Department of Health and Human Services
Office of Inspector General
Office of Audit Services

September 2026 | A-09-23-03001

Methodist Hospital Received at Least $12.4 Million in Medicare Overpayments

REPORT HIGHLIGHTS

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Why OIG Did This Audit

- For calendar year 2021, Medicare paid hospitals $182 billion, which represents 46 percent of all fee-for-service payments; accordingly, it is important that hospital payments comply with requirements.
- This audit is part of a series of audits examining hospitals with a high volume of claims previously identified as high-risk for noncompliance.
- Methodist Hospital (the Hospital) was selected because it submitted a substantial number of potentially high-risk claims to Medicare.

What OIG Found

- Of the 100 inpatient and outpatient claims we reviewed totaling $1,426,020, the Hospital complied with Medicare billing requirements for 73 claims. However, it did not fully comply with Medicare billing requirements for the remaining 27 claims, resulting in net overpayments of $256,926 from January 1, 2020, through December 31, 2021 (audit period).
- We estimated that, of the $62 million Medicare paid the Hospital, the Hospital received a net overpayment of at least $12.4 million for selected types of inpatient and outpatient services that did not comply with Medicare requirements during the audit period.
- These errors occurred primarily because the Hospital did not always follow its written policies and procedures to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

What OIG Recommends

We recommend that the Hospital refund to the Federal government the $12.4 million in estimated net overpayments, consider conducting internal audits for claims after our audit period based on the risks identified by this audit, and provide additional training regarding Medicare billing requirements. Our complete recommendations are found in the audit report.

The Hospital did not concur with our first and second recommendations and stated that it is willing to conduct education to address our third recommendation.

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INTRODUCTION

WHY WE DID THIS AUDIT

For calendar year (CY) 2021, Medicare paid hospitals $182 billion, which represented 46 percent of all fee-for-service payments. This audit is part of a series of hospital compliance audits. Previous Office of Inspector General (OIG) audits at other hospitals identified certain types of inpatient and outpatient hospital claims as being at risk for noncompliance.[1] Using computer matching, data mining, and other data analysis techniques, we identified hospitals with a disproportionate number of these claims. We selected Methodist Hospital (the Hospital) for this audit because it was one of those hospitals that had a substantial number of claims submitted to Medicare in areas OIG designated as high-risk.[2]

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims from January 1, 2020, through December 31, 2021 (audit period).[3]

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for enrollees 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 Administrative Contractors (MACs) to, among other things, process and pay claims submitted by hospitals.

[1] Hospital compliance audit reports issued by OIG are published on the OIG website.

[2] Submitting claims at risk for noncompliance does not by itself mean the claims were noncompliant. Determinations of noncompliance are completed by independent medical review.

[3] This was the most recent data available at the time we started this audit.

Hospital Inpatient Prospective Payment System

Under the inpatient prospective payment system (PPS), CMS pays hospital costs at predetermined rates for enrollee discharges.[4] The rates vary according to the diagnosis-related group (DRG) to which an enrollee's stay is assigned and the severity level of the enrollee'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 enrollee'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 enrollees who require a hospital level of care, including an 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 PPS for IRFs. Under the payment system, CMS established Federal prospective payment rates for distinct case-mix groups (CMGs). The assignment to a CMG is based on the enrollee's clinical characteristics and expected resource needs.

Hospital Outpatient Prospective Payment System

Under the hospital outpatient PPS, Medicare pays for hospital outpatient services on a 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.[5] All services and items within an APC group are comparable clinically and require similar resources. The HCPCS includes the American Medical

[4] The inpatient PPS pays the costs of inpatient stays at acute care hospitals, also known as "subsection (d) hospitals" because they are defined at section 1886(d)(1)(B) of the Social Security Act (the Act). Inpatient Rehabilitation Facilities (IRFs) are excluded from this definition and are not paid under the inpatient PPS. We discuss and treat IRF claims separately.

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

Association's (AMA's) Current Procedural Terminology (CPT®)[6, 7] codes for physician services and CMS-developed codes for certain nonphysician services.[8]

Hospital Claims at Risk for Incorrect Billing

We reviewed the following OIG-designated high-risk areas as part of this audit:

- IRF claims
- Inpatient claims with the following:
    - Comprehensive error rate testing (CERT) error prone DRG codes[9]
    - High-severity level DRG codes
    - Mechanical ventilation
    - DRGs for severe malnutrition
    - Same-day discharge and readmission
    - Resumption of home health services[10]

[6] *CPT copyright 2020 American Medical Association. All rights reserved.*

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[8] 45 CFR § 162.1002(c)(1); *The Medicare Claims Processing Manual*, Publication No. 100-04 (the *Manual*), chapter 4, § 20.1.

[9] 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. As a result of our analysis of CERT data, we identified 27 DRGs that are most at risk for billing errors: 069, 073, 074, 149, 313, 461, 462, 469, 470, 472, 473, 515, 516, 517, 518, 519, 520, 553, 554, 555, 556, 562, 563, 604, 605, 742, and 743.

[10] Resuming home health services means that an enrollee who previously received those services is starting to receive them again after a period of hospitalization.

- Outpatient claims that:
    - Include bypass modifiers[11]
    - Are paid in excess of charges
    - Contain surgery units greater than one
    - Are subject to Skilled nursing facility (SNF) consolidated billing

For the purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas."

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 to 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* (the *Manual*), (chapter 1, § 80.3.2.2) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly.

Limitation on Recovery of Overpayments

MACs may reopen a claim for good cause within 4 years from the date of the initial determination or redetermination.[12] Novitas Solutions, Inc., the Hospital's MAC, reopened all claims in our audit sampling frame within 4 years from the date of the initial determination of each of those claims.

[11] A bypass modifier refers to a two-character code appended to a medical procedure code (CPT or HCPCS) on a claim submitted for reimbursement by Medicare. The modifier serves to override edits that otherwise prevent payment for two or more services billed together.

[12] 42 CFR § 405.980(b)(2).

Section 1870 of the Act prohibits the recovery of Medicare fee-for-service overpayments if the provider was without fault with respect to the overpayment.[13] A provider is presumed to be without fault for Medicare fee-for-service overpayments if the overpayment determination is made by the Medicare program after the fifth year following the year in which notice of such payment was sent to the provider.[14] MACs typically waive recovery in accordance with this presumption but have the authority to determine whether there is sufficient evidence to rebut the presumption.

Methodist Hospital

The Hospital is a 1,976-bed short-term, acute-care hospital, located in San Antonio, Texas. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately $621 million for 40,110 inpatient and 97,557 outpatient claims during the audit period.

HOW WE CONDUCTED THIS AUDIT

Our audit covered roughly $62 million in Medicare payments made to the Hospital for 6,625 claims in the risk areas identified above.[15] We selected for review a stratified random sample of 100 claims (20 IRF, 60 inpatient, and 20 outpatient) with Medicare payments totaling about $1.4 million made during our audit period.[16]

We evaluated compliance with selected billing requirements and submitted all claims to an independent medical review contractor to determine whether each claim was supported by the medical record. 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.

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[13] The Act, § 1870; 78 Fed. Reg. 74230, 74445 (Dec. 10, 2013); *Medicare Financial Management Manual*, chapter 3, §§ 70.3 and 80.

[14] The Act, § 1870; 78 Fed. Reg. 74230, 74445 (Dec. 10, 2013); *Medicare Financial Management Manual*, chapter 3, §§ 70.3 and 80.

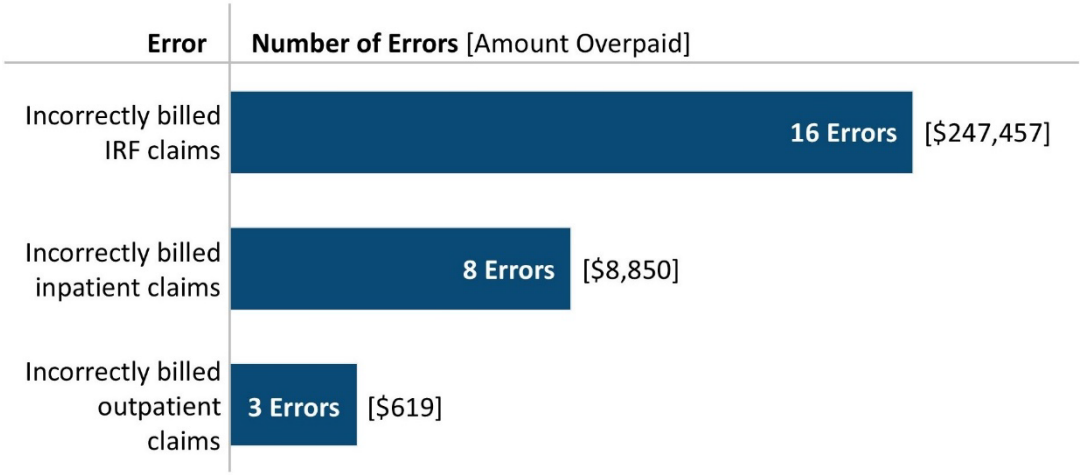
[15] The total Medicare payments were $62,048,673.

[16] The total paid was $1,426,020.

FINDINGS

The Hospital complied with Medicare billing requirements for 73 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 27 claims, resulting in net overpayments of $256,926. Figure 1 provides a breakdown of the error types, number of claims in error and the associated overpayments.

Figure 1: Inpatient and Outpatient Billing Errors*



* Incorrectly billed inpatient claims include both underpayments and overpayments resulting in net overpayments.

These errors occurred primarily because the Hospital did not always follow its policies and procedures to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

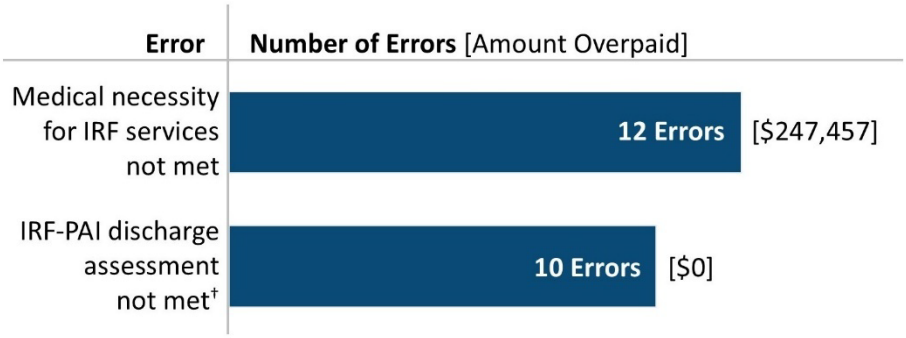
On the basis of our sample results, we estimated that the Hospital received net overpayments of at least $12.4 million for the audit period.[17] See Appendix B for statistical sampling methodology, Appendix C for sample results and estimates, and Appendix D for the results of our audit by risk area.

[17] Our actual estimate is $12,499,714. 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.

INCORRECTLY BILLED INPATIENT REHABILITATION FACILITY CLAIMS

For 16 of the 20 selected IRF claims, our independent medical review contractor determined that the hospital incorrectly billed Medicare Part A for enrollee stays that did not meet Medicare criteria for inpatient rehabilitation services. Overpayments associated with these 16 claims totaled $247,457. Figure 2 provides a breakdown of the error types, number of claims in error, and the associated overpayments.

Figure 2: Inpatient Rehabilitation Facility Billing Errors*



* Each claim could have errors in more than one of the above categories, which results in the total number of IRF errors exceeding 20 IRF claims.

† Although IRF Payment Assessment Instrument requirements are not a condition for payment, we counted these claims as errors for compliance purposes; however, the amounts remain allowable.

Medical Necessity for Inpatient Rehabilitation Facility Services Not Met

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 enrollee (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 to be able to actively participate in the intensive rehabilitation program; and (4) requires supervision by a rehabilitation physician (42 CFR § 412.622(a)(3)(i–iv)). During the COVID-19 Public Health Emergency, the second requirement and the

IRF Claim Did Not Meet Medical Necessity Criteria

One enrollee was admitted for inpatient rehabilitation services after a fall resulted in pelvic fractures requiring non-operative management. The patient did not experience any significant changes from the baseline medical condition. The independent medical review contractor determined that a non-rehabilitation physician could have overseen the patient's recovery and monitoring, and the patient did not require an IRF stay.

"intensive" nature of rehabilitation therapy in the third requirement were waived (42 CFR § 412.622(a)(3)(ii–iii)).

For 12 of the 20 selected IRF claims, the Hospital incorrectly billed Medicare Part A for stays that did not meet Medicare criteria for acute inpatient rehabilitation because the patients did not reasonably require supervision by a rehabilitation physician. Overpayments associated with these claims totaled $247,457.

Inpatient Rehabilitation Facility Payment Assessment Instrument Discharge Assessment Not Met

Medicare requires IRF Payment Assessment Instrument (IRF-PAI) discharge assessments to be completed by the 5th calendar day after the enrollee is discharged from an IRF.[18, 19]

For 10 of the 20 selected IRF claims, the Hospital did not comply with Medicare requirements because the medical records did not support that the discharge assessment was completed within 5 calendar days of discharge. Although IRF-PAI requirements are not a condition for payment, we counted these claims as errors for compliance purposes; however, the amounts remain allowable.[20]

INCORRECTLY BILLED INPATIENT CLAIMS

For 8 of the 60 selected inpatient claims, our independent medical review contractor determined that the Hospital incorrectly billed Medicare Part A for enrollee stays that did not meet Medicare criteria for inpatient services at acute care hospitals.[21] These errors resulted in net overpayments totaling $8,850. Figure 3 provides a breakdown of the error types, number of claims in error and the associated net overpayments.

