Department of Health and Human Services
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Office of Audit Services

June 2026 | A-04-22-07101

Jefferson Regional Medical Center Received at Least $4.7 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.
- We selected Jefferson Regional Medical Center (the Hospital) because it submitted a substantial number of inpatient and outpatient claims that we identified as high risk for erroneous billing.

What OIG Found

- Of the 100 inpatient and outpatient claims we reviewed totaling $1,313,299, the Hospital complied with Medicare billing requirements for 67 claims. However, it did not fully comply with requirements for the remaining 33 claims, resulting in net overpayments of $348,677 from July 1, 2019, though June 30, 2021 (audit period).
- We estimated that, of the $17.5 million Medicare paid the Hospital, the Hospital received net overpayments of at least $4.7 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.

What OIG Recommends

We made three recommendations, including that the Hospital refund to the Federal government $4.7 million in estimated net overpayments. The full recommendations are in the report.

The Hospital disagreed with most of our findings. It did not concur with our first recommendation to refund the estimated overpayment, did not concur with our second recommendation, and did not indicate concurrence or nonconcurrence with our third recommendation.

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INTRODUCTION

WHY WE DID THIS AUDIT

For calendar year 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 Jefferson Regional Medical Center (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 July 1, 2019, through June 30, 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 contractors 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 that are 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). All services and items within an APC group are comparable clinically and require comparable resources. CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.[5] The HCPCS includes the

[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 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.

American Medical 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:
    - High-severity level DRG codes
    - Comprehensive error rate testing (CERT) error-prone DRG codes[9]
    - Claims paid in excess of charges
    - DRGs for severe malnutrition
    - Mechanical ventilation
- Outpatient claims with bypass modifiers[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 have identified 10 DRGs that are most at risk for billing errors: 149, 312, 313, 518, 519, 520, 742, 743, 947, and 948.

[10] 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.

- Outpatient claims paid in excess of charges

- Outpatient surgery claims billed with units greater than one

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, section 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

Medicare contractors may reopen a claim for good cause within 4 years from the date of the initial determination or redetermination.[11] Novitas Solutions, Inc., the Hospital's Medicare contractor, reopened all claims in our audit sample frame within 4 years from the date of the initial determination of each of those claims.

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.[12] 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.[13] Medicare contractors typically waive recovery in

[11] 42 CFR § 405.980(b)(2).

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

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

accordance with this presumption, but have the authority to determine whether there is sufficient evidence to rebut the presumption.

Jefferson Regional Medical Center

The Hospital is a 300-bed, acute-care hospital, located in Pine Bluff, Arkansas. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately $78 million for 4,455 inpatient and 27,203 outpatient claims during the audit period.

HOW WE CONDUCTED THIS AUDIT

Our audit covered roughly $18 million in Medicare payments made to the Hospital for 1,400 claims in the risk areas identified above.[14] We selected for review a stratified random sample of 100 claims (65 inpatient, 20 IRF, and 15 outpatient) with Medicare payments totaling about $1.3 million made during our audit period.[15]

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

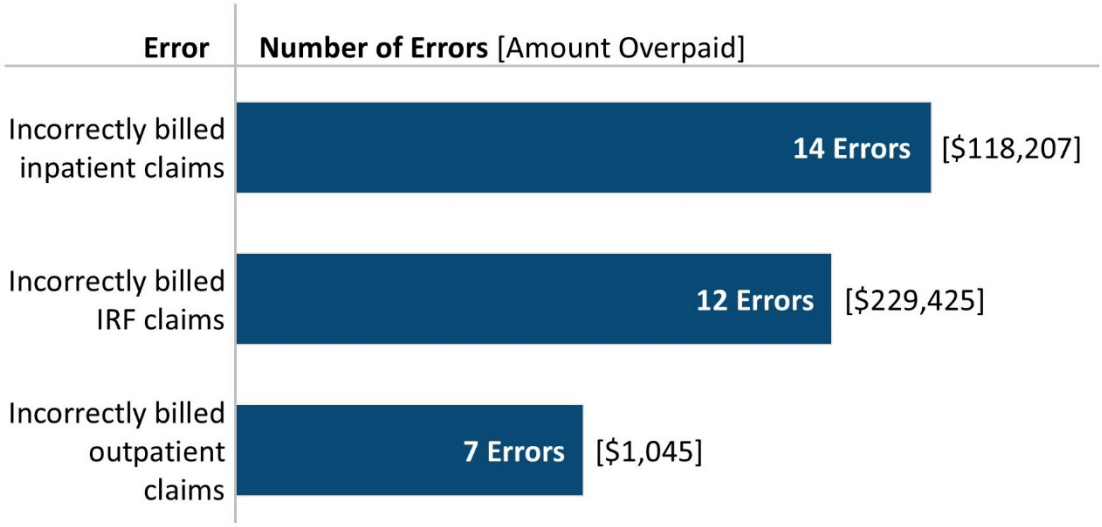
FINDINGS

The Hospital complied with Medicare billing requirements for 67 of the 100 inpatient and outpatient claims we reviewed totaling $1,313,299. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 33 claims, resulting in net overpayments of $348,677 for the audit period. Figure 1 provides a breakdown of the error types, number of claims in error and the associated overpayments.

[14] The total Medicare payments were $17,516,005.

[15] The total paid was $1,313,299.

Figure 1: Inpatient and Outpatient Billing Errors



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.

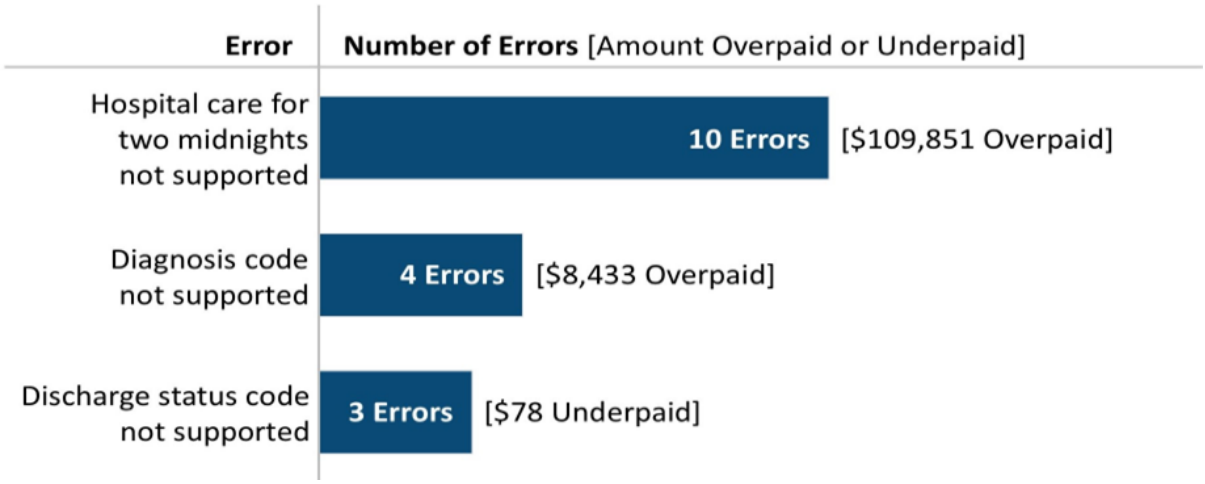
On the basis of our sample results, we estimated that, of the $17.5 million Medicare paid the Hospital, the Hospital received net overpayments of at least $4.7 million for selected types of inpatient and outpatient services that did not comply with Medicare requirements during the audit period.[16] See 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.

