pollack
Executive Vice President
American Hospital Association

Cc: Daniel Levinson
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[21] SSA § 1893(f)(2)(A).
[22] 42 C.F.R. § 405.379(a),(d).