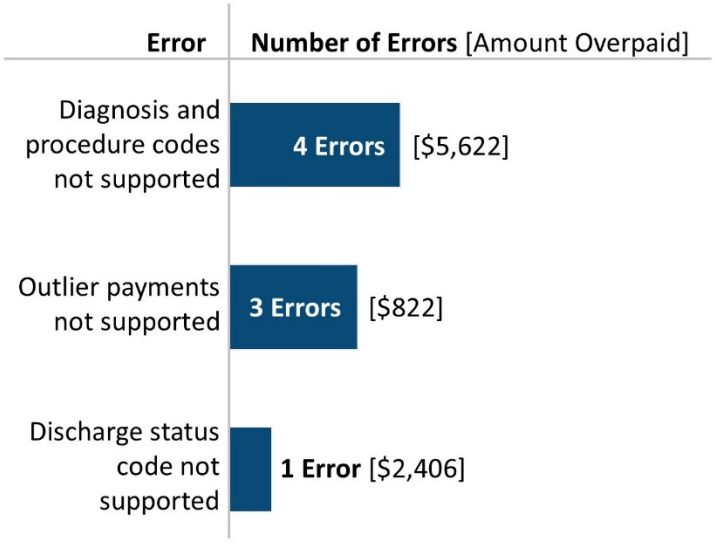
[18] 42 CFR § 412.610(c)(2).

[19] The discharge assessment reference date is typically the day of discharge from the IRF and ensures standardization in how patient data is collected and reported. It also affects quality reporting, payment determination, and compliance with CMS regulations. This date is critical for ensuring the data reflects the enrollee's status at discharge and for meeting submission deadlines.

[20] Six of the 10 claims were also reported as errors for not meeting medical necessity of the IRF services. In addition, our medical review contractor also determined that the documentation for all 20 IRF claims did not support the plan of care was individualized. See the second item in Other Matters for additional information.

[21] Our medical review contractor also determined that 19 of the 60 selected claims did not meet InterQual® Level of Care Criteria for inpatient hospital admission. These criteria are evidence-based clinical decision support tools that many hospitals use to help assess clinical appropriateness and strengthen patient outcomes. Failure to meet InterQual Level of Care Criteria does not equate with failure to meet Medicare requirements, but we believe this is useful information for the Hospital for their quality assurance efforts. See the first item in the Other Matters section of this report for additional information.

Figure 3: Inpatient Billing Errors*



* Diagnosis and procedure codes not supported, and outlier payments not supported, include both underpayments and overpayments resulting in net overpayments.

Diagnosis and Procedure Codes Not Supported

DRG codes are assigned to specific hospital discharges based on claims data submitted by hospitals (42 CFR § 412.60(c)), so claims data must be accurate.

For 4 of the 60 selected inpatient claims, the Hospital submitted claims to Medicare with diagnosis and procedure codes that were not supported by the medical records, resulting in $5,622 in net overpayments.

Principle Diagnosis Code Not Supported
One enrollee was admitted to the Hospital with an incorrect principal diagnosis code for atrial fibrillation (irregular, rapid heart rhythm) when the actual cause of admission was cancer-related leg pain. The change in the principal diagnosis code caused a change in the DRG code, which should have been reimbursed at a lower payment rate.

Outlier Payments Not Supported

The Act requires Medicare to pay an additional amount beyond the basic DRG payment for outlier cases (§ 1886(d)(5)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due to the provider (§§ 1815(a)). Pursuant to Federal regulations, to qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount. The costs are computed by multiplying the total covered charges by the operating and capital cost-to-charge ratios (42 CFR § 412.84).

For 3 of the 60 selected inpatient claims, the Hospital incorrectly billed units of service and charges, resulting in $822 in net overpayments.

Discharge Status Code Not Supported

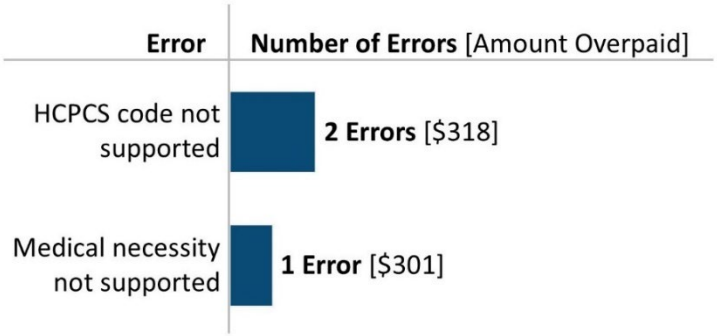
Hospitals receive the full inpatient PPS payment when an inpatient is formally discharged or dies in the hospital. However, if an inpatient is discharged and readmitted to another acute care hospital on the same day, the discharge is classified as a transfer, unless the readmission is unrelated to the initial discharge. A discharge is classified as a transfer when a patient assigned to a qualifying DRG is discharged to post-acute care, such as home with a written home-health care plan that starts within 3 days (42 CFR § 412.4(c)).

For 1 of the 60 selected inpatient claims, the Hospital assigned the incorrect discharge status code to home. The discharge status should have been to home-health services from a home health agency. Overpayments associated with this one claim totaled $2,406.

INCORRECTLY BILLED OUTPATIENT CLAIMS

For 3 of the 20 selected outpatient claims, our independent medical review contractor determined that the Hospital incorrectly billed Medicare Part B for claims that did not meet Medicare criteria for outpatient services. These errors resulted in overpayments of $619. Figure 4 provides a breakdown of the error types, number of claims in error, and the associated overpayments.

Figure 4: Outpatient Billing Errors



HCPCS Code Not Supported

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 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 on outpatient claims (the *Manual*, chapter 4, § 20.1), 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).

For 2 of the 20 selected outpatient claims, the medical record documentation did not contain sufficient support for the HCPCS code billed to Medicare Part B. Overpayment associated with these two claims totaled $318.

Medical Necessity Not Supported

No payment may be made under Medicare Part B for any expenses incurred 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 1 of the 20 selected outpatient claims, the medical record did not support that the procedures performed were medically reasonable and necessary. The overpayment associated with that claim was $301.

Medical Necessity Not Supported
The Hospital submitted improper HCPCS codes on a claim for an enrollee who received a CT scan of the abdomen and an intravenous antibiotic administration. The medical record lacked clinical indications, such as abdominal complaints or signs of infection, to justify these services. As a result, the claim did not meet Medicare's requirement for medical necessity.

HOSPITAL STAFF DID NOT ALWAYS FOLLOW PROCEDURES TO PROPERLY BILL HOSPITAL SERVICES

The 27 incorrectly billed claims did not comply with Medicare requirements because staff did not consistently follow the Hospital's written policies designed to prevent noncompliance with IRF admissions and documentation, billing, and coding. Although Hospital officials contend that the claims met Medicare requirements, they did not provide any additional information that would affect our findings.

RECOMMENDATIONS

- We recommend that the Hospital refund to the Federal government the estimated $12,499,714 in net overpayments for incorrectly billed claims, excluding amounts presumed to be unrecoverable under the Section 1870 waiver of liability provision.[22, 23]

- We recommend that the Hospital consider conducting one or more internal audits or investigations for claims beyond our audit period, based on the risks identified by this audit,

[22] 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.

[23] Novitas Solutions, Inc., retains the authority to determine whether there is sufficient evidence to rebut the Act's § 1870 "fifth year following" "without fault" presumption that might limit the recovery of any of these overpayments.

to identify any similar overpayments and return any identified overpayments to the Medicare program.

- We recommend that the Hospital provide additional training to clinical and billing personnel on its policies and procedures related to IRF admissions and documentation requirements, and inpatient and outpatient coding.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital disagreed with 14 of the 29 claims we identified as in error in the draft report—including the two Two-Midnight Rule claims later removed—and did not concur with our first and second recommendations.

Regarding the claims tied to our first recommendation, the Hospital stated that it had already identified and refunded 11 incorrectly billed inpatient and outpatient claims during its self-review. Regarding our second recommendation, the Hospital stated that it routinely monitors compliance and therefore believes additional auditing is unnecessary. Regarding our third recommendation, the Hospital said it is willing to provide education for staff.

Of the 14 claims we identified as erroneous, the Hospital challenged our findings on 12 IRF claims and 2 inpatient claims related to the Two-Midnight Rule, arguing that our review relied on questionable medical reviews, misapplied coverage criteria, took an overly technical reading of regulatory requirements, and inappropriately used extrapolation. The Hospital acknowledged our finding that 10 IRF-PAI discharge assessments were completed late but said that the associated amounts remained allowable.[24]

We summarized the Hospital's agreements, disagreements, and objections below.[25]

After reviewing the Hospital's comments, we revised our findings by removing the two inpatient claims related to the Two-Midnight Rule and reducing the associated recommended refund amount (from $13,455,341 to $12,499,714) for this final report. We also revised our third recommendation by removing the additional training related to the Two-Midnight Rule.

The Hospital's complete comments, excluding its appendix, are included as Appendix E.[26]

[24] Six of the 10 claims were also reported as errors for not meeting medical necessity of the IRF services.

[25] We listed the Hospital's agreements, disagreement, and objections by subject matter because the Hospital addressed several topics across multiple headings. We have responded to the Hospital's comments within each topic area.

[26] The Hospital submitted an additional document labeled Appendix A Inpatient Rehab Case Summaries prepared by the Hospital's independent board-certified physical medicine and rehabilitation physician. Although this appendix is not included in this report, we considered it in its entirety and will provide it to CMS.

AUDIT RECOMMENDATIONS

Hospital Comments

The Hospital disagreed with our first and second recommendations and stated that it is willing to conduct education to address our third recommendation. The hospital stated that its admission, coding, and billing practices, policies, and procedures fully comply with Medicare requirements.

Regarding our first recommendation, the Hospital does not agree that it is required to refund Medicare for overpayment of incorrectly billed claims other than the 11 that were disclosed as part of the Hospital's self-review, which was undertaken at our request at the start of the audit. The Hospital stated that all other claims were correctly billed and disagrees with our findings regarding errors related to the rehabilitation physician (or the IRF-PAI or a POC) and the Two-Midnight Rule.

Regarding our second recommendation, the Hospital disagreed that any additional auditing is necessary because it routinely monitors its compliance with the Two-Midnight Rule, IRF, and coding.

Regarding our third recommendation, the Hospital stated that it believes that its current protocols and ongoing training efforts ensure that patients meet Medicare coverage requirements; however, it is willing to provide additional education to staff.

Office of Inspector General Response

Regarding the two claims we found that did not comply with the Two-Midnight Rule, we revised our findings by removing the two inpatient claims and reducing the associated recommended refund amount for this final report. However, we disagree with the Hospital's assertion that the remaining claims were billed in compliance with CMS requirements. We submitted the selected claims to an independent medical review contractor and ensured that their review was conducted by experienced professionals—including physicians and coders—with relevant expertise and that the appropriate Medicare criteria were applied. The Hospital has the right to appeal any overpayment determinations and recovery actions taken by CMS or the MAC.

We also disagree that the errors do not warrant conducting internal audits or investigations for claims beyond our audit period, based on the risks identified in this audit. We found multiple errors in several categories—such as incorrectly coded inpatient and outpatient claims—that indicate these errors are not isolated and similar issues may exist.

We appreciate that the Hospital is willing to conduct additional staff education.

INPATIENT REHABILITATION FACILITY CLAIMS

Hospital Comments

The Hospital disagreed with our findings related to IRF claims and stated that it strongly maintains that the 12 claims OIG found to be in error met Medicare criteria. The Hospital provided the results of its independent medical reviewer's evaluation that the IRF admissions were appropriate. The Hospital stated that we misunderstood the role of a rehabilitation physician in managing IRF patients and that our medical reviewer took an overly technical reading of regulatory requirements. The Hospital added that we should defer to the treating physician's admission decision unless the medical records contradict the decision. It also said our reliance on more stringent standards is not reflected in the regulatory text and indicated that a reasonable expectation existed at the time of admission that each patient required supervision by a rehabilitation physician.

The Hospital said it appreciated that the IRF-PAI discharge assessment errors are not a condition of payment and acknowledged that the discharge assessments for the 10 claims OIG found to be in error were late. The Hospital stated that standards and requirements on completing and submitting the IRF-PAI are complex, vague, and inconsistent.

The Hospital disagreed that the plans of care (POCs) for the 20 claims OIG found to be in error were not individualized. The Hospital stated that it appears we equated their use of template forms with a lack of individualized POCs. The Hospital added that it uses templates for consistency and thoroughness, but that their use does not mean that each patient's POC is not individualized. The Hospital stated that the POCs documented each patient's need for intensive therapy, each patient's ability to participate, and adequate physician oversight.

Office of Inspector General Response

CMS regulations state that there must be a reasonable expectation that at the time of admission to the IRF an enrollee requires supervision by a rehabilitation physician. It does not require that our medical reviewer defer to the admitting physician's clinical judgment, which would negate the reasonableness standard. Our medical reviewer evaluated the medical records for each sampled claim to determine whether the enrollee met the requirement for supervision by a rehabilitation physician in accordance with CMS's requirement.[27]

We appreciate the Hospital's acknowledgement that the discharge assessments for the 10 claims were completed late.

Regarding the POC's, CMS regulations do not explain what "individualized" means or define what should be documented. The lack of clarity in the regulations raises concerns about increased risks that an enrollee's specific needs are not adequately addressed and that

[27] 42 CFR § 412.622(a)(3)(iv).

Medicare experiences financial loss or inefficiency. Nevertheless, contrary to the Hospital's assertion, our medical review contractor did not base its determinations on the Hospital's use of templated forms; rather, our medical review contractor took issue with the documentation of a patient's specific assessments, goals, planned interventions, and levels function for physical therapy and occupational therapy.