INCORRECTLY BILLED INPATIENT CLAIMS

For 14 of the 65 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. These errors resulted in net overpayments totaling $118,207. Figure 2 provides a breakdown of the error types, number of claims in error and the associated net overpayments.

[16] Our actual estimate is $4,701,168.

Figure 2: Inpatient Billing Errors*



* The number of errors associated with each error category will not match the total number of claims (14) because some claims had multiple error types.

Hospital Care for Two Midnights Not Supported

No payment may be made under Medicare Part A 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)).

Federal regulations provide that an inpatient admission, and subsequent payment under Medicare Part A, is appropriate if the ordering physician expects the enrollee to require care for a period that crosses 2 midnights (42 CFR § 412.3(d)(1)). This is referred to as the Two-Midnight Rule. We found that 10 of the 65 selected inpatient claims did not comply with the Two-Midnight Rule because the medical records did not support that it was reasonable for the admitting physician, at the time the inpatient order was written, to have expected

Two Midnight Stay for High Blood Pressure Was Not Supported

One enrollee, who had been taking medication for hypertension, presented to the Hospital with acute high blood pressure. The enrollee's blood pressure responded to oral medications administered in the Hospital. Cardiac enzymes were negative, and the electrocardiogram was unremarkable. The enrollee was admitted for medication adjustment, and the admitting physician expected the enrollee could be discharged within 24 to 48 hours. Although the stay was billed as an inpatient admission, the medical record did not support an expectation that the enrollee would require hospital care spanning at least two midnights, as required under CMS's Two-Midnight Rule.

that hospital care was required for 2 or more midnights.[17] Overpayments associated with these 10 claims totaled $109,851.

Diagnosis Code 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 65 selected inpatient claims, the Hospital submitted claims to Medicare that had certain diagnosis codes that were not supported by the medical records. Three of those claims resulted in incorrect DRG payments to the Hospital. Overpayments associated with these 4 claims totaled $8,433.

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 (unless the readmission is unrelated to the initial discharge) or an inpatient with a qualifying DRG is discharged to a post-acute care facility such as an IRF or skilled nursing facility, the discharge is classified as a transfer. In such cases, Medicare pays a per diem rate rather than the full DRG amount (42 CFR § 412.4).

For 3 of the 65 selected inpatient claims, the Hospital assigned the incorrect discharge status code. Net underpayments associated with these three claims totaled $78.

INCORRECTLY BILLED INPATIENT REHABILITATION FACILITY CLAIMS

For 12 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 12 claims that did not meet Medicare requirements totaled $229,425.

[17] Our medical review contractor also determined that 12 of the 65 selected claims, which includes all 10 claims that were found not in compliance with the Two-Midnight Rule, 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 enrollee 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 Other Matters section for additional information.

Medical Necessity for Inpatient Rehabilitation Facility Services Not Met

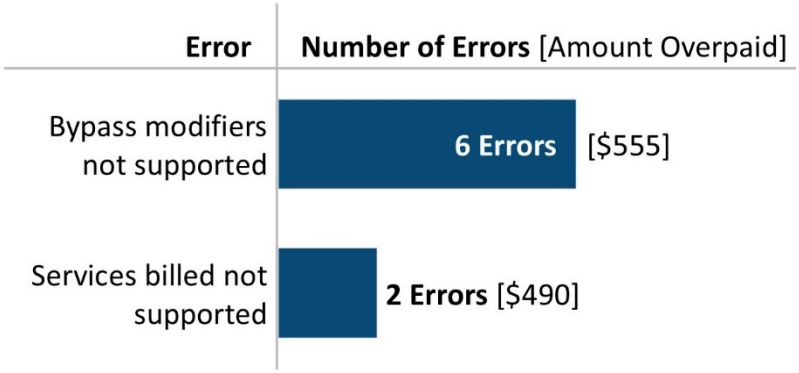
For an IRF claim to be considered reasonable and necessary, Federal regulations require that there be a reasonable expectation that, at the time of admission, the enrollee: (1) requires the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) is sufficiently stable at the time of admission to the IRF 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 (PHE), the second requirement and the "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 enrollee stays that did not meet Medicare criteria for acute inpatient rehabilitation. For 11 of these claims, there was not a reasonable expectation that the enrollee required supervision by a rehabilitation physician. For the remaining claim, there was not a reasonable expectation that the enrollee was sufficiently stable to be able to actively participate in a rehabilitation therapy program. Overpayments associated with these 12 claims totaled $229,425.

INCORRECTLY BILLED OUTPATIENT CLAIMS

For 7 of the 15 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 $1,045, as shown in Figure 3.

Figure 3: Outpatient Billing Errors*



* The number of errors associated with each error category will not match the total number of claims in error (seven) because some claims had multiple error types.

Bypass Modifiers Not Supported

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)). Claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)). Acute care hospitals are required to report HCPCS codes, of which CPT codes are a subset, on outpatient claims (the *Manual*, chapter 4, § 20.1), 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).

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M [Evaluation/Management] services performed on the same day. Modifier 59 is used to identify procedures and services, other than evaluation and management services, that are not normally reported together but are appropriate under certain circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual (*Medicare National Correct Coding Initiative* (NCCI) Policy Manual, chapter 1, section E).[18]

Modifiers XE, XS, XP, XU became effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be used in lieu of modifier 59 whenever possible. The modifiers are defined in the NCCI Policy Manual as follows:

- **XE—**Separate Encounter: A service that is distinct because it occurred during a separate encounter. This modifier shall only be used to describe separate encounters on the same date of service.

- **XS—**Separate Structure: A service that is distinct because it was performed on a separate organ/structure.

- **XP—**Separate Practitioner: A service that is distinct because it was performed by a different practitioner.

[18] *The responsibility for the content of any "National Correct Coding Policy" included in this product is with the Centers for Medicare & Medicaid Services and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, nonuse or interpretation of information contained in this product.*

- **XU—**Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.

For 6 of 15 selected outpatient claims, the Hospital incorrectly billed Medicare Part B using HCPCS codes with bypass modifiers XS, XU, or 59, even though the services on the claim were not separate and distinct. Overpayments associated with these six claims totaled $555.