INPATIENT CLAIMS

Hospital Comments

The Hospital stated that the eight claims OIG found to be in error related to the Diagnosis and Procedure Codes Not Supported, Outlier Payment Not Supported, and Discharge Status Code Not Supported were identified, disclosed, and refunded due to the Hospital's self-review, which was conducted at our request. In addition, the Hospital disagreed that the two claims OIG found to be in error related to the Two-Midnight Rule did not meet the CMS Two-Midnight Rule requiring the admitting physician's reasonable expectation for the patient to require two or more midnights of hospital services. The Hospital stated that it found support in the medical records for both claims that affirmed its original clinical decision that a reasonable expectation existed that each of the recipients would require hospital care spanning at least 2 midnights. The Hospital indicated that at the minimum, a revised payment amount should be noted to reflect the payment as an inpatient Part B procedure (if not allowed as inpatient Part A procedure) and the revision should be taken into consideration for extrapolation.

The Hospital indicated that it will not address the issue on the Claims Associated With InterQual Level of Care Criteria because InterQual is not a mechanism that can be used to determine the appropriateness of an inpatient admission.

Office of Inspector General Response

We appreciate that the Hospital identified, disclosed, and refunded the eight claims related to the inpatient claims. However, the refund occurred after we requested that the Hospital perform a self-review at the start of this audit; therefore, we included them as errors for extrapolation purposes. After considering the Hospital's comments and reviewing the additional information that the Hospital provided, we removed the two claims that did not meet the Two-Midnight Rule, revised our findings, and reduced the associated recommended refund amount (from $13,455,341 to $12,499,714) for the final report. We also revised our third recommendation by removing the additional training related to the Two-Midnight Rule.

We included information on the Claims Associated With InterQual Level of Care Criteria as Other Matters in this report for informational purposes. As previously stated, although those claims do not constitute a failure to meet Medicare requirements, the results of our audit suggest that properly applying a screening tool to the Hospital's compliance or utilization review programs could reduce inappropriately billed claims.

OUTPATIENT CLAIMS

Hospital Comments

The Hospital stated that the three claims OIG found to be in error related to HCPCS Code Not Supported and Medical Necessity Not Supported were identified, disclosed, and refunded due to the Hospital's self-review, which was conducted at our request.

Office of Inspector General Response

We appreciate that the Hospital identified, disclosed and refunded the three claims related to the outpatient claims. However, the refund occurred after we requested that the Hospital perform a self-review at the start of this audit; therefore, we included them as errors for extrapolation purposes.

REOPENING PERIOD

Hospital Comments

The Hospital stated that the MAC did not properly reopen the claims in our audit period and cannot recover any overpayments because the 4-year "good cause" reopening period has expired. The Hospital said the reopening letter from the MAC was unsigned and undated. It added that the letter was written in future tense and only indicated a prospective intent to reopen.

The Hospital also stated that even if the MAC reopened the claim, "Novitas has no basis for arguing 'good cause' to extend its reopening deadline from one-year from the date of the initial determination (e.g., payment) to four years from the date of the initial determination." The Hospital indicated that the letter makes only a vague reference to "good cause" without any facts supporting the regulatory requirement.

Office of Inspector General Response

Although the MAC letter was unsigned, undated, and written in the future tense, 42 CFR § 405.980 imposes no requirements for signatures, dates, and verb tense of reopening letters. Indeed, a letter is not even required. All that is required to constitute a reopening is that the contractor "takes some action (which can be documented) questioning the correctness of the determination within 4 years … after the date the initial determination was approved."[28] Novitas's letter went beyond the requirement, giving the Hospital written notice of the reopening.

[28] *In the Case of Memorial Hospital of Long Beach*, Departmental Appeals Board, Medicare Appeals Council, 2008 WL 11591949, *4 (H.H.S.) (July 23, 2008), quoting *Medicare Financial Management Manual*, ch. 3, § 170.2.B.

Novitas reopened the claims based upon its authority under 42 CFR § 405.980. Specifically, a claim may be reopened within 4 years from the date of the initial determination or redetermination for "good cause." This audit is part of a series of OIG hospital compliance audits. Using computer matching, data mining, and data analysis techniques, the OIG identified hospital claims that were at risk for noncompliance with Medicare billing requirements. OIG selected the Hospital for further review based upon certain risk factors and notified Novitas. After receiving this additional information, Novitas reopened the claims. Pursuant to Federal regulations (42 CFR § 405.980(a)(5)), the MAC's decision is not subject to appeal.

PUBLIC HEALTH EMERGENCY

Hospital Comments

The Hospital said that our audit period was during the COVID-19 public health emergency (PHE), when flexibility with regulatory requirements was necessary and encouraged by CMS. The Hospital stated, for example, that patient care needs were primary to administrative assessments, such as completion of the IRF-PAI discharge assessment. The Hospital appreciated that we did not attribute any overpayments to this deficiency, but it finds the inclusion of this finding in the report unnecessarily inflammatory and unfair.

Office of Inspector General Response

CMS, the Federal agency responsible for administering the Medicare program, waived certain requirements during the PHE, while it kept most in place. We worked closely with our independent medical review contractor to ensure that it considered relevant waiver provisions in place during our audit period due to the PHE, including flexibilities outlined in CMS's "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers." For all relevant sample claims, our reviewers used the regulations within the context of those waivers.

STATISTICAL SAMPLING

Hospital Comments

The Hospital objected to our use of extrapolation, arguing that it creates an unreasonable burden on appeal. It asked that we recoup only the claims in error, stating that individualized medical necessity determinations are not appropriate for extrapolation. The Hospital also said that it does not concede the two claims in error related to the Two-Midnight Rule are improper, but if extrapolation proceeds, those claims should first be adjusted to reflect proper inpatient Part B-only payments. Finally, it said that claims not properly reopened or not legally recoverable for CY 2020 should be excluded from any extrapolation.

Office of Inspector General Response

The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[29] Moreover, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts.[30] Our statistical sampling methodology was proper because we defined our sampling frame and sample unit, selected a sample of claims at random, applied relevant criteria in evaluating the sample, and used statistical sampling software to apply the correct formulas for the extrapolation.

The Hospital's contention that statistical sampling is inappropriate in the context of medical necessity reviews is incorrect. We submitted the claims selected for review to an independent medical review contractor who reviewed the medical record to determine whether the services were medically necessary and provided in accordance with Medicare requirements. We worked with our reviewer to ensure that it applied the correct Medicare criteria that were applicable during the audit period, and that it used professionals with appropriate medical expertise, including physicians with appropriate training and expertise. Further, the statistical lower limit that we use for our recommended recovery represents a conservative estimate of the overpayment that we would have identified if we had reviewed every claim in the sampling frame. The conservative nature of our estimate is not changed by the nature of the errors identified in this audit. Moreover, the court cases that the Hospital referenced in support of the proposition that extrapolation is inappropriate are limited to False Claims Act cases and therefore are inapplicable to OIG audit recommendations and CMS recoveries arising from OIG audits. Furthermore, in *Chaves County Home Health Services v. Sullivan*, 732 F. Supp. 188 (D.C.D.C. 1990), a provider alleged that the use of statistical sampling and extrapolation without individual review of each claim was illegal. The District Court held otherwise, and the Court of Appeals affirmed, finding that the provider had the opportunity to challenge the statistical validity of both the sample and the extrapolation on appeal (*Chaves County Home Health Services v. Sullivan*, 931 F.2d 914 (DC Cir. 1991)). The Hospital has five levels of appeal to challenge the statistical validity of both the sample and the extrapolation.

[29] *See John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at *34-35 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), *aff'd*, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); Miniet v. Sebelius, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

[30] *Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), *adopted by* 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

Regarding the two claims related to the Two-Midnight Rule, we revised our findings by removing the two inpatient claims and reducing the associated recommended refund amount for this final report.

In addition, we previously noted in footnote 22 that our audit recommendations do not represent final determinations by Medicare and outlined the process for appeal.

OTHER MATTERS

Claims Associated With InterQual Level of Care Criteria

During our audit period, CMS required its medical review contractors to use a screening tool as part of their medical review of acute inpatient PPS claims (*Medicare Program Integrity Manual* (*MPIM*), chapter 6, § 6.5.1). CMS did not require that the contractor use a specific tool, nor does CMS or the OIG endorse any specific tool.[31] During an earlier series of hospital compliance audits, in response to findings that claims did not meet Medicare inpatient admission requirements, several auditees noted that their documentation supported that the claims met the InterQual® or Milliman (the predecessor to MCG) Level of Care Criteria screening tools.[32]

As part of this audit, we asked our independent medical review contractor to apply clinical screening criteria to review the Hospital's inpatient PPS claims. This was done for informational purposes to provide the auditee with additional information that might assist them with their compliance and utilization review programs.

The contractor used InterQual® criteria to evaluate a sample of 60 claims. For 19 of those claims, our independent medical review contractor found that the admissions did not meet InterQual® criteria.[33] Although those claims do not constitute a failure to meet Medicare requirements, the results of our audit suggest that properly applying a screening tool to the Hospital's compliance or utilization review programs would reduce inappropriately billed claims.

Claims Associated With Inpatient Rehabilitation Facility Regulations

According to CMS regulations, a patient's medical record at the IRF must contain an "individualized" overall Plan of Care (POC) that is "developed by a rehabilitation physician with

[31] Several commercially available screening tools exist, including InterQual® Level of Care Criteria, MCG Inpatient & Surgical Care Guidelines, and other proprietary systems.

[32] For example, see *Medicare Hospital Provider Compliance Audit: Lake Hospital System* (A-05-19-00024), June 30, 2021, and *Medicare Hospital Provider Compliance Audit: St. Vincent Hospital* (A-05-18-00040), Nov. 27, 2019.

[33] Two of the 19 claims did not have documentation supporting the diagnosis and procedure codes and one did not meet requirements for outlier payments.

input from the interdisciplinary team within 4 days of the patient's admission to the IRF" (42 CFR §§ 412.622(a)(4)(ii)(A) and (B)).

For all 20 selected IRF claims, documentation supported that a rehabilitation physician developed the POC, but it did not support that the POCs were individualized. However, CMS regulations do not explain what "individualized" means or define what should be documented. The lack of clarity in the regulations raises concerns about increased risks that an enrollee's specific needs are not adequately addressed and that the Medicare program experiences financial loss or inefficiency.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $62,048,673 in Medicare payments to the Hospital for 6,625 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (20 IRF, 60 inpatient, and 20 outpatient) with payments totaling $1,426,020.[34] Medicare paid these 100 claims from January 1, 2020, through December 31, 2021 (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 record.

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

During our audit, we did not assess the overall internal control structure of the Hospital. Rather, we limited our review to the Hospital's internal controls for compliance with Medicare billing requirements. To evaluate these internal controls, we:

- Interviewed Hospital officials regarding the Hospital's internal controls for compliance with Medicare billing requirements that related to the risk areas we identified

- Reviewed the Hospital's policies and procedures for the Two-Midnight Rule, medical necessity of inpatient and outpatient services, IRF admissions and documentation requirements, billing of services provided and inpatient and outpatient coding

- Reviewed a stratified random sample of 20 IRF claims, 60 inpatient claims, and 20 outpatient claims to determine if claims were properly billed and reimbursed

- Discussed with Hospital officials the cause of the identified errors

[34] For claim selection, CMS instructs Medicare review contractors to apply the Two-Midnight Presumption and avoid reviewing stays spanning 2 or more midnights unless there is evidence of systemic abuse, gaming, or care delays (*MPIM*, chapter 6, § 6.5.2). The Two-Midnight Presumption is CMS guidance directing Medicare reviewers to presume that an inpatient admission is appropriate and medically necessary when a patient remains in the hospital for at least two midnights after a physician orders inpatient status, unless there is evidence of systemic abuse, gaming, or care delays. However, OIG is not constrained by the Two-Midnight Presumption for the purpose of selecting claims for review.

METHODOLOGY

We took the following steps to accomplish our objective:

- 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
- Created a sampling frame of paid Medicare claims from selected risk areas consisting of 6,625 claims with a paid amount of $62,048,673
- Selected a stratified random sample of 100 claims (20 IRF, 60 inpatient, and 20 outpatient) with payments totaling $1,426,020
- Reviewed data from the Recovery Audit Contractor Data Warehouse for the claims included in the sample to determine whether the claims had been previously reviewed
- Reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted
- Obtained from the Hospital all supporting documentation for the claims in our sample
- Used an independent medical review contractor to determine whether all claims complied with selected billing requirements
- Calculated the correct payments for those claims requiring adjustments
- Used the results of the sample review to calculate the estimated Medicare net overpayment in the sampling frame (Appendix C)
- Discussed the results 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

Our sampling frame contained 6,625 Medicare paid claims in 11 risk areas totaling $62,048,673 from which we selected our sample (Table 1). The sampling frame included claims:

- With only certain discharge status and revenue codes
- With payments greater than $0
- Not under review by the Recovery Audit Contractor as of October 7, 2022

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 High CERT Error DRG Codes, Inpatient Claims Billed With High–Severity Level DRG Codes, Inpatient Claims Billed With Mechanical Ventilation, Inpatient Claims Billed With Severe Malnutrition, Inpatient Claims Covering Same Day Discharge and Readmission, Inpatient Claims Billed for Resuming Home Health, Outpatient Claims Billed With Bypass Modifiers, Outpatient Claims Billed in Excess of Charges, Outpatient Surgery Claims Billed With Units Greater Than One, and Outpatient SNF Consolidated Billing Claims.