Unsupported Modifier
One claim was incorrectly coded with modifier XU, which improperly unbundled the billing for compression dressings that were part of an unhealthy tissue removal procedure performed on the same anatomic area. These services should not have been billed separately.

Outpatient Services Billed Not Supported

Under the hospital outpatient PPS, predetermined amounts are paid for designated services furnished to Medicare enrollees. These services are identified by HCPCS codes (42 CFR § 419.2(a)). 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)).

For 2 of 15 outpatient claims, the documentation did not support that each service billed was rendered. Overpayments associated with these two claims totaled $490.

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

The 33 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 the Two-Midnight Rule, IRF admissions, documentation, billing, and coding. Although Hospital officials contended that the claims met Medicare requirements, they did not provide any additional information that would affect our finding.

RECOMMENDATIONS

- We recommend that the Hospital refund to the Federal government the estimated $4,701,168 in net overpayments for incorrectly billed claims, excluding amounts presumed to be unrecoverable under the Section 1870 waiver of liability provision.[19, 20]

- We recommend that the Hospital consider conducting one or more internal audits or investigations for claims after our audit period, based on the risks identified by this audit, to identify any similar overpayments the Hospital might have received 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 the Two-Midnight Rule, IRF admissions 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 most of our findings, did not concur with our first and second recommendations, and did not indicate concurrence or nonconcurrence with our third recommendation.

The Hospital stated that the OIG's contracted medical reviewer misapplied CMS regulatory requirements for payment for multiple claims at issue and overlooked key medical record documentation supporting the claims. The Hospital also stated that it was not given an opportunity to engage with the medical review contractor on those determinations with which it disagreed. In addition, the Hospital stated that any resolution of the audit involving an extrapolated overpayment was unwarranted because the errors identified in the sample did not constitute the sustained or high-level error rate needed to justify sampling and extrapolation. The Hospital further stated that the OIG's statistical sampling methodology contained flaws. Lastly, the Hospital stated that our report improperly included claims outside of the Medicare 4-year period for reopening claims, and that those claims were not reopened timely.

[19] OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a Medicare 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 Parts A and B appeals processes have 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.

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

We summarized the Hospital's disagreement and objections below.[21]

After reviewing the Hospital comments, we maintain that all our findings and recommendations are valid.

The Hospital's comments are included as Appendix E.

AUDIT RECOMMENDATIONS

Hospital Comments

The Hospital did not concur with our first and second recommendations and did not indicate concurrence or nonconcurrence with our third recommendation.

Regarding our first recommendation, the Hospital said the estimated $4.7 million in net overpayments, excluding amounts presumed to be unrecoverable under the Section 1870 waiver of liability provision, do not reflect an accurate calculation of the overpayments for the reasons outlined in its response (and summarized below). It also said that our use of extrapolation was improper and that the claims were not reopened timely.

Regarding our second recommendation, the Hospital said that any additional review would be premature because our report did not reflect an accurate calculation of the overpayments. In addition, the Hospital stated that it plans to appeal the alleged errors if its MAC seeks to recover the overpayments.

In response to our third recommendation, the Hospital stated that it regularly provides billing and coding training and will continue to evaluate the need for additional training on the Two-Midnight Rule and billing and coding requirements as part of its compliance program.

Office of Inspector General Response

For our first recommendation, we disagree with the Hospital's assertion that the estimated net overpayments reflected an inaccurate calculation of the overpayments. We submitted the selected claims to an independent medical review contractor who reviewed the medical records in their entirety to determine whether the services were medically necessary and provided in accordance with Medicare requirements. We worked with our medical reviewer to ensure that their review was conducted by professionals, including physicians and coders, with relevant expertise, and that the appropriate Medicare criteria were applied. As stated below, our extrapolation was proper and conformed to all requirements. As previously stated in this report, Medicare contractors may reopen a claim for good cause within 4 years from the date

[21] We list the Hospital's disagreements and objections by subject matter because the Hospital touched on a number of topics across several headings. We have responded to the Hospital's comments within each topic area.

of the initial determination or redetermination.[22] Novitas Solutions, the Hospital's Medicare contractor, reopened all claims in our audit sample frame within 4 years from the date of the initial determination of each of those claims.

For our second recommendation, we disagree that our calculation of the overpayment is inaccurate and continue to believe the Hospital should conduct internal audits or investigations for claims beyond our audit period. The Hospital has the right to appeal any action taken by CMS or the Medicare contactor based on our findings (see footnote 21).

For our third recommendation, we continue to believe that additional training for clinical and billing personnel on the Hospital's policies and procedures related to the Two-Midnight Rule, IRF admissions requirements, and inpatient and outpatient coding is necessary to increase compliance with Medicare requirements.

INPATIENT REHABILITATION FACILITY FINDINGS

Hospital Comments

Rehabilitation Physician Supervision

The Hospital stated that the medical review contractor failed to review the totality of the medical records and misapplied relevant payment criteria for the IRF claims, specifically by adding criteria beyond those in the CMS regulations.

Sufficient Stability

For two sample claims, the Hospital disagreed that the documentation failed to show a reasonable expectation at the time of admission that the enrollee would be stable enough to participate in IRF therapy. It also said that the medical review contractor improperly considered the therapy's intensive nature, given that CMS had waived the intensive rehabilitation therapy requirement during the COVID-19 PHE.

Plan of Care Development

The Hospital said that when it compared our draft report with the Summary of Audit Findings spreadsheet that we provided, it was unclear whether we found one specific sample to have been paid in error because the documentation did not support that the overall plan of care was developed by a rehabilitation physician with input from the interdisciplinary team. The Hospital stated that the medical review contractor appeared to have misread the requirement and relied on the wrong notes in the medical record when it made its determination. Further, the Hospital stated that the documentation demonstrated that the overall individualized plan of

[22] 42 CFR § 405.980(b)(2).

care was authored and supervised by the rehabilitation physician with direct input from both the physical and occupational therapist.

Office of Inspector General Response

Rehabilitation Physician Supervision

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. Our medical review contractor applied that criteria and did not add criteria as the Hospital claimed. The Hospital gave two examples. For one example, the Hospital stated that our medical review contractor questioned the service because the enrollee did not have a complex neurological condition or other listed conditions. But those were only mentioned in our medical review contractor's write-up as possible conditions in the context of the enrollee that might require IRF care and not an exhaustive list of requirements. For the second example, the Hospital stated the patient was at risk of thromboembolic disease that required monitoring by a rehabilitation physician.[23] Our medical review contractor found that the patient had no significant complications or changes in their baseline medical condition. In both cases, our medical review contractor found that care required by the enrollees was not complex enough to require the supervision of a rehabilitation physician.