Table 1: Risk Areas

Medicare Risk Area	Frame Size	Value of Frame
1. IRF Claims	1,509	$31,295,567
2. Inpatient Claims Billed with High CERT Errors DRG Codes	1,324	12,289,813
3. Inpatient Claims Billed with High–Severity Level DRG Codes	765	7,710,653
4. Inpatient Claims Billed with Mechanical Ventilation	77	2,295,489
5. Inpatient Claims Billed with Severe Malnutrition	117	4,821,051
6. Inpatient Claims Covering Same Day Discharge and Readmission	3	18,486
7. Inpatient Claims Billed for Resuming Home Health	84	1,032,622
8. Outpatient Claims Billed with Bypass Modifiers	2,718	2,435,436
9. Outpatient Claims Billed in Excess of Charges	4	33,982
10. Outpatient Surgery Claims Billed with Units Greater Than One	7	112,820
11. Outpatient SNF Consolidated Billing Claims	17	2,754
Total	**6,625**	**$62,048,673**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified sample. We grouped the sampling frame into strata based on risk areas in Table 1 and claim paid amount, resulting in five strata. Stratum 1 includes all claims from risk area 1; strata 2, 3, and 4 include claims from inpatient risk areas 2 through 7, separated by paid amount; and stratum 5 includes all outpatient claims from risk areas 8 and 11.[35] All claims were unduplicated, appearing in only one risk area and only once in the entire sampling frame.

We selected 100 claims for review as shown in Table 2.

Table 2: Claims by Stratum

Stratum	Claims Type	Frame Size (Claims)	Value of Frame	Sample Size
1	Inpatient Risk Areas 1	1,509	$31,295,567	20
2	Inpatient Risk Areas 2–7, Low Dollar Claims	1,224	7,653,053	20
3	Inpatient Risk Areas 2–7, Medium Dollar Claims	959	12,390,829	20
4	Inpatient Risk Areas 2–7, High Dollar Claims	187	8,124,232	20
5	All Outpatient Claims (Risk Areas 8–11)	2,746	2,584,992	20
	Total	**6,625**	**$62,048,673**	**100**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We sorted the items in each stratum by a unique claim identifier, and then consecutively numbered the items in each stratum in the sampling frame. After generating the random numbers in accordance with our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

[35] Paid claims less than $10,000 are in stratum 2, paid claims greater than or equal to $10,000 and less than $20,000 are in stratum 3, and paid claims greater than or equal to $20,000 are in stratum 4.

We used the OIG/OAS statistical software to estimate the total amount of net overpayments in the sampling frame made to the Hospital at the lower limit of the two-sided 90-percent confidence interval (See Appendix C). 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 Details and Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Net Overpayments in Sample
1	1,509	$31,295,567	20	$415,412	16	$247,457
2	1,224	7,653,053	20	119,241	3	(1,389)
3	959	12,390,829	20	249,481	0	0
4	187	8,124,232	20	625,250	5	10,239
5	2,746	2,584,992	20	16,636	3	619
Total	**6,625**	**$62,048,673**	**100**	**$1,426,020**	**27***	**$256,926**

* For 4 of the 27 sampled claims, the related requirements were not a condition of payment.

Table 4: Estimates of Net Overpayments in the Sampling Frame for the Audit Period (Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$18,766,379
Lower limit	12,499,714
Upper limit	25,033,044

APPENDIX D: RESULTS OF AUDIT BY RISK AREA

Table 5: Sample Results by Risk Area*

Risk Area	Sample Size	Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Net Overpayments in Sample
IRF Claims	20	$415,412	16	$247,457
IRF Total	**20**	**$415,412**	**16**	**247,457**
Inpatient Billed with High CERT Error DRG Codes	31	307,720	1	(157)
Inpatient Billed with High–Severity-Level DRG Codes	15	231,722	6	8,225
Inpatient Severe Malnutrition	7	228,453	1	782
Inpatient with Mechanical Ventilation	6	213,145	0	0
Inpatient for Resuming Home Health Services	1	12,932	0	0
Inpatient Totals	**60**	**$993,972**	**8**	**$8,850**
Outpatient With Bypass Modifiers	20	16,636	3	619
Outpatient Totals	**20**	**$16,636**	**3**	**$619**
Inpatient and Outpatient Totals	**100**	**$1,426,020**	**27†**	**$256,926**

* The table above illustrates the results of our audit by risk area. We 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. Because the information is organized differently, the information in the individual risk areas in this table does not precisely match the information in the Findings section of this report.

† For 4 of the 27 sampled claims, the related requirements were not a condition of payment.

APPENDIX E: HOSPITAL COMMENTS

June 12, 2026

VIA Secure HHS/OIG Delivery Server

Tom Lin
Assistant Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 - 7th Street, Suite 3-650
San Francisco, CA 94103

RE: **Methodist Response to OIG Draft Report Number: A-09-23-03001**

Dear Mr. Lin:

Methodist Healthcare System of San Antonio, Ltd., L.L.P., doing business as Methodist Hospital ("Methodist"), appreciates the opportunity to comment on the U.S. Department of Health and Human Services Office of the Inspector General's ("OIG's") draft report entitled *Methodist Hospital Received at Least $13.4 Million in Medicare Overpayments* ("the Draft Report"). Methodist is committed to complying with all statutes, regulations, and other standards governing participation in federal health care programs, including Medicare, and works continuously to update and improve its internal compliance controls and monitoring processes. Methodist stands by its coverage and payment decisions and believes that the audit upon which the Draft Report is based was fundamentally flawed. Therefore, the Draft Report should be withdrawn.

With few exceptions, Methodist strongly disagrees with the conclusions and recommendations contained in the Draft Report. OIG reviewed a stratified sample of 100 inpatient and outpatient claims from calendar years ("CY") 2020 and 2021 and alleges that Methodist did not fully comply with Medicare billing requirements for 16 inpatient IRF claims, 10 acute inpatient claims, and three outpatient claims, resulting in net overpayments of $279,220. OIG used that flawed determination to calculate an extrapolated overpayment of $13.4 million. It also recommended that Methodist conduct internal audits based on the risks identified by the audit and provide additional training on Medicare billing requirements.

I. Executive Summary

Methodist Hospital is a 1,976-bed short-term, acute care hospital in San Antonio, Texas, and is part of the Methodist Healthcare system. Opened in 1963, the hospital has grown to be Methodist Healthcare System's most comprehensive medical care facility, with several prestigious accreditations for clinical excellence. Methodist Healthcare serves over 600,000 patients annually, and has a strong commitment to its community, providing $317 million in charity and indigent care in 2018 alone. Over the past ten years, Methodist has invested $1.4 billion into the community.

It should also be noted that the time frame at issue was during the unprecedented COVID-19 Public Health Emergency. Methodist is deeply concerned with OIG sampling during a period when the COVID-19 pandemic was in full effect and significantly impacting the operations of all healthcare providers. On March 13, 2020, President Trump declared a National State of Emergency. This State of Emergency was in effect from March 1, 2020 through May 13, 2023. During this timeframe CMS enabled regulatory flexibilities to ensure that healthcare providers could rapidly and effectively provide services to patients impacted by the pandemic. CMS wanted to enable and empower providers to "focus on patient care in the most flexible and innovative ways possible."[1] It is entirely illogical and unfair to audit providers during this period, when flexibility with regulatory requirements was necessary and encouraged by CMS.

Methodist also reminds the OIG that Methodist received general and targeted distributions from the Provider Relief Fund in 2020. During the fourth quarter of 2020, Methodist voluntarily returned its share of those Provider Relief Fund distributions and repaid

[1] CMS, *Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge* (March 30, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-u-s-healthcare-system-address-covid-19.

Medicare accelerated payments. These actions underscored the organization's long-standing commitment to ethical conduct, sound governance, and responsible stewardship.

In light of these voluntary repayments and other work by Methodist during the pandemic, the selection of this time period for audit scrutiny is difficult to reconcile or understand. Methodist believes this history provides important context for evaluating the matters addressed in this response and hopes the OIG will agree.

The Draft Report, if finalized, has the potential to harm Methodist's reputation and ongoing mission of benefiting the community it serves, not to mention inappropriately undermining the confidence that patients and their families have in Methodist. It is paramount to note that OIG *did not find any evidence of fraud or inadequate quality of care* in the claims reviewed. Methodist has an excellent history of compliance and a strong internal system of policies, procedures, controls, and ongoing education and training to ensure its services are consistent with good medical practice and program integrity. OIG's unfounded claim that Methodist received $13.4 million in Medicare overpayments undermines its reputation and the trust it has built in the communities it serves.

Methodist disputes the vast majority of the audit findings memorialized in the Draft Report, and it specifically disagrees that the 12 inpatient rehabilitation facility ("IRF") and two inpatient-hospital ("Two-Midnight") claims were not payable. Methodist has a rigorous process for admitting patients and stands behind the medical necessity of these admissions.

OIG's summaries of the 12 IRF claims make clear that its contracted reviewer profoundly misunderstands rehabilitation medicine, especially the role of the rehabilitation physician in patient care. The majority of the denials stem from the deeply flawed premise that inpatients in a rehabilitation hospital could be treated by a "non-rehabilitation physician." This conclusion reflects a lack of understanding of the highly-respected and long-standing specialty of rehabilitation medicine. Board-certified rehabilitation physicians have unique training and experience to treat the diverse and often complex medical and rehabilitation needs of their patients, enabling them to safely recover from significant injuries or illnesses.

We also are seriously concerned by the OIG reviewer's application of standards that go beyond the requirements of Medicare rules and regulations. For example, the OIG concluded that some cases in the sample had Individualized Overall Plans of Care ("IOPOC"), which are a regulatory requirement of IRFs, that were not individualized, despite the fact that the plain language of the medical records shows clear individualization to each patient. It appears that the OIG's reviewer is inappropriately biased against the use of templates, which are permitted by Medicare and enable providers to efficiently organize information to best treat the patient. Further, the OIG reviewer's hyper-technical reading of the regulatory requirements does not align with the deference consistently granted to treating physicians by Medicare through the regulation's 'reasonable expectation' standard. The Medicare regulations simply do not create bright-line coverage rules that can be applied mechanically by auditors. A review of paper records cannot replace—and should not supersede—an in-person examination by a treating physician who specializes in the care of rehabilitation. The auditor should defer to the treating physician's admission decision, unless that decision is clearly contradicted by the paper record.

Methodist disagrees that the Two-Midnight cases, as discussed later in this response, did not meet the CMS Two-Midnight Rule, requiring only that the admitting physician reasonably expected the patient to require two or more midnights of hospital services.

We also fault the failure of the Medicare Administrative Contractor, Novitas, to properly re-open the claims included in the OIG Audit. As discussed in more detail below, Novitas cannot lawfully recover alleged overpayments made in CY 2020, since the fifth year following payment has expired. While Methodist does not concede that extrapolation is permitted for this Audit, should the OIG proceed with extrapolation, claims from this CY must be excluded from any such calculation.

Methodist also objects to OIG's decision to use extrapolation to calculate an estimated overpayment in excess of $13.4 million—especially since it is based upon claims OIG knows are disputed by Methodist. This is an excessive and misleading figure that assumes that Methodist will not prevail in any individual appeal of the 14 claims at issue. While Methodist believes it will prevail on the vast majority of its appeals, the time and effort required by the administrative appeals process will require Methodist to pay an extrapolated overpayment

early on the front end and will expose the government to significant interest payments on any overturned claim on the back end. Given that, Methodist respectfully requests that the OIG recommend recoupment of payment only for the claims that it actually audited in the 100-claim sample and not impose an extrapolated overpayment on Methodist.

Methodist does not agree with the findings of the audit and maintains that there is no basis for most of OIG's recommendations. Methodist disagrees that it should be required either to refund $13.4 million, an extrapolated figure based solely on flawed claim determinations, or conduct additional audits of claims and training of staff. While Methodist is always aware of the need for staff training, it believes that its current protocols and ongoing training efforts are rigorous and ensure that patients meet Medicare coverage requirements.

II. Background of Audit and Methodist's Interaction With OIG

On November 9, 2022, Methodist received a letter from OIG notifying it of OIG's audit and request for specific documentation. Over the following months, Methodist worked with OIG and submitted all requested documentation. On December 1, 2022, Methodist submitted the first 50 medical records, UB-04s, Remittance Advices, and itemized bills to OIG. On December 15, 2022, Methodist submitted the same documentation for the remaining 50 medical records.

On December 9, 2022, Methodist submitted:

- Internal Control Questionnaire
- Details of prior internal audits of Methodist for fiscal years ("FY") 2018, 2019, and 2020 that included Medicare claims;
- Audited financial statements for FY 2018, 2019, and 2020;
- Policies, procedures, and rules pertaining to admissions, care management, medical records, coding, rehabilitation services, and physician orders;
- Organizational charts involving admission, care management, medical records, and coding processes;
- An overview of internal risk assessments regarding Medicare claims; and
- A list of non-routine audits of Methodist Medicare claims conducted from 2017 to 2022.

On January 6, 2023, and per the OIG's request, Methodist provided the OIG with the results of its self-audit of the 100 claims selected by the OIG. That self-audit resulted in the identification of 11 claims with overpayments and eight claims with underpayments, creating a net overpayment of approximately $4,085. Each of the 11 claims with overpayments were refunded in a timely manner to Medicare.

Thereafter, the OIG provided Methodist with the preliminary audit findings in four batches.

Batch 1, which contained the preliminary results for outpatient claims, was provided to Methodist on September 5, 2025. Methodist responded to the OIG on September 12, 2025. While Methodist concurred with one error it already had discovered in its self-audit, Methodist

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did not concur with two alleged errors identified by the OIG and provided documentation disputing those findings.

Batch 2, which contained the preliminary results for the inpatient claims, was provided to Methodist on December 16, 2025. Methodist responded to the OIG on January 30, 2026. While Methodist concurred with seven errors it already had discovered in its self-audit, Methodist did not concur with five alleged errors identified by the OIG and provided documentation disputing those findings.