Sufficient Stability

Our medical reviewer assessed whether the enrollee was sufficiently stable at the time of admission to actively participate in rehabilitation therapy. The Hospital stated that the enrollees' stability was demonstrated by things that happened after admission, but the regulation clearly states that only information available to the admitting physician at the time of admission is relevant. Our medical review contractor only considered information known to the admitting physician at the time of admission. Moreover, as indicated in our report, we did not assess the ability of an enrollee to participate in an intensive rehabilitation therapy program, because the intensive requirement was waived during this period.

Plan of Care Development

We did not report the sample claim in question by the Hospital to be an error in our report.

[23] Thromboembolic disease occurs when blood clots form in veins, often breaking loose to block blood flow in the lungs.

INPATIENT FINDINGS

Hospital Comments

Two-Midnight Rule

The Hospital disagreed with our finding that the 10 claims were errors because documentation did not support that it was reasonable for the admitting physician to have expected the necessity of hospital care spanning two or more midnights.

For each of these claims, the Hospital said that either the claims crossed 2 midnights and therefore were subject to the presumption that the inpatient stay was appropriate, or that they were not subject to the presumption but were properly admitted for inpatient care. In addition, the Hospital asserted the example provided "fails to paint a full picture" of the patient.

Coding Findings

The Hospital disputes the findings that four claims contained unsupported diagnosis codes (3 resulted in incorrect DRG payments) and notes that the draft report does not explain what criteria was used for these findings.

Office of Inspector General Response

Two-Midnight Rule

The Two-Midnight Presumption is the name given for CMS's instruction to Medicare contractors to presume hospital stays spanning 2 or more midnights after an enrollee is formally admitted as an inpatient are reasonable and necessary for Part A payment. CMS directs Medicare contractors to not focus their medical review efforts on stays spanning 2 midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the Two-Midnight Presumption.[24] The Two-Midnight Presumption is limited in scope to Medicare contractors' selection of claims for review.[25] It cannot override the Two-Midnight Rule, a regulation properly established through notice and comment rulemaking. Moreover, the Two-Midnight Presumption does not limit what claims OIG can review, as that is governed by the Inspector General Act.

We disagree with the Hospital and maintain that the documentation did not support that it was reasonable for the admitting physician to have expected the necessity of hospital care spanning two or more midnights. As for the Hospital's assertion that the summary of an example of this

[24] Medicare Program Integrity Manual (MPIM), chapter 6, § 6.5.1.

[25] 78 Fed. Reg. 50496, 50952 (Aug. 19, 2013).

type of error, on page 7 of this final report, “fails to paint a full picture” of the patient, our medical review contractor reviewed the entire medical record for each audited claim, even though the report includes only a summary of the case.

Coding Findings

As stated in the report, 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. In addition, the medical review determination letters we provided to the Hospital for each of these errors explained why our medical review contractor found that the medical records did not support the diagnosis codes assigned to these claims pursuant to the ICD-10-CM Diagnosis Codebook and the ICD-10-CM Official Guidelines for Coding and Reporting, which changed the DRG codes for the claims. We disagree with the Hospital and maintain that the diagnosis codes were not supported by the medical records.

MEDICAL REVIEW ENGAGEMENT

Hospital Comments

The Hospital contends that it did not have the opportunity to engage with us or our medical review contractor on those determinations with which it disagreed in order to better understand the bases for our conclusions. The Hospital stated that it had the opportunity to engage with OIG, including during an exit conference, but OIG declined to engage in claim-specific discussion regarding the reported errors.

Office of Inspector General Response

We acknowledge the Hospital’s concern regarding its opportunity to engage with OIG or our medical review contractor on claim-specific discussions regarding the determinations with which it disagreed. As noted, the medical review contractor reviewed the medical records to determine whether the services were medically necessary and provided in accordance with Medicare requirements. We worked with our medical reviewer to ensure that it applied the correct Medicare criteria applicable during the audit period and that it used professionals with appropriate medical expertise, including physicians with relevant training and experience. In addition, we provided the Hospital with the medical review determinations, which included detailed explanations and specific reasons for each sampled item identified as an error. We also informed the Hospital that it had appeals rights with respect to our audit findings and recommendations.

EXTRAPOLATION, REOPENING PERIOD, AND LIMITATION ON RECOVERY OF OVERPAYMENTS

Hospital Comments

The Hospital contended that extrapolation is not appropriate because there was not a sustained or high rate of error and the sampling methodology contained flaws. The Hospital further contended that extrapolation is particularly unwarranted because all of the claims were for care provided during the COVID-19 PHE.

The Hospital also asserted that it is not appropriate to recommend recovery of extrapolated overpayments because many of the claims we questioned are beyond the 4-year reopening period established in regulations. Moreover, the Hospital argued that some of extrapolated overpayment is unrecoverable under Section 1870 of the Act.

Office of Inspector General Response

The requirement that a determination of a sustained or high level of payment error or documented failed educational intervention before extrapolation applies only to extrapolations made by Medicare contractors.[26, 27] Moreover, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[28] 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] We properly executed our statistical sampling methodology because we defined our sampling frame and sample unit, selected a sample of claims at random from each stratum, applied relevant criteria in evaluating the sample, and used statistical sampling software to apply the correct formulas for the extrapolation. We provided the Hospital with the information necessary to replicate the sample from the sampling frame and to recalculate the estimated

[26] The Act § 1893(f)(3) and CMS' *MPIM*, Pub. No. 100-08, chapter 8, § 8.4.

[27] We also dispute the Hospital's assertion that the Medicare contractor charged with processing any associated overpayments connected to this audit is subject to the CMS policies it cited. These policies prohibit a Medicare contractor from using extrapolation in its own audits unless there is a sustained or high level of payment error or there is a failure of documented educational interventions. The Medicare contractor is not subject to such limitations in the adjudication of an OIG audit.

[28] *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).

[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).

overpayment amount.[30] In addition, the Hospital has direct access to its own claims information, which it can use to validate the sampling frame.

The Hospital's contention that extrapolation is unwarranted because the claims were for care provided during the PHE and assertion that it is not appropriate to recommend recovery of extrapolated overpayments for claims beyond the 4-year reopening period is incorrect. We submitted the claims selected for review to an independent medical review contractor who reviewed the medical records 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 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.

In addition, we worked closely with our independent medical review contractor to ensure that for all sample items where the enrollee received services during the PHE, it considered all relevant waiver provisions in place during our audit period. We instructed our medical review contractor to consider flexibilities outlined in CMS's "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers."

Furthermore, according to 42 CFR § 405.980(b)(2), a claim may be reopened within 4 years from the date of the initial determination or redetermination for "good cause." As stated above, Novitas Solutions, Inc., the Hospital's Medicare contractor, reopened all claims in our audit sample frame within 4 years from the date of the initial determination of each of those claims. As for section 1870 of the Act, 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.[31] But this is a presumption and not an absolute bar as the Hospital appears to have asserted. The Medicare contractor retains the authority to determine whether there is sufficient evidence to rebut the Section 1870 "fifth year following" "without fault" presumption that might limit the recovery of any of these overpayments.

[30] We provided the Hospital with the sampling plan, the numbered sampling frame, the random seed, the output of software used to generate the random numbers and the sample results file.

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

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*, 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.[32] 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 Milliman Care Guidelines) Level of Care Criteria screening tools.[33]

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 it with its compliance and utilization review programs.

The contractor used InterQual® criteria to evaluate a sample of 65 claims. For 12 of those claims, our independent medical review contractor found that the admissions did not meet InterQual® criteria.[34] Although those claims do not constitute a failure to meet Medicare requirements, the results of our audit suggest that properly applying a screening tool in the Hospital's compliance or utilization review programs would reduce inappropriately billed claims.

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

[33] 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.

[34] Ten of the 12 claims were reported as errors for not meeting two-midnight requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $17,516,005 in Medicare payments to the Hospital for 1,400 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (65 inpatient, 20 IRF, and 15 outpatient) with payments totaling $1,313,299.[35] Medicare paid these 100 claims from July 1, 2019, through June 30, 2021 (audit period).

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

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:

- Reviewed 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 65 inpatient claims, 20 IRF claims, and 15 outpatient claims to determine if claims were properly billed and reimbursed

- Discussed with Hospital officials the cause of the identified errors

We performed our audit work from August 2022 to October 2025.

[35] For claim selection, CMS instructs Medicare review contractors to apply the "Presumption" and avoid reviewing stays spanning 2 or more midnights, unless there is evidence of systematic 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 an enrollee remains in the hospital for at least two midnights after a physician orders inpatient status, unless there is evidence of abuse. 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 1,400 claims with a total paid amount of $17,516,005
- Selected a stratified random sample of 100 claims (65 inpatient, 20 IRF, and 15 outpatient) with payments totaling $1,313,299
- 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 select claims complied with selected billing requirements
- Calculated the correct payments for those claims requiring adjustments
- Used the results of the sample review to estimate the Medicare net overpayment in the sampling frame to the Hospital (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 1,400 Medicare paid claims in 9 risk areas totaling $17,516,005 from which we selected our sample (Table 1). The sampling frame included claims:

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

We assigned each claim that appeared in multiple risk areas to just one area on the basis of the following hierarchy: Inpatient Claims Billed with High-Severity Level DRG Codes, IRF Claims, Inpatient Claims Billed with High CERT Error DRG Codes, Inpatient Claims Paid in Excess of Billed Charges, Inpatient Claims Billed with Severe Malnutrition, Inpatient Claims Billed with Mechanical Ventilation, Outpatient Claims Billed with Bypass Modifiers, Outpatient Claims Paid In Excess of Charges, and Outpatient Surgery Claims Billed with Units Greater than One.

Table 1: Risk Areas

Medicare Risk Area	Frame Size	Value of Frame
1. Inpatient Claims Billed with High-Severity Level DRG Codes	471	$4,902,489
2. IRF Claims	381	7,608,474
3. Inpatient Claims Billed with High CERT Error DRG Codes	321	3,920,405
4. Inpatient Claims Paid in Excess of Billed Charges	30	540,456
5. Inpatient Claims Billed with Severe Malnutrition	10	261,229
6. Inpatient Claims Billed with Mechanical Ventilation	2	85,595
7. Outpatient Claims Billed with Bypass Modifiers	169	129,044
8. Outpatient Claims Paid In Excess of Charges	11	17,812
9. Outpatient Surgery Claims Billed with Units Greater than One	5	50,501
Total	**1,400**	**$17,516,005**

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 four strata. Stratum 1 includes all claims from risk area 2; strata 2 and 3 include claims from inpatient risk areas 1 and 3 through 6, separated by

paid amount;[36] and stratum 4 includes all outpatient claims from risk areas 7 through 9. 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 Area 2, Inpatient Rehabilitation Facility Services Claims	381	$7,608,474	20
2	Inpatient Risk Areas 1, 3–6, Low Dollar Claims	594	5,231,716	34
3	Inpatient Risk Areas 1, 3–6, High Dollar Claims	240	4,478,458	31
4	All Outpatient Claim (Risk Areas 7–9)	185	197,357	15
	Total	**1,400**	**$17,516,005**	**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 claims in each stratum.

ESTIMATION METHODOLOGY

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.

[36] Paid claims less than or equal to $12,557 are in stratum 2 and paid claims greater than $12,557 are in stratum 3.

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	381	$7,608,474	20	$389,613	12	$229,425
2	594	5,231,716	34	304,475	12	101,076
3	240	4,478,458	31	609,546	2	17,131
4	185	197,357	15	9,665	7	1,045
Total	**1,400**	**$17,516,005**	**100**	**$1,313,299**	**33**	**$348,677**

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

Point estimate	$6,281,913
Lower limit	4,701,168
Upper limit	7,862,658

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	$389,613	12	$229,425
IRF Total	**20**	**$389,613**	**12**	**$229,425**
Inpatient Billed with High-Severity Level DRG Codes	39	$454,772	8	$44,743
Inpatient Billed with High CERT Error DRG Codes	23	355,957	6	73,464
Inpatient Severe Malnutrition	2	91,059	-	-
Inpatient Paid in Excess of Charges	1	12,233	-	-
Inpatient Totals	**65**	**$914,021**	**14**	**$118,207**
Outpatient With Bypass Modifiers	15	$9,665	7	$1,045
Outpatient Totals	**15**	**$9,665**	**7**	**$1,045**
Inpatient and Outpatient Totals	**100**	**$1,313,299**	**33**	**$348,677**

* 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 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.

APPENDIX E: HOSPITAL COMMENTS

Jefferson Regional
1600 W. 40th Ave.
Pine Bluff, AR 71603
(870) 541-7100
www.jrmc.org

December 12, 2025

VIA E-MAIL (Denise.Novak@oig.hhs.gov)

Ms. Denise R. Novak
Assistant Regional Inspector General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Re: Jefferson Regional Medical Center's Response to the OIG Draft Report A-04-22-07101

Dear Ms. Novak,

Jefferson Hospital Association, Inc. d/b/a Jefferson Regional Medical Center ("JRMC") appreciates the opportunity to provide a written response to the U.S. Department of Health and Human Services ("HHS"), Office of Inspector General's ("OIG") draft audit report A-04-22-07101 ("OIG Draft Report"). For the reasons outlined in this response, JRMC disputes the OIG's draft findings and requests that the OIG Draft Report be substantially revised prior to being finalized.

I. EXECUTIVE SUMMARY

More than three years have elapsed since JRMC received notice from OIG on August 1, 2022, of the start of this audit, which covers claims for services that are now more than five years old. OIG alleges that 33 of the 100 claims reviewed were billed in error. JRMC disagrees. JRMC takes this audit very seriously and has requested the opportunity to have a claim-specific discussion with OIG or its medical review contractor to better understand the bases for the alleged claim errors. While JRMC has had the opportunity to engage with OIG, including during an exit conference, OIG has declined to engage in claim-specific discussion regarding the alleged 33 errors.