Batch 3, which included the first set of IRF claims, was provided to Methodist on December 18, 2025. Methodist responded to the OIG on January 30, 2026. Methodist disagreed with OIG's finding that the patients at issue in 12 of the IRF claims did not require the supervision and oversight of a rehabilitation physician. Methodist disputed the OIG's position that the care of these12 patients did not require the ongoing involvement of a rehabilitation physician because they ultimately did not need the specific interventions listed by the OIG's reviewer (i.e., complex wound care, tube feeding, neurogenic bowel or bladder management, or tracheostomy management). The involvement and expertise of a rehabilitation physician absolutely was necessary for these 12 patients, and Methodist followed all regulatory requirements for those patients.

Batch 4, which included the second set of IRF claims, was provided to Methodist on February 3, 2026. Methodist responded to the OIG on February 11, 2026. Methodist agreed with OIG's finding that 10 of the IRF Patient Assessment Instrument ("IRF-PAI") discharge assessments were completed late. However, Methodist disagreed that this fact created a payment error, since the timeframe in question was *at the height of the COVID-19 pandemic* and that all other regulatory requirements for payment had been met. Methodist also confirmed to the OIG that it already implemented the appropriate actions to ensure compliance with timely documentation requirements.

On April 29, 2026, OIG provided Methodist with its draft audit report. OIG maintained its position that there were two inpatient Two-Midnight errors, ten IRF-PAI errors and 12 IRF medical necessity errors.[2] OIG also asserted that all 20 IRF claims did not meet the requirement

[2] As pointed out in OIG's report, the number of claims with errors totals more than 20 because some claims were found to have both a medical necessity error and an IRF-PAI error.

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that the plan of care be individualized, although this did not impact payment of the claims. Methodist strongly disagrees with the medical necessity and plan of care conclusions, as well as the process by which OIG audited these claims, and continues to disagree with the OIG's extrapolation decision.

III. The Medicare Contractor Failed to Properly Reopen the Claims Identified in the Draft Report

A. Claim Reopening and Claim Recovery

Over the years, Congress and CMS have developed a detailed legal framework pursuant to which CMS, through its Medicare contractors, may (1) reopen and revise a claim that has been subject to an "initial determination" (e.g., a claim that the contractor has previously adjudicated and paid), and (2) thereafter recover any amount determined to have been overpaid in the course of the reopening and revision process.

Even if the claims at issue were properly "reopened" by the December 13, 2023 letter from Novitas, which Methodist does not concede, the question of whether the Medicare contractor can lawfully recover the alleged overpayments is an entirely separate one, governed by Section 1870 of the Social Security Act ("SSA") and its implementing regulations. As set forth below, Methodist contends that (1) Novitas did not properly reopen the claims at issue, and (2) Section 1870 bars recovery of alleged overpayments for CY 2020 claims because Methodist is presumed to be "without fault" as a matter of federal law, and no evidence has been—or could be—produced to rebut that presumption.

B. Claim Reopening: Novitas's December 13, 2023, Letter Was Not a Valid Reopening of the Claims at Issue

Methodist received an unsigned and undated letter on or about December 13, 2023, which Novitas apparently intended to serve as a notice of "reopening" of the claims at issue ("Novitas Letter" or "Letter"). Methodist disagrees that this Letter was an effective "reopening" for two (2) reasons.

First, as noted above, the Novitas Letter was *unsigned and undated* and seems, at best, to be a draft of some form of notice. Moreover, the Letter lacks any assertion or preservation of any rights to "reopen" claims. Instead, Novitas indicates that it "will reopen" claims, not that

it is reopening the claims. Saying that Novitas "will reopen ..." signals only prospective intent. Under § 405.980, a reopening is an action "taken to change" a binding determination; under § 405.982, the notice obligation attaches when the determination is "reopened and revised," not when a contractor contemplates reopening. A future-tense, non-specific letter therefore cannot be found to be a timely "reopening."

Given that, the claims at issue were not reopened properly and are beyond the reopening rules even if, for the sake of argument, there was arguably "good cause" that allowed Novitas to reopen claims within four years of payment. 42 C.F.R. § 405.980(b)(2).

Second, even if the Novitas Letter is deemed an official "reopening" of the claims at issue, Novitas has no basis for arguing "good cause" to extend its reopening deadline from one-year from the date of the initial determination (e.g., payment) to four years from the date of the initial determination.

The Novitas Letter makes only a vague reference to asserting that it is authorized to reopen claims for "good cause." Not only does Novitas not provide the factual bases upon which such a claim could be made, the facts themselves do not exist to allow Novitas to claim "good cause."

The full (and accurate) regulatory citation for reopening timeframes is found at 42 C.F.R. § 405.980(b).

Time frames and requirements for reopening initial determinations and redeterminations initiated by a contractor. A contractor may reopen an initial determination or redetermination on its own motion –

(1) Within 1 year from the date of the initial determination or redetermination for any reason.

(2) Within 4 years from the date of the initial determination or redetermination for good cause as defined in § 405.986.

The universe of claims at issue in the OIG Audit span from January 1, 2020 to December 31, 2021. Under 42 C.F.R. § 405.908(b)(1), (reopening one-year from the date of payment) Novitas could have reopened the claims from January 1, 2021 until December 31, 2022, depending on the date of payment at issue – but Novitas *did not meet this deadline*.

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Further, with regard to Novitas' vague reference to "good cause," there are only certain things that support a finding of "good cause," and the mere existence of an OIG audit is not one of them. Specifically, Section 405.986 of the same regulations defines "good cause."

> (a) **Establishing good cause for reopening**. Good cause may be established when—
>
> (1) There is new and material evidence that—
>
> (i) Was not available or known at the time of the determination or decision; and
>
> (ii) May result in a different conclusion; or
>
> (2) The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.
>
> (b) A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, or a change in legal interpretation or policy by SSA in a regulation, SSA ruling, or SSA general instruction in entitlement appeals, whether made in response to judicial precedent or otherwise, is not a basis for reopening a determination or hearing decision under this section. This provision does not preclude contractors from conducting reopenings to effectuate coverage decisions issued under the authority granted by section 1869(f) of the Act.
>
> (c) A request to reopen a claim based upon a third party payer's error in making a primary payment determination when Medicare processed the claim in accordance with the information in its system of records or on the claim form does not constitute good cause for reopening.

In sum, there simply are *no facts* to support the regulatory requirement of "good cause."

There is not new or material evidence that was unknown at the time of the initial determination – the evidence is the same that was available to Novitas at the time of its initial determination. Further, the evidence does not clearly show on its face that an obvious error

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was made by Novitas at the time of the decision. Novitas has made no assertion of material evidence or obvious error in its Letter.

There has been no change of legal interpretation or policy by regulation, ruling, or general instruction by either CMS or the Social Security Administration. Finally, the OIG is not the third party as mentioned in subsection (c) because the OIG is not making a primary payment determination.

Therefore, all of the claims at issue are beyond the one-year reopening timeframe, which is the only one at issue here. Novitas's vague and unenforceable attempt at reopening claims as part of this audit is not proper, as they have failed to cite any proper authority to do so and the authority cited explicitly prohibits Novitas from doing what it seeks to do.

Even if one were to agree that Novitas has good cause, it still is outside the clear timeframe of four years. There is no tolling of this timeframe mentioned in any of the regulations, by virtue of being subject to an OIG Audit or otherwise. It has been more than four years since the initial determination of every claim subject to the OIG Audit. The original request for the OIG Audit was dated November 2022. It has almost been four years since the audit began, which was a full year after the universe of claims closed. There is no exception in any relevant statute or regulation granting good cause for reopening a claim after four years.

IV. The Medicare Contractor Cannot Lawfully Recover Alleged Overpayments for CY 2020 Claims

Even if the claims at issue were properly reopened, which Methodist does not concede, Novitas has no authority to recoup overpayments related to claims that were paid during CY 2020, as discussed in more detail below.

A. The Statutory Presumption That a Provider Is "Without Fault"

Section 1870(b) of the SSA provides that neither CMS nor its Medicare contractors may recover payments from a provider that is "without fault" with respect to those payments.[3]

[3] SSA § 1870(b); Medicare Financial Management Manual ("MFMM") Pub. 100-06, Ch. 3, § 70.3.A.

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Thus, even if a claim has been properly reopened, the Medicare contractor cannot lawfully recover any alleged overpayment unless the provider is shown not to be "without fault."[4]

In the interests of administrative and financial finality, Section 1870(b) establishes a statutory presumption that a provider is "without fault" after the passage of a designated period of time—specifically, five calendar years following the year of initial payment.[5] This presumption is rebuttable, but only if the Medicare contractor can produce "evidence to the contrary"—that is, evidence that the provider was not without fault with respect to the payment at issue.[6] In the absence of such evidence, the presumption is dispositive and bars recovery.

1. **Application of the "Without Fault" Presumption to Methodist's CY 2020 Claims**

The claims at issue include claims for services rendered and paid for during CY 2020. Under Section 1870(b), the five-calendar-year period runs from the year of initial payment—meaning that for claims paid in CY 2020, the presumption that Methodist is "without fault" takes effect beginning in the fifth year after 2020, which is CY 2025.[7]

OIG will issue its final report likely in June 2026. Thereafter, the MAC will issue a demand letter seeking recovery of the alleged overpayments—a process that customarily occurs 30 to 60 days following publication of the final report. Any such demand for recoupment of CY 2020 claims will therefore occur no earlier than July 2026—well into the sixth year after the year in which those claims were paid.

Because the MAC will not issue its demand for recovery until 2026 at the earliest—the sixth calendar year after the year of payment—Methodist is presumed as a matter of federal law to be "without fault" with respect to all CY 2020 claims. The MAC cannot lawfully recover these claims absent evidence sufficient to rebut that statutory presumption.

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[4] *See* MFMM, Ch. 3, § 80.
[5] *See* SSA § 1870(b), which originally called for the without fault presumption to attach after the third calendar year following the year of payment. On January 2, 2013, SSA § 1870(b) was amended to extend the recovery period by two additional years. *See* P.L. 112-240, § 638 (Jan. 2, 2013). *See also* 42 C.F.R. § 405.350(c).
[6] MFMM, Chapter 3, § 80.
[7] *See* MFMM, Ch. 3, § 80.1.

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2. No Evidence Exists to Rebut the Presumption

Once the statutory presumption attaches, the Medicare contractor must produce affirmative evidence that the provider was not "without fault." A mere conclusory assertion that the provider "should have known" it was not entitled to payment or a contractor's "mere say so" is insufficient to overcome the presumption.

Under established CMS guidance, a provider is considered "without fault" if it made full disclosure of all material facts when presenting its claim for payment and had a reasonable basis for assuming that the claim and payment was correct.[8] Here, no party has alleged—nor could any party credibly allege—that Methodist withheld material facts when submitting its claims. Methodist submitted the CY 2020 claims at issue in good faith, based on the clinical judgments of its treating physicians and its reasonable understanding of applicable billing requirements.

OIG's identification of documentation deficiencies in the course of an audit does not, standing alone, constitute evidence that the provider was "at fault" at the time of billing. The MFMM provides that a "pattern of billing errors" may serve as evidence of fault,[9] but no such pattern has been identified here. The findings in the draft report reflect the type of individualized clinical and documentation determinations that are inherently complex—not a systemic failure or pattern of improper billing that would suggest fault on the part of the provider.

In fact, the OIG report states, " MACs typically waive recovery in accordance with this presumption but have the authority to determine whether there is sufficient evidence to rebut the presumption." As there is not evidence to rebut the presumption, claims from CY 2020 must not be recouped.

B. CY 2020 Claims Should Be Excluded from the Extrapolation

Because the CY 2020 claims cannot be lawfully recovered under Section 1870(b), they should be excluded from any extrapolation calculation. An extrapolated overpayment is only as valid as the universe of claims from which it is derived. Claims that are not subject to lawful

[8] MFMM, Ch. 3, § 90.
[9] *See* MFMM, Ch. 3, § 80.

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recovery cannot form the basis of—or be included within—an extrapolated demand. To include non-recoverable claims within the extrapolation universe would permit the government to accomplish indirectly what it cannot accomplish directly: the recovery of payments that Section 1870(b) expressly protects.

Accordingly, while Methodist does not concede that extrapolation is permitted for this audit, should the OIG employ extrapolation, we respectfully submit that all CY 2020 claims must be carved out of OIG's extrapolated overpayment calculation.

V. OIG's Audit Unfairly Targets a Time Period Impacted by the COVID-19 PHE

Fundamentally, Methodist is deeply concerned with OIG sampling during a period when the COVID-19 pandemic was significantly and detrimentally impacting all healthcare operations. On March 13, 2020, President Trump declared a National State of Emergency. This State of Emergency was in effect from March 1, 2020 until May 13, 2023. In recognition of the unprecedented pressure the pandemic put on healthcare providers, CMS enabled regulatory flexibilities, many designed to ensure the rapid provision of services to patients impacted by COVID-19. CMS provided these flexibilities to ensure that providers could "focus on patient care in the most flexible and innovative ways possible."[10] It is both illogical and unfair to audit providers during this period and to seek extrapolated repayments for care provided during this period, when the need for flexibility with coverage requirements was fully recognized and addressed by CMS.

VI. OIG's Audit of IRF Services Is Flawed and Should Be Performed Again

OIG's reviewer demonstrates a concerning lack of understanding of the long-standing and respected specialty of rehabilitation medicine, and the OIG report should be withdrawn on that basis alone. There must be a more appropriate level of deference provided in the Medicare Coverage regulations to the admission decisions of treating physicians and their documentation. Doing otherwise will force Methodist into a likely years-long appeals process and expose the hospital and its IRF personnel to unfair and unwarranted public scrutiny.

[10] CMS, *Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge* (March 30, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-u-s-healthcare-system-address-covid-19.