JRMC engaged independent experts to assess OIG's alleged claim errors and the draft findings. JRMC believes OIG's contracted medical reviewer misapplied the Centers for Medicare & Medicaid Services ("CMS") regulatory requirements for payment for multiple claims at issue and overlooked key medical record documentation supporting the claims. JRMC believes that any

resolution of the audit involving an extrapolated overpayment would be particularly unwarranted in this case, in part because there was no sustained or high-level error rate necessary to justify the sampling and extrapolation in the first place. Additionally, the OIG's statistical sampling methodology contains flaws and therefore should not be used for purposes of extrapolating an overpayment. Finally, the OIG Draft Report improperly included claims outside of the Medicare four-year period for reopening claims.

II. AUDIT OVERVIEW

OIG performed a review of 100 inpatient and outpatient claims from a period ranging from July 1, 2019, through June 30, 2021. Since JRMC received notice from OIG on August 1, 2022, of the start of this audit, JRMC has responded quickly and diligently to all requests from OIG related to the matter. After the entrance conference on August 23, 2022, JRMC provided the requested medical record documentation on September 14, 2022. On December 9, 2022, JRMC submitted further documentation related to a requested self-review to OIG. OIG's medical review contractor then took more than two and a half years to review the claims, and JRMC did not receive the OIG Draft Report until November 13, 2025.[1] At this point, the audit now covers claims for services that were provided more than five years ago.

The audit shows that JRMC provided outstanding care to patients during the height of the COVID-19 pandemic, one of the greatest public health emergencies in our history, and simultaneously (under very difficult circumstances) met Medicare documentation requirements. JRMC has requested the opportunity to have a substantive claim-specific discussion with OIG or its medical review contractor to better understand the bases for their conclusions. Since we have been unable to have a substantive claim-specific discussion with the medical review contractor or OIG about the claims at issue, JRMC's response is based on the written information that has been provided by OIG and is informed by JRMC's expert reviews. Based upon that review, set forth in more detail below, we believe the alleged claims errors are inappropriate due to the medical review contractor's erroneous interpretation and application of applicable Medicare coverage and documentation requirements. Additionally, OIG's medical review contractor overlooked medical record documentation supporting the claims. Finally, extrapolation is inappropriate.

A. Overview of Draft Findings

OIG found that JRMC complied with Medicare billing requirements for 67 of the 100 inpatient and outpatient claims. JRMC closely reviewed the alleged errors and, as detailed in this response, disputes OIG's findings that 33 of the 100 claims were billed in error. The 33 claims at issue included inpatient rehabilitation facility ("IRF"), inpatient, and outpatient claims. Specifically,

[1] Draft claim findings were provided to JRMC on July 23, 2025.

OIG's contract medical reviewer determined that the JRMC incorrectly billed Medicare for: 12 of the 20 IRF claims; 14 of the 65 inpatient claims; and seven of the 15 selected outpatient claims.

OIG provides the following three recommendations based on its findings:

- "[R]efund to the Federal government the estimated $4,701,168 in net overpayments for incorrectly billed claims, excluding amounts presumed to be unrecoverable under the Section 1870 waiver of liability provision."

- "[C]onsider conducting one or more internal audits or investigations for claims after [the] audit period, based on the risks identified by the audit, to identify any similar overpayments JRMC might have received and return any identified overpayments to the Medicare program."

- "[P]rovide additional training to clinical and billing personnel on its policies and procedures related to the Two-Midnight Rule, IRF admissions requirements, and inpatient and outpatient coding."

III. JRMC's Detailed Response

A. IRF Findings

OIG alleges that JRMC incorrectly billed for 12 of the 20 IRF claims reviewed. For the reasons set forth below, JRMC disputes these findings.[2]

1. Relevant Regulatory Requirements for IRF Claims

Under the IRF coverage criteria, there must be a reasonable expectation that the patient (1) requires the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) is sufficiently stable to be able to actively participate in the intensive rehabilitation program; and (4) requires supervision by a rehabilitation physician.[3] The OIG Draft Report acknowledges that during the COVID-19 Public Health Emergency, the second requirement in the regulation and the "intensive" nature of rehabilitation therapy in the third requirement were waived.[4]

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[2] The IRF closed June 2024.
[3] See 42 CFR§ 412.622(a)(3)(i) through (iv).
[4] The waiver period ranged from March 27, 2020, to the end of the COVID-19 Public Health Emergency on May 11, 2023.

OIG's contract medical reviewer looked at 37 questions for each claim in the IRF review. OIG found that JRMC met the criteria for an overwhelming amount of the questions and bases its conclusion that 12 IRF claims were incorrectly billed based only on two questions: (1) "Does the documentation support that upon admission to the IRF there was a reasonable expectation that the patient required physician supervision by a rehabilitation physician,"[5] and (2) "Does the documentation support that upon admission to the IRF there was a reasonable expectation that the patient was sufficiently stable to be able to actively participate in a rehabilitation therapy program?"[6]

2. OIG Incorrectly Determined Patients Did Not Require Supervision by a Rehabilitation Physician

As shared with OIG during the audit process, OIG's contractor failed to review the totality of the medical records and misapplied the relevant payment criteria for the inpatient rehabilitation facility claims. Specifically, it appears that the contractor added criteria beyond what is found in the CMS regulations related to payment for IRF claims.

For example, for **Sample 11**, the following sentence appears at the end of the contractor's response to Question 26:

> The patient did not require rehabilitation **physician oversight for a complex neurological condition or management of complex wound care, tube feeding, tracheostomy management or management of neurogenic bowel or bladder**. (emphasis added).

Medicare regulations do not require these impairments as justification for supervision by a rehabilitation physician. During the dates of service at issue, Medicare guidance is clear that "denials of services based on . . . diagnosis or specific treatment norms . . . or any other 'rules of thumb' are not appropriate."[7] Yet, that appears to be how OIG's medical review contractor approached the review. OIG's contractor applied a different standard than the relevant program requirements and ignored the totality of the medical record, including the patient's significant underlying medical conditions and interventions the patient received, when assessing the reasonable expectation that the patient needed physician supervision by a rehabilitation physician. Within the relevant regulation, the contractor's language about "complex wound care, tracheostomy management or management of neurogenic bowel or bladder" simply does not appear.

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[5] Samples 1, 3, 6, 7, 11, 12, 13, 16, 17, 19, and 20.
[6] Samples 14 and 17.
[7] Medicare Program Integrity Manual (Pub. 100-02), Ch. 1, § 110.1.

JRMC believes that the claims met the Medicare requirement that the patient require supervision by a rehabilitation physician. These patients' specific medical conditions, as documented in the medial record, put them at higher risk while undergoing intensive therapy and required supervision by a rehabilitation physician.