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A. OIG's Audit of Methodist Shares Concerning Similarities with OIG's Flawed Nationwide IRF Audit

On May 14, 2026, OIG released a report entitled, "Unclear Medicare Requirements Led to Differing Interpretations of Inpatient Rehabilitation Facility Documentation, Coverage, and Billing Requirements."[11] The report detailed OIG's findings from a nationwide audit of 200 Medicare claims from the 2022 federal fiscal year ("FFY") for compliance with Medicare coverage requirements. OIG permitted various stakeholders, including the American Medical Rehabilitation Providers Association ("AMRPA"), the American Academy of Physical Medicine and Rehabilitation ("AAPM&R"), and the Federation of American Hospitals ("FAH"), to provide data and feedback throughout the audit, in part due to concerns with a 2018 nationwide audit that returned a high error rate inconsistent with other audits.

In an appendix to the 2026 OIG report, AMRPA, AAPM&R, and FAH highlighted key themes that led to improper denial of Medicare claims. The stakeholders selected and discussed with OIG 19 cases that shared common denial themes, and the Centers for Medicare and Medicaid Services ("CMS") ultimately agreed that Medicare coverage criterion actually was met for 14 of the 19 cases. In its response to the report, also included as an appendix, CMS stated that, "CMS believes that the OIG's findings and perceived risks may be overstated."[12] In other words, both the industry stakeholders and CMS agreed that OIG's reading of the Medicare coverage requirements was incorrect, creating serious concerns that OIG was improperly interpreting the coverage criteria to deny claims.

We are deeply concerned that many of the same inappropriate reasons for denial identified by the stakeholders and CMS also are present in the OIG report related to Methodist. As an example, the primary reason OIG denied IRF claims was because it determined that the patient at issue did not need a *rehabilitation* physician. In the national OIG audit, IRF stakeholders determined that a lack of understanding of rehabilitation medicine led to erroneous conclusions by the OIG about the need for rehabilitation physicians.[13] They found that OIG treated rehabilitation physicians like general practitioners or hospitalists practicing in an IRF, failing to recognize the distinct and specialized training and experience rehabilitation

[11] OIG, U.S. Dep't of Health & Hum. Servs., Unclear Medicare Requirements Led to Differing Interpretations of Inpatient Rehabilitation Facility Documentation, Coverage, and Billing Requirements, No. A-04-23-08096 (2026).
[12] *Id.* at Appendix E.
[13] *See id.* at Appendix F.

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physicians have to treat patients recovering from disabling injuries or illnesses. They also found that a lack of appropriate physician deference and of practical knowledge by the reviewers led to incorrect conclusions by OIG about the need for patient supervision by a physician trained and experienced in rehabilitation. As evidenced in the discussion below, these same problems pervade the OIG's review of Methodist's claims.

Given the common themes and lack of confidence in the OIG's conclusions when compared to both industry stakeholder and CMS interpretations of the IRF coverage requirements, we believe it is inappropriate to extrapolate Methodist's claims. Indeed, in the national OIG report, OIG declined to extrapolate its findings beyond the sampled claims themselves.

B. Methodist Complied with Medicare IRF Coverage Criteria

Methodist has complied with the IRF coverage criteria established by CMS. Methodist requires its providers to complete a comprehensive preadmission and (during the time period at issue) post-admission screening process to ensure that all admitted patients meet CMS coverage requirements for an IRF admission. Each patient admitted to Methodist is reasonably expected to require and participate in an intensive rehabilitation therapy program under the supervision of a rehabilitation physician.

For Medicare to cover an IRF admission, a patient must need an interdisciplinary approach to care and be stable enough at admission to participate in intensive rehabilitation. There must be a "reasonable expectation" that the patient will need multidisciplinary therapy, intensive rehabilitation, and supervision by a rehabilitation physician.[14] The interdisciplinary approach to care is demonstrated by weekly meetings of the rehabilitation team, led by the rehabilitation physician.[15] The requirement for multidisciplinary therapy must include physical or occupational therapy.[16] Intensive rehabilitation is defined as three hours per day, five days per week (or 15 hours per week).[17] The therapy must be reasonably likely to result in measurable, practical improvement to the patient's functional capacity or adaptation to

[14] 42 C.F.R. § 412.622(a)(3), (5).
[15] *Id.* § 412.622(a)(5).
[16] *Id.* § 412.622(a)(3)(i).
[17] *Id.* § 412.622(a)(3)(ii).

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impairments.[18] The rehabilitation physician must see the patient at least three times per week.[19]

Methodist employs a comprehensive preadmission screening process to ensure that all IRF admissions meet Medicare coverage requirements. Methodist complies with the federal regulation requiring that, at the time of admission, there is a reasonable expectation that the patient meets all of the following:

> (1) The patient requires the active and ongoing intervention of multiple therapies, including physical or occupational therapy;
> (2) The patient is sufficiently stable and able to participate actively in and benefit from in an intensive rehabilitation therapy program; and
> (3) The patient requires supervision by a rehabilitation physician to assess the patient medically and functionally and to modify the course of treatment to maximize the patient's capacity to benefit from the rehabilitation process.[20]

Within the 48 hours immediately preceding a patient's admission to the IRF, a qualified medical professional at Methodist conducts a preadmission screening assessment to evaluate the patient's ability to tolerate an intensive rehabilitation program and to determine if the expected functional gains warrant IRF care. Following the assessment, a physician who is Board-certified in physical medicine and rehabilitation reviews and approves the assessment and the patient's admission to the IRF.

This thorough preadmission process results in Methodist admitting, on average, only 50% of patients referred for potential admission. These numbers are significant and demonstrate strong compliance with Medicare IRF admission requirements, with nearly half of all referrals made to Methodist's IRF rejected under the preadmission screening process. These figures help demonstrate that Methodist's safeguards ensure that only appropriate patients are admitted to the IRF.

During the time period of the audit, Methodist also complied with post-admission documentation requirements. While no longer required, during the dates in question, the rehabilitation physician was required to conduct a Post-Admission Physician Evaluation

[18] *Id.*
[19] *Id.* § 412.622(a)(3)(iv).
[20] 42 C.F.R. § 412.622(a)(3).

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("PAPE"). Following admission, the patient was formally assessed by the rehabilitation physician to confirm the patient's ability to participate in an intensive rehabilitation therapy program of at least three hours per day, five days per week. The rehabilitation physician also reviewed the patient's need for multiple therapy disciplines and assessed the patient's functional status and capacity to benefit from IRF care.

Methodist's compliance with all Medicare documentation requirements was confirmed by the fact that OIG found *no errors pertaining to the documentation requirements* that would render a claim non-payable. OIG did allude to possible errors related to the individualization of the plan of care, but did not deem the impacted claims as incorrectly paid on that basis. As discussed in depth in this response, Methodist disagrees that the plans of care at issue in the audit were not sufficient to satisfy the regulatory coverage requirements and asserts that all plans of care were appropriately individualized to each patient, including by documenting each patient's need for intensive therapy, each patient's ability to participate, and adequate physician oversight. Methodist takes all documentation requirements very seriously, both to ensure compliance with its Medicare obligations and to ensure the patient's medical and functional needs are appropriately addressed and adjusted by all members of the care team, as needed, throughout the patient's IRF stay. Methodist's ability to ensure that the documentation required under federal regulation was accurately and timely completed, even in the midst of a Public Health Emergency, stands as a testament to the quality of its patient care and internal quality and compliance controls.

Methodist rehabilitation practitioners regularly assess whether patients continue to require active and ongoing therapeutic intervention from multiple therapy disciplines, including physical or occupational therapy. Its staff members review patient medical records to confirm that an individualized overall plan of care is completed within four days of admission; the rehabilitation physician is conducting face-to-face visits at least three times per week; the patients are receiving the required minutes of therapy per week; and interdisciplinary team conferences are held weekly.

Post-admission, Methodist's rehabilitation physicians work closely with nursing and therapy staff to ensure that each patient's medical and functional needs are addressed. They provide medical supervision and management, coordinate care, consult with specialists, and use diagnostically-appropriate tests to keep patients stable enough to participate in intense therapy services. This medical management enables patients to progress and regain functional abilities, as demonstrated by Functional Independence Measure ("FIM") score gains, and ultimately to be discharged home or to a home-like setting.

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C. OIG's Denials Are in Error and Should Be Reversed

OIG's reviewer determined that 16 IRF claims did not comply with Medicare billing requirements. Of the 16 claims, the OIG found that 12 did not meet medical necessity requirements and that 10 did not meet IRF-PAI discharge assessment requirements. Methodist disagrees and strongly maintains that Medicare criteria were met for all of these claims. Methodist stands by the IRF admissions as appropriate, as does a third-party independent medical reviewer who reviewed the claims at Methodist's request. *See* Appendix A.[21] Methodist's independent, Board-certified physical medicine and rehabilitation physician fully supports Methodist's decision to oppose OIG's IRF findings and appeal any unfavorable determinations.

The OIG's contracted reviewer denied the 16 IRF claims for two reasons[22]:

(1) The patient did not need the oversight of a rehabilitation physician; and/or
(2) IRF-PAI discharge assessment submission timeline was not met.[23]

1. The Patient Did Not Need the Oversight of a Rehabilitation Physician

OIG's reviewer clearly misunderstood the role of a rehabilitation physician in managing IRF patients. In an example highlighted in the OIG's draft audit report, OIG states that "a non-rehabilitation physician *could have* overseen the patient's recovery and monitoring."[24] This is not the proper standard and goes above and beyond what the regulations require. The regulations require a "*reasonable expectation*" that the patient required supervision by a rehabilitation physician at the time of admission "to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's

[21] Appendix A contains summaries of the 12 patient records alleged to fail coverage criteria due to there being no need for the patient to be under the supervision of a rehabilitation physician. Since it likely contains protected health information ("PHI"), it should be omitted from the published version of the final report.
[22] In a section titled "Other Matters," the OIG asserts that all 20 selected IRF claims were not individualized. While it does not appear that this is reported as a formal error, we disagree with this conclusion and dispute it below, along with two explicit reasons given by OIG for claim denial.
[23] The draft OIG report states that "although IRF-PAI requirements are not a condition of payment, we counted these claims as errors for compliance purposes; however, the amounts remain allowable." Because the OIG still identified these claims as errors, we address them here.
[24] Draft report at 7 (emphasis added).

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capacity to benefit from the rehabilitation process."[25] In each of the 12 cases flagged by OIG on this basis, there was a reasonable expectation at the time of admission that the patient required the expertise of a rehabilitation physician.[26]

Rehabilitation physicians are not merely hospitalists practicing in an IRF setting. Rehabilitation medicine is a distinct medical specialty, and rehabilitation physicians are Board-certified to practice this specialty. This distinct area of practice gives rehabilitation physicians the unique ability to identify, address, and manage a patient's medical and rehabilitation needs. The rehabilitation physician has unique expertise to manage a patient's complex conditions and to direct and lead the patient's care *via* an interdisciplinary rehabilitation care team.

Rehabilitation physicians are intimately familiar with the complications that can arise for patients recovering from surgery, illness, injury, and disability and have specialized training and experience to both prevent complications and manage them when they arise. For all of the cases identified by the OIG, as is evident in the examples below, it was reasonable to conclude, upon the patient's preadmission screening and at the time of admission, that the expertise of a rehabilitation physician would be necessary to manage the patient's care.

Patient Sample 5: The patient in Sample 5 was an elderly man admitted to acute care after a fall caused a hip fracture. He was on a blood thinner at the time of the fall, increasing his bleeding risk. He underwent surgery, where an intramedullary nail was placed to stabilize the hip fracture. Following the surgery, he was 50 percent weight bearing. His acute care course was complicated by blood loss anemia that required a transfusion and consultation with hematology. He also had an acute kidney injury that required consultation by nephrology. Both delirium and bleeding risk required close medical management. He had a past medical history of hypertension, coronary artery disease and a coronary artery bypass graft surgery, prostate cancer, stroke, and chronic heart failure. Prior to his hospitalization, the patient lived at home with his wife. He was independent for both mobility and self-care and did not require assistive devices.

When screened for admission to the IRF, the patient required total assistance (100%) for bathing, upper and lower body dressing, functional transfers, stairs, and ambulation. The

[25] 42 C.F.R. § 412.622(a)(3)(iv).
[26] *Id.*

patient required total assistance (100%) for supine to sitting and maximal assistance (75%) for sitting to standing. At the time of admission, the patient was assessed to be dependent for bathing, upper and lower body dressing, and gait. With these functional deficits, it was unsafe for the patient to ambulate due to poor standing tolerance and stability.

During his IRF stay, the patient required rehabilitation physician oversight and management to track the effect of his anemia on his general medical and functional status, ensure compliance with weight bearing precautions, facilitate pain management and medication simplification, monitor his high blood clot risk, and manage ongoing delirium. The rehabilitation physician also treated his pneumonia with medication. The patient made slow and steady progress throughout his rehabilitation stay. At discharge, the patient required contact guard assistance with bed mobility, supervision with upper body dressing, moderate assistance with lower body dressing and toileting, and minimal assistance with ambulating 30 feet.

OIG's reviewer concluded that the patient did not require the supervision of a rehabilitation physician. The reviewer reasoned that the patient's conditions were not complex enough to require a rehabilitation physician, that the patient's monitoring could have been supervised by a non-rehabilitation physician, and that the patient did not require rehabilitation physician care for "complex wound care, tube feeding, tracheostomy management or management of neurogenic bowel or bladder."

Contrary to the reviewer's findings, this patient had a complex medical history and ongoing complications that required management by a rehabilitation physician. Particular conditions are not required for IRF admission, and the reviewer's listing of specific medical conditions that the patient did not have suggests use of an improper "rule of thumb." The patient's complex comorbidities, including blood clot risk, bleeding risk, delirium, and pain, all required the close medical supervision of a rehabilitation physician, especially while the patient participated in an inpatient rehabilitation hospital's intensive therapy programs. Monitoring these complexities while addressing the patient's high-risk weight bearing needs as he participated in intensive rehabilitation therapy is a classic illustration of an IRF patient in need of the expertise of a rehabilitation physician.