For example, OIG uses the sample highlighted on Page 9 of the OIG's Draft Report (which JRMC presumes to be **Sample 11**) to illustrate why it believes this requirement was not met. OIG explains that the patient did not meet medical necessity criteria because the patient

> [u]nderwent an elective total knee replacement. The patient was noted to have shortness of breath after surgery that worsened with activity and therefore required supplemental oxygen. However, the patient had no significant complications, changes in their baseline medical condition, or onset of new neurological conditions after surgery. The patient required physical and occupational therapies for decreased mobility and function resulting from the surgery, but the patient's condition was not complex enough to require a rehabilitation physician's supervision of an interdisciplinary approach to care.

The excerpt in OIG's Draft Report lacks important context. This patient was morbidly obese with a BMI of 40.3, placing the patient at a very high risk for failure of the new prosthetic left knee joint and thromboembolic disease that required monitoring by a rehabilitation physician. Although the patient did present with acute shortness of breath, the OIG Draft Report makes no mention of the physician's concern for pulmonary embolism with decreased oxygen saturations which necessitated supplemental oxygen. While admitted at the IRF, the patient had a stat CTA of the chest with IV contrast and arterial blood gas measurements were ordered to exclude the pulmonary embolism.

3. OIG Incorrectly Determined Patients Were Not Sufficiently Stable to Participate in a Rehabilitation Therapy Program

For two claims (**Samples 14** and **17**), OIG asserts there was not a reasonable expectation that the patient was sufficiently stable to be able to actively participate in a rehabilitation therapy program. With respect to the IRF claims where OIG believes the documentation does not support that upon admission to the IRF there was a reasonable expectation that the patient was sufficiently stable to be able to actively participate in a rehabilitation therapy program, JRMC disagrees.

As to **Sample 14**, the medical record showed the patient did participate in the therapy, it was reasonable to try the therapy since the goal was to discharge the patient to home as opposed to a SNF, and the patient was ultimately discharged home.

As for **Sample 17**, there was also a reasonable expectation that the patient was sufficiently stable. The patient was living independently in an assisted living facility prior to the hip fracture and upon presentation to the IRF the patient's vital signs were within normal limits, their pain was controlled, and the patient was alert and able to follow commands despite mild confusion. OIG's contract reviewer appears to largely base its denial on the patient's "severe cognitive impairment," which the reviewer determined negated the patient's ability to tolerate therapy sessions. First, cognitive impairment does not necessarily disqualify a patient from IRF coverage. The relevant question is whether the patient can actively participate in a rehabilitation program.[8] Second, this patient was able to actively participate in the therapy. Here, there are many citations in the record where it was noted that the patient participated well in the therapy sessions.

Although the OIG Draft Report acknowledges that the "intensive" nature of rehabilitation therapy in the third requirement of the regulation was waived during COVID-19 Public Health Emergency, the contract medical reviewer appears to have improperly considered the intensive nature of the therapy in its review. The documentation showed that the patients were sufficiently stable to receive rehabilitation, *and they did, in fact, receive the therapy.* Given the waiver, if there is any doubt whether the third element of the regulation was met for these claim (and JRMC believes there is not any) such doubt should be resolved in the hospital's favor and the claims should not be counted as errors.

4. OIG Incorrectly Determined Patient Plans of Care Were Not Developed by Rehabilitation Physicians

It is also unclear from the OIG Draft Report when compared to the Summary of Findings whether OIG asserts that **Sample 9** was paid in error because the documentation did not support that the overall plan of care was developed by a rehabilitation physician with input from the interdisciplinary team. In the review results for Sample 9, OIG's contract medical reviewer stated that the documentation indicated that the nurse authored the plan of care and the physician cosigned the note. However, the documentation clearly demonstrates that the overall individualized plan of care was authored and supervised by the rehabilitation physician with direct input from both PT and OT. OIG's contract medical reviewer appears to have misread this requirement and relied on the wrong notes in the medical record when it determined that this specific criterion was not satisfied.

[8] When CMS proposed the sufficient stable criterion, it explained that it was "proposing to require that the patient be sufficiently stable at the time of admission *to allow the patient to actively participate* in an intensive rehabilitation program." 74 Fed. Reg. 21052, 21069 (May 6, 2009) (emphasis added).

B. Inpatient Findings

OIG alleges that JRMC incorrectly billed for 14 of the 65 inpatient claims reviewed. For the reasons set forth below, JRMC disputes these findings.

1. Relevant Regulatory Requirements for Inpatient Claims

According to the two-midnight rule, inpatient admissions are payable under Medicare Part A if the admitting practitioner expected that the patient would require a hospital stay that crossed two midnights and the medical record supported that reasonable expectation.[9] When CMS promulgated the two-midnight rule, it also provided specific guidance to its contract reviewers as to how they should review these claims. Under the two-midnight presumption, CMS has instructed its contractors to presume that inpatient hospital claims with lengths of stay greater than two midnights following a valid inpatient order are medically necessary and appropriate for Medicare Part A payment.[10]

As the Medicare Program Integrity Manual states, "[p]er the 2-midnight presumption, Medicare contractors shall presume hospital stays spanning 2 or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Medicare contractors shall not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption."[11]

2. The Inpatient Claims at Issue Met the Two-Midnight Rule

For 10 of the 65 selected inpatient claims, OIG's contract medical reviewer concluded that the documentation showed it was not reasonable for the admitting physician, at the time the inpatient order was written, to have expected that hospital care was required for a period that crosses two or more midnights.[12] JRMC disagrees with OIG's findings and believes all 10 claims appropriately met the regulatory requirements for the two-midnight rule. Eight of these ten claims crossed two-midnights and therefore are subject to the presumption that the inpatient stay was appropriate. For example, OIG's contract medical reviewer found **Sample 21** to purportedly be in error, but JRMC believes the regulatory requirement was met *based upon the physician's explicit statement in the history and physical notes*. The remaining two claims are not subject to the presumption but were properly admitted for inpatient care.

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[9] See 42 C.F.R. § 412.3
[10] See 78 Fed. Reg. 50,949 (Aug. 19, 2013).
[11] See Medicare Program Integrity Manual (Pub. 100-08), Ch. 6, § 6.5.2.
[12] See 42 C.F.R. § 412.3(d)(1); Sample items 21, 22, 23, 24, 27, 34 ,44, 51, 54, and 78.

The sample (which JRMC presumes to be **Sample 23**) highlighted on Page 7 of the OIG's Draft Report further exemplifies discrepancies in the OIG's contract medical reviewer's reasoning. OIG explains that the patient

> [w]as noted to have been taking medication for hypertension, presented to the Hospital with acute high blood pressure. The patient's blood pressure responded to oral medications administered in the Hospital. Cardiac enzymes were negative and the electrocardiogram was unremarkable. The patient was admitted for medication adjustment and the admitting physician expected the patient could be discharged within 24 to 48 hours. Although the stay was billed as an inpatient admission, the medical record did not support an expectation that the patient would require hospital care spanning at least two midnights, as required under CMS's Two-Midnight Rule.