Patient Sample 11: OIG's findings in Sample 11 were equally erroneous. The patient was a very elderly woman who sustained a left hip fracture after falling, which required surgery

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and cephalomedullary nailing. She experienced complications during her acute care hospital stay, including acute kidney injury and blood loss anemia that required a transfusion.

The patient's past medical history included major depressive disorder, hyperlipidemia, hypertension, pneumonia, chronic obstructive pulmonary disease, chronic kidney disease, and congestive heart failure. She was oxygen dependent at home and lived in an assisted living facility. Prior to her fall, she was modified independent for walking with a front-wheeled walker and was otherwise independent with mobility tasks.

At the time of the preadmission screening, the patient was markedly more disabled than her baseline. She was dependent for bathing, lower body dressing, and stairs; required moderate assistance for upper body dressing, level transfers, and gait; and required maximum assistance for toilet transfers. She required the expertise of a rehabilitation physician to prevent consequences of immobility such as blood clots, ensure therapy tolerance, and direct modification of her therapy schedule as necessary, manage pain control to allow successful therapy participation, and evaluate her mood and mental health as a potential impediment to her rehabilitation progress.

During her IRF stay, she did indeed require significant interventions by the rehabilitation physician. The rehabilitation physician prescribed medication for pain management and sleep needs and adjusted her rehabilitation therapy plan as her worsening pulmonary status impacted her therapy tolerance. During her stay, she was consulted by pulmonary and renal specialists. She also was evaluated by psychology due to major depressive disorder and low mood. She received a blood transfusion and intravenous antibiotics while at the IRF. After worsening white blood cell counts, fatigue, and fluid status was observed, she was re-hospitalized in inpatient acute care.

The OIG reviewer concluded that the patient did not require the supervision of a rehabilitation physician. The reviewer stated that the patient's "conditions and care were not complex enough to require a rehabilitation physician for the oversight of an interdisciplinary approach to rehabilitation care." The reviewer stated that the patient could have been overseen by a non-rehabilitation physician and (again) noted that the patient did not require interventions such as "complex wound care, tube feeding, management of neurogenic bowel or bladder, or tracheostomy management."

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The OIG's conclusion that the patient was not complex enough to require a rehabilitation physician is both unfounded and not the standard prescribed by the coverage regulations. First, there is no standard for IRF admission that requires a patient's nursing and rehabilitation needs to be sufficiently "complex." Rather, the standard is that the patient requires medical supervision by a rehabilitation physician to assess the patient both medically and functionally and modify the course of treatment as needed.[27] This individual had complex needs based on the interplay between her mental and physical conditions that required the specialized training and experience of a rehabilitation physician. In practice, rehabilitation physician intervention throughout the patient's stay was crucial as her ailments worsened, and eventually led to her requiring a higher, not lower, level of care.

Conclusions from Review of Patient Samples 5 and 11: Methodist's review of the records—as corroborated by the third-party reviewer—creates very serious concerns about the contracted reviewer's qualifications, understanding of rehabilitation diagnoses, and basic knowledge of the role of a rehabilitation physician in an IRF. Throughout the audit, the reviewer made statements indicating that the patient must be sufficiently complex or require certain interventions to justify admission to an IRF. The reviewer also consistently considered whether a "non-rehabilitation physician could have" provided this care, rather than assessing whether it was reasonable to conclude that a rehabilitation physician's supervision was necessary to assess the patient both medically and functionally and modify the course of treatment as needed. Reliance on more stringent standards not reflected in the regulatory text to deny claims is extremely concerning and flatly incorrect.

2. IRF-PAI Discharge Assessment Requirements Were Not Satisfied

The draft report states that the OIG found ten errors where IRF-PAI discharge assessment requirements were not met. The OIG states that while these were counted as errors, they are not conditions of payment, and the amounts remain allowable.

Methodist appreciates OIG's recognition that the IRF-PAI discharge assessment errors are not conditions of payment. We acknowledge the OIG's finding that the discharge assessments for ten claims were completed late; however we emphasize that IRF-PAI deficiencies have no impact on patient care or payment status of the claim. Moreover, the

[27] *Id.*

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standards and requirements surrounding completion and submission of the IRF-PAI are complex, vague, and (at times) inconsistent.

It is noteworthy that this issue was raised in the stakeholders' response to the OIG's nationwide IRF audit report. Given the relative pervasiveness of this issue, we believe that a single IRF should not be penalized when the entire field and CMS are grappling with this issue. Rather, there is an industry-wide disconnect between OIG's interpretation and expectations surrounding the IRF-PAI and the understanding maintained not only by IRFs but also by CMS itself. Indeed, CMS has proposed to revise certain IRF-PAI timeframes in the annual IRF Prospective Payment System proposed rule that currently is out for public comment.

Also, as the review timeframe was during the COVID-19 PHE, immediate patient care needs were primary to administrative assessments such as completion of the IRF PAI/Discharge Assessment.

3. The Plan of Care Was Not Individualized

In a section titled, "Other Matters," OIG asserts that, for all 20 of the selected IRF claims, the plan of care was not individualized. While it does not appear that OIG counted these findings as errors for purposes of determining the overpayment amount due (or the extrapolated overpayment calculated therefrom), Methodist disagrees with OIG's conclusion that the plans of care for the 20 selected claims were not individualized. Methodist is concerned with OIG's inconsistency in characterizing the plans of care as deficient, while also admitting that "CMS regulations do not explain what 'individualized' means or define what should be documented."[28] OIG's conclusion that the CMS regulation lacks clarity should not be held against the provider, even in an inconclusive "Other Matters" section of its report. Indeed, flexibility in how a care plan is structured can give providers greater opportunity to tailor the care plan development process to the particular needs of the IRF, its providers, and its patients.

As detailed in the examples below, further review of the care plans in question shows clear individualization. OIG appears to equate the use of a template in care planning with a lack of individualization. This is patently false. Templates can be used as a helpful tool to aid providers in organizing information. Particularly in the age of electronic medical records,

[28] Draft Report at 13.

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templates can assist providers in quickly finding, analyzing, and conveying relevant patient information in a comprehensive manner. Again, this is an issue that overlaps significantly with OIG's findings in its nationwide IRF audit report. In that report, deficiencies tied to a failure to adequately individualize the plans of care for patients resulted in a finding that more than 40 percent of the sampled IRF claims had plans of care that were not sufficiently individualized. However, in its response, CMS again disagreed with OIG's determination and OIG itself acknowledged that there is nothing in the regulations that defines what the term "individualized overall plan of care" even means.

Additionally, Methodist takes issue with OIG's statement that a "lack of clarity in the regulations may lead to increased risks that an enrollee's specific needs are not adequately addressed."[29] We strongly disagree with this conclusion and its unfounded implications about the quality of care rendered by Methodist. OIG found absolutely no indication that there were deficiencies by Methodist in meeting patient care needs. Indeed, OIG found no errors on questions related to the quality of care rendered by Methodist with respect to any IRF claim included in the sample. There is an entire system of quality reporting through the IRF-PAI and, other than the timeliness of submission of some of the IRF-PAI data elements, OIG rendered no findings or conclusions on the quality of care Methodist provided to its patients.

Patient Sample 3: OIG concluded that Sample 3's plan of care was not individualized. Specifically, the OIG reviewer stated that "The patient's specific assessments, planned interventions, and level of function for PT, ST, and OT were not provided." These specific elements that the OIG reviewer was looking for go above and beyond what the regulations require.[30] As noted above, OIG itself states that the regulations do not detail what should be specifically documented to show care plan individualization.

Contrary to OIG's finding, the patient's care plan does show significant individualization. The patient's function, impairment group, and comorbidities are all individualized and unique to the patient. The plan of care states that the patient had a right-sided body stroke and lists comorbidities such as diabetes, hypertension, and chronic atrial fibrillation. The plan of care lists anticipated services including physical therapy, occupational therapy, and speech therapy, and provides anticipated functional outcomes as "independent."

[29] Draft Report at 13.
[30] *See* 42 C.F.R. § 412.622(a)(4)(ii)

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It appears that the reviewer was biased against the use of templates to aid in care plan development, which simply places information in a consistent table form for all patients. The reviewer also ignores the fact that, given the detailed coverage criteria for IRF admission, a certain amount of similarity across patient conditions and needs can reasonably be expected. Despite the fact that the structure of Methodist's charts is the same across patients, the content of each table is individualized and tailored to the care needs of each patient. To further support this, the rehabilitation physician notes indicate that the plan of care was developed in conjunction with the therapy team.

Patient Sample 14: OIG concluded that the plan of care for Sample 14 was not individualized. OIG again provided the same reasoning as for Sample 3, stating that, "The patient's specific assessments, planned interventions, and level of function for PT, ST, and OT were not provided." As stated above, the information the OIG reviewer references is not necessary to show individualization.

Similar to Sample 3, the plan of care in Sample 14 demonstrates clear individualization. It lists the patient's impairment group as nontraumatic spinal cord injury and his diagnosis as cervical myelopathy. It provides that the patient has a history of a below-knee amputation. The plan of care lists the anticipated interventions as physical therapy and occupational therapy. The patient's functional outcomes are presented in table form but, as with Sample 3, they are unique to the patient. The patient's functional outcomes range from independent, to supervision or touching assistance, to setup or clean up assistance depending on the activity, demonstrating a high level of attunement to the patient's specific functional goals.

Conclusions from Review of Patient Samples 3 and 14: While Methodist relies on a templated, consistent format for all of its patients, this does not mean that the patients' plans of care are not individualized. Instead, established formatting aids in thoroughness and consistency. It is evident that Patient Samples 3 and 14 are individualized simply by comparison to one another—they have differing diagnoses, therapy needs, and expected functional outcomes, all of which are noted as appropriate on the plan of care documentation. Such differences would be impossible to demonstrate if the patients' plans of care were truly not individualized.

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VII. OIG's Assessment of Acute Inpatient Admissions

A. Diagnosis and Procedure Codes Not Supported; Outlier Payment Not Supported; Discharge Status Code Not Supported

The Inpatient Billing Errors related to Diagnosis and Procedure Codes Not Supported, Outlier Payment Not Supported, and Discharge Status Code Not Supported were all identified, disclosed and refunded as part of the self-review required as a part of this audit.

B. Hospital Care for Two-Midnights Not Supported

OIG found that two (2) of 60 inpatient claims did not support that the admitting physician, at the time the inpatient order was written, had a reasonable expectation that the patients would require hospital services across two or more midnights. Methodist respectfully disagrees.

CMS's regulations defining an appropriate inpatient admission provide that the physician's expectation "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 C.F.R. § 412.3(d)(1).

These records were carefully reviewed by Methodist in the evaluation of hospital care, supported by physician inpatient orders, physician expectations for two or more midnights, and clinical documentation.[31] This review supported the initial determinations made by the admitting physician. Specifically, Methodist found support in the medical records for both cases affirming the original clinical decision that there was a reasonable expectation that each of the beneficiaries would require hospital care spanning at least two midnights and, thus, they were appropriate patients to admit as inpatients. We respectfully request that the review results be corrected to reflect that these claims were correct as submitted.

Even in the event that OIG continues to allege that these two (2) claims were not supported as inpatient claims, then, at a minimum, a revised payment amount should be

[31] Methodist provided the relevant medical record and other documentation to the OIG as part of its initial response on or about January 27, 2026. As these documents are in the record, Methodist is not resubmitted documentation it previously submitted as part of this official process.

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noted to reflect proper payment for the medically necessary procedures performed as an Inpatient Part B Only, and this revision should also be taken into account if extrapolation is to be applied.

C. InterQual

OIG references that its medical reviewer applied InterQual®, a proprietary screening tool, to evaluate the acute inpatient PPS claims, and the two (2) claims at issue failed to meet the InterQual Level of Care Criteria. The Draft Report goes on to acknowledge that the failure to meet InterQual®, or MCG Inpatient & Surgical Care Guidelines, or any other proprietary system does not mean that the claims did not meet Medicare requirements. *See* Draft Report at 13. Indeed, CMS specifically addressed the use of screening tools in several Final Rules, including this very clear statement in 2015: "While Medicare review contractors may continue to use commercial screening tools to help evaluate the inpatient claims, admission decision for purposes of payment under Medicare Part A, such tools are not binding on the hospital, CMS, or its review contractors." 80 Fed. Reg. 70298, 70541-42 (Nov. 13, 2015). Given the OIG's concession that the claims that fail to meet a proprietary screening tool may nonetheless qualify as valid inpatient admissions for which CMS should provide payment, Methodist will not address this issue in substance. As the OIG concedes that InterQual® is not the mechanism that determines the appropriateness of an inpatient admission, Methodist objects to inclusion of this narrative in the Draft Report.

VIII. OIG's Assessment of Outpatient Claims

The Outpatient Billing Errors related to HCPCS Code Not Supported and Medical Necessity Not Supported were all identified, disclosed and refunded as part of the self-review required as a part of this audit.

IX. Methodist's Response to OIG's Recommendations

OIG's Draft Report makes three recommendations. First, OIG recommends that Methodist refund $13.4 million in "net overpayments for incorrectly billed claims," including both the actual payment error identified by review of the 100 claims in the sample and the estimated overpayment based on application of the error rate to the full universe of claims for the time period covered by the audit. Second, OIG recommends that Methodist consider conducting internal audits for claims outside of the audit period to identify similar overpayments. Third, OIG recommends that Methodist provide additional training to clinical and billing personnel on

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policies and procedures pertaining to the Two-Midnight Rule, IRF admissions and documentation requirements, and inpatient and outpatient coding. Methodist disagrees with the first two recommendations. However, Methodist is amenable to conducting education for its personnel related to the Two-Midnight Rule, IRF admission and documentation requirements, and inpatient and outpatient coding as training and education are never detrimental to the mission of providing high quality care and maintaining compliance with regulatory requirements. As education is an inherent component of Methodist's operations and compliance program, current and future education endeavors will continue to provide information related to the Two-Midnight Rule, IRF admission and documentation requirements, and inpatient and outpatient coding.

For the reasons discussed above, Methodist disputes that it is required to refund Medicare for overpayments of incorrectly billed claims that were not previously disclosed as part of the Methodist's self-review of these claims. All claims were billed in compliance with CMS requirements, and Methodist disagrees with OIG's conclusion that there were errors related to the Two-Midnight Rule and the need for a rehabilitation physician (or the IRF-PAI or plan of care) that warrant nonpayment. While Methodist concedes that some IRF-PAI compliance deadlines were not met, OIG in turn concedes that this requirement is not a condition of payment. This small infraction does not permit recoupment of any Medicare payments from Methodist.

Methodist also disagrees that it is necessary to conduct any additional auditing. Methodist routinely carries out auditing and compliance monitoring, especially with respect to the Two-Midnight Rule, IRF and coding. These audits will continue in the normal course of business for Methodist. Errors related to the IRF-PAI are isolated errors unlikely to be replicated in any systemic way. As stated above, the IRF-PAI requirements are not conditions of payment and do not reflect on the propriety of Methodist's Medicare payments. Methodist strongly asserts that OIG's adverse Two-Midnight Rule and IRF determinations are in error, and intends to appeal 100% of any denials.

Finally, Methodist maintains that its admission, coding, and billing practices, policies, and procedures fully comply with Medicare requirements. It has an especially strong process for assessing patients for admission to the IRF and complies with all documentation requirements for IRF services. Methodist will continue its regular review of its compliance practices, policies, and procedures and will update its education for staff as needed to address any identified systemic errors or changes in Medicare requirements.

X. Methodist's Requests and Recommendations

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Methodist HOSPITAL

A. OIG Should Re-Review the Denied Claims With Appropriate Deference to the Treating Physician

As demonstrated by the attached clinical summaries of each of the 12 IRF claims with a medical necessity-based denial and the previously provided medical records, Methodist appropriately admitted and treated the patients audited by OIG. Methodist urges OIG to re-review these claims using the proper 'reasonable expectation' standard, which gives appropriate deference to the rehabilitation physician who actually examined and treated the patients at issue. As CMS has acknowledged, the IRF coverage regulation places "more weight on the rehabilitation physician's decision to admit the patient to the IRF."[32] Under the IRF regulation, IRF physician documentation requirements are extensive and designed to ensure that the treating physician addresses all coverage requirements. This heightens the rehabilitation physician's role under the IRF regulations, and CMS itself has acknowledged that the treating physician is solely qualified to assess coverage.[33] This important distinction warrants at least some deference to the treating physician.

Given OIG's contracting processes and substantial similarities to the recent nationwide IRF audit, Methodist is also concerned that OIG may have used the same contracted reviewer for its audit of Methodist. The rehabilitation stakeholders involved with that audit expressed serious concerns that this reviewer significantly misapplied the coverage criteria to deny IRF claims. In fact, the IRF stakeholders' response to the OIG report evidence many of the same concerns Methodist expresses here, such as a lack of deference to the rehabilitation physician's expertise and an unduly narrow reading by the contractor of the Medicare regulations.[34] The IRF stakeholders involved in supplying data and feedback to OIG throughout the course of the nationwide audit identified multiple problems with the contractor's review, including:

- A lack of understanding of physician-led rehabilitation medicine;
- A "bright-line" approach to complex medical reviews;
- Lack of appropriate rehabilitation physician deference;

[32] Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010, 74 Fed. Reg. 39,762, 39,791 (Aug. 7, 2009) (final rule) [hereinafter "IRF Final Rule Fiscal Year 2010"].
[33] *Id.*
[34] OIG, U.S. Dep't of Health & Hum. Servs., Unclear Medicare Requirements Led to Differing Interpretations of Inpatient Rehabilitation Facility Documentation, Coverage, and Billing Requirements, No. A-04-23-08096 app. F (2026) ("2026 OIG Report"); *see also* OIG, U.S. Dep't of Health & Human Servs., No. A-01-15-00500, Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements (2018).

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- Lack of practical knowledge by contract reviewers; and
- Incongruity of the purpose of medical records to both treat the patient and for after-the-fact audit purposes.

With respect to the last problem identified, regarding the core purpose of medical records, we find OIG's choice of auditing period—in the middle of the COVID-19 Public Health Emergency—to be especially problematic. The years 2020 and 2021 were especially taxing and chaotic years for healthcare providers, and IRFs in particular were heavily impacted due to the expectation that they serve as overflow capacity for acute inpatient hospitals in addition to serving their usual patient load, which now included patients recovering from COVID infection. Expecting perfectly compliant documentation that exceeds the standards set forth in the regulations during this time period is unfair and seemingly punitive. Clinical staff were fully occupied during this time in providing complex and, at times, non-routine care to a full load of patients, along with taking additional infection control measures and grappling with provider burnout. While we appreciate that OIG did not attribute any overpayments to this alleged deficiency, we nonetheless find the inclusion of this "finding" in the report unnecessarily inflammatory, unfairly (and improperly) painting Methodist in a poor light.

B. OIG's Draft Audit Report Replicates Many of the Same Flaws of Prior IRF Audits

The serious flaws in OIG's audit of Methodist are typical of previous OIG IRF audits. We believe this demonstrates that OIG should revise its processes and improve its contractors' knowledge of IRF care. OIG's contracted reviewer repeated many of the errors apparent in other IRF audits, including the most recent nationwide audit of the IRF field, published on May 14, 2026, as well as the first OIG nationwide audit published in 2018. For nearly ten years, the IRF field has urged the Medicare program to improve the quality of its IRF reviewers, who do not seem to understand this specialized setting of care.

The May 2026 nationwide audit of IRFs concluded that "unclear Medicare requirements led to differing interpretations of the Medicare documentation, coverage, and billing requirements."[35] Of 19 claim denial examples brought forth by IRF stakeholders to highlight common themes they frequently identified in their review of the OIG contractor's denials, CMS agreed that the patient met the Medicare coverage criterion at issue in 14 of the 19 cases. This

[35] *Id.*

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conclusion reflects a fundamental disconnect between the OIG reviewer's interpretation of the coverage criteria and the interpretations held by industry and CMS. The IRF stakeholders stated in their response to that draft report, which was published as an addendum to the final report:

> This rate of concurrence between CMS and the Stakeholders and discord with OIG's contractor is reflected in OIG's finding that differing interpretations of often unclear Medicare requirements were the primary reason for the error rate (and the related extrapolation of Medicare payments) found by OIG . . . The audit underscores the challenges of applying detailed regulatory standards to patients receiving individualized rehabilitation hospital services."[36]

Unfortunately, Medicare contractors audit IRFs without a proper understanding of the intricacies and complexities of IRF care. An IRF is a hospital, but it differs from a general acute care hospital because IRF patients generally are medically stable. The core purpose of the IRF is intensive rehabilitation coupled with medical management to ensure that the patient remains stable enough to participate in an intensive rehabilitation therapy program to achieve functional outcomes. Contractors routinely misapply the coverage criteria, tending toward hypertechnical readings of detailed regulatory requirements, for determining whether IRF services should be reimbursed.

Contractors also strictly apply manual guidance as grounds for denying claims— which is directly contrary to the Supreme Court's decision in *Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019). The holding in this case established that guidance documents—such as the Medicare Benefits Policy Manual—cannot be enforced to deny payment when such guidance is not subject to public notice and comment. The reviewer who audited Methodist's IRF claims made these same errors, both misapplying the binding regulatory coverage criteria and treating manual guidance as binding.

XI. OIG Should Not Extrapolate its Findings and Impose a $13.4 Million Overpayment Amount

Methodist strongly objects to OIG's use of extrapolation at this point in the process, if ever. OIG currently estimates an overpayment to Methodist of $13,455,341. This amount is

[36] *Id.*

grossly excessive and the threat of it places an unreasonable administrative burden on Methodist to go through the lengthy appeal process.

A. OIG's Use of Extrapolation Is Premature

Methodist believes that an independent re-review of the 16 IRF claims, if completed with proper deference to the rehabilitation physician and in a manner that does not read-in additional requirements unsupported by the text of the regulations, will result in significantly fewer denials, if any. In addition, Methodist maintains that the claims were properly submitted and intends to appeal. We are aware that IRFs across the country, including Methodist in the case of past denials, experience a high rate of reversal on appeal, and given the strength of the claims at issue, it is highly probable that the final error rate will be quite low.

In light of IRFs' traditional appeal reversal rates and CMS' general agreement with the concepts addressed by the IRF stakeholders in response to OIG's nationwide audit, the likelihood that appeals will lower the error rate has significant implications for OIG's extrapolation. For each claim that is ultimately determined to be proper following appeal, the extrapolated amount will decrease dramatically. Further, Methodist anticipates that at least some of the estimated overpayment amount may be recouped while appeals are pending at the ALJ level. Given the excessive dollar value of OIG's current estimate, the application of extrapolation will have a disproportionate and extremely detrimental impact on Methodist. The additional administrative burden of appealing an extrapolated overpayment is exponential compared to the appeal of individual claim denials, both for the provider and for CMS and its components. Imposing this burden on Methodist and the administrative appeals system is incongruous with OIG's stated intention of managing and reducing the improper expenditure of Medicare program funding.

B. OIG's Use of Extrapolation for Claims Is Inappropriate

The requirements for coverage of IRF services and related documentation supporting admission under Medicare are very specific—much more specific than almost any other covered item or service under the program. By regulation, careful individualized determinations must be made by a specialized physician in order for IRF care to be covered and reimbursable. The individualized nature of IRF admissions makes these claims particularly inappropriate for extrapolation. In fact, in our view, CMS should never use extrapolation when assessing the medical necessity of individual claims which, by definition, cannot be generalized and treated with uniformity. Similarly, the decision whether to admit a patient into an acute care unit is subjective and based on the individual facts of the case.

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As recognized by a federal court, "[t]he essence of the science of inferential statistics is that one may confidently draw inferences about the whole from a representative sample of the whole."[37] The permissibility of statistical sampling turns on "the degree to which the evidence is reliable in proving or disproving the elements of the relevant cause of action."[38] OIG did not identify routine and related documentation errors that might serve as some indicator of *payment* errors in other claims within the universe (based on how OIG applied determinations of overpayment versus non-payment related errors).

Instead, OIG made medical necessity determinations, and the nature of these claims requires an individualized determination that cannot be replaced by an examination of a sample that is then projected to the whole. When medical necessity is involved, courts have rejected the use of extrapolation.[39] Because "each and every claim at issue" was "fact-dependent and wholly unrelated to each and every other claim," and determining eligibility for "each of the patients involved a highly fact-intensive inquiry involving medical testimony after a thorough review of the detailed medical chart of each individual patient," the court found the case was not "suited for statistical sampling."[40] Thus, extrapolating the alleged errors in the sampled IRF and acute care claims to the entirety of similar Methodist claims is unsupportable.

Based on the fact-specific and individualized nature of the admission errors alleged by OIG, only a claim-by-claim examination and determination process is appropriate for IRF and acute-care claims. Therefore, OIG should recommend to the MAC that no extrapolated overpayment be assessed, but if OIG presses forward with such an extrapolation, OIG should recommend to the MAC that it not conduct an extrapolation until Methodist has exhausted it appeal rights, and the true amount of the overpayment and payment error rate is known.

While Methodist does not concede that the two alleged errors related to the Two-Midnight Rule are improper, if the OIG continues to allege that these two (2) claims were not supported as inpatient claims, then, at a minimum, a revised payment amount should be

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[37] *In re Chevron U.S.A., Inc.* 109 F.3d 1016, 1019-20 (5th Cir. 1997); *see also United States v. Pena*, 532 F. App'x 517, 520 (5th Cir. 2013).
[38] *Tyson Foods, Inc. v. Bouaphakeo*, 136 S. Ct. 1036, 1046 (2016).
[39] *United States ex rel. Wall v. Vista Hospice Care, Inc.*, No. 3:07-CV-00604-M, 2016 WL 3449833, at *11-13 (N.D. Tex. June 20, 2016); *United States ex rel. Michaels v. Agape Senior Cmty., Inc.*, No. CA 0:12-3466-JFA, 2015 WL 3903675, at *2 (D.S.C. June 25, 2015).
[40] *Agape Senior Cmty, Inc.*, at *2, *8; *see also U.S. v. Medco Phys. Unlimited*, No. 98-C-1622, 2000 U.S. Dist. LEXIS 5843, at *23 (N.D. Ill. Mar. 15, 2000).

noted to reflect proper payment for the medically necessary procedures performed as an Inpatient Part B Only, and this revision should also be taken into account if extrapolation is to be applied.

In addition, Methodist does not concede that extrapolation is appropriate, however if employed, claims that were not properly reopened as well as those that cannot be lawfully recovered must be excluded from any such extrapolation.

XII. Conclusion

Methodist strongly disagrees with OIG's conclusions and recommendations, with very narrow exceptions. OIG's audit of Methodist is fundamentally flawed due to its reliance on questionable medical reviews, its misapplication of coverage criteria, its hypertechnical reading of regulatory requirements, and its inappropriate use of extrapolation.

Methodist sincerely hopes that this final set of comments and feedback, as well as its thorough rebuttal of the individual determinations, will lead OIG either to correct its serious errors in the final report of this audit or withdraw the Draft Report entirely. Again, we appreciate the opportunity to respond in depth to OIG's draft report.

Sincerely,

Michael Herron, CFO
Methodist Hospital

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Washington, DC 20201

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