OIG's summary of the patient fails to paint a full picture. This patient presented to the hospital with high blood pressure as well as a headache, congested cough, and generalized weakness. The OIG Draft Report fails to mention that the inpatient admission order stated that the estimated length of stay is greater than 2 midnights, that the patient was treated in the ICU, and that the combination of the patient's acute congestive heart failure and uncontrolled hypertension typically requires at least 2 midnights of care to adequately diurese the patient and to lower blood pressure in a controlled fashion without compromising cerebral, coronary or renal perfusion. Additionally, contrary to the statement in OIG's Draft Report, there was no such documentation of the admitting physician's expectation that the patient could be discharged within 24 to 48 hours. Instead, it appears that OIG was applying its own expectation rather than that of the treating physician.

3. JRMC Disputes the Inpatient Coding Findings

For four of the 65 selected inpatient claims, the OIG's Draft Report concludes that JRMC submitted claims to Medicare that had certain diagnosis codes that were not supported by the medical records, where three of those claims resulted in incorrect DRG payments.[13] JRMC disputes these findings. It is unclear what criteria the OIG auditor believed needed to be in the record to support the relevant diagnosis codes.

C. Outpatient Findings

OIG alleges that JRMC incorrectly billed seven of the 15 outpatient claims reviewed. Specifically, OIG's contract medical review contractor determined that JRMC incorrectly billed Medicare Part B for claims that did not meet criteria for outpatient services. For six of 15 selected outpatient claims, OIG's contract medical reviewer determined that JRMC incorrectly billed Medicare Part

[13] See Samples 39, 40, 77.

B using HCPCS codes with bypass modifiers XS, XU, or 59, even though the services on the claim were not separate. For two of 15 outpatient claims, the OIG's contract medical reviewer determined that the documentation did not support that each service billed was rendered.

With respect to the six errors related to modifier application, it appears that the outpatient modifiers should not have been appended to the claims.[14] Over the past several years since this audit was initiated, JRMC has provided billing and coding education, including specific training to staff on outpatient coding.

D. Extrapolation, Reopening Period, and Limitation on Recovery of Overpayments

OIG's Draft Report relies upon statistical sampling to allege JRMC received net overpayments in the sample of $348,677, and an extrapolated overpayment of at least $4.7 million for the audit period from July 1, 2019, though June 30, 2021. Extrapolation is not appropriate because (1) there is not a sustained or high rate of error, and (2) there are flaws in the sampling methodology.

The sample included claims that are now more than five years after the services were provided and JRMC believes that under these circumstances OIG and CMS lack authority to use statistical sampling and extrapolate an overpayment without finding a sustained or high rate of error. There are limited circumstances in which Medicare contractors may use statistical sampling and extrapolation to estimate an overpayment.[15] The OIG Draft Report fails to demonstrate that extrapolation is appropriate here. Further, the OIG cannot (and should not) recommend that a Medicare contractor recoup an alleged overpayment that was calculated inconsistently with the Medicare Program Integrity Manual, which the Medicare contractors must follow in order to initiate a recoupment. According to that Manual:

> The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandates that before using extrapolation (i.e., projection, extension, or expansion of known data) to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, *there must be a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error.*[16]

Moreover, as described above, to require extrapolation in this audit would particularly unwarranted given: (1) the wide degree of disagreement between OIG's contract medical reviewer and JRMC on the alleged errors, and (2) the fact that all of these claims were for care provided during the public health emergency.

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[14] See Samples 86, 87, 90, 97, 98, 100.
[15] See 42 U.S.C. § 1395ddd(f)(3).
[16] Medicare Program Integrity Manual (Pub. 100-08), Ch. 8, § 8.4.1.2 (emphasis added).

Importantly, JRMC has concerns related to OIG's sampling methodology. The distribution of the 1,400 claims across the nine OIG-designated risk areas varies widely. Because there are differences between the low-count risk areas and the high-count risk areas with respect to the degree of any overpayments, any extrapolations from the sample to the full set of claims may be flawed. Similarly, the bulk of OIG's estimate of Medicare overpayments comes from Stratum 1 (IRF Claims) and Stratum 2 (Low-dollar Inpatient Claims). Stratum 1 accounts for nearly two thirds of the value of net overpayments in the sample but is based on just 12 claims that OIG identified as an overpayment. Stratum 2 accounts for another 29% of the value of net overpayments in the sample but is also based on just 12 claims that OIG identified as an overpayment. Therefore, approximately 95% of the value of net overpayments in the sample is based on a review of just 24 claims. JRMC is concerned that this sample of claims is not representative of all claims in the universe.

Additionally, many of the claims at issue are now well beyond the time-period for CMS to reopen them for good cause.[17] As a result, it is not appropriate for OIG to recommend recovery of any extrapolated overpayment (or for CMS to attempt to collect one) for claims that today are beyond the time set by regulation for reopening.

Finally, the OIG Draft Report recommends that JRMC refund to the Federal government the estimated $4,701,168 in net overpayments for incorrectly billed claims, *excluding amounts presumed to be unrecoverable under the Section 1870 waiver of liability provision* (emphasis added). Here, these amounts are unrecoverable because JRMC is presumed to be without fault given the dates of service at issue in this audit.

E. Response to Recommendations

JRMC carefully reviewed the recommendations included in the OIG Draft Report and responds to each recommendation as follows.

- JRMC does not concur with OIG's recommendation to refund to the Federal government the estimated $4,701,168 in net overpayments, excluding amounts presumed to be unrecoverable under the Section 1870 waiver of liability provision, because JRMC does not believe that number reflects an accurate calculation of the overpayments associated with this audit for the reasons outlined in this response and extrapolation is improper. Additionally, JRMC does not believe these claims were timely reopened.

- Similarly, JRMC does not concur with OIG's recommendation to consider conducting one or more internal audits or investigations for claims after the audit period, because JRMC does not believe that OIG's Draft Report reflects an accurate calculation of the

[17] See 42 C.F.R. § 405.980.

overpayments associated with this audit. To the extent the Medicare Administrative Contractor seeks to recover the alleged overpayments in OIG's Draft Report, JRMC intends to appeal the alleged errors. According to CMS, "[i]f the provider appeals the contractor identified overpayment, the provider may reasonably assess that it is premature to initiate a reasonably diligent investigation into the nearly identical conduct in an additional time period until such time as the contractor identified overpayment has worked its way through the administrative appeals process."[18] As such, any additional review would be premature at this point.

- As part of its compliance program, JRMC regularly provides billing and coding training and will continue to evaluate the need for additional training on the Two-Midnight Rule and billing and coding requirements.

IV. CONCLUSION

Thank you for the opportunity to comment on the OIG Draft Report. JRMC is committed to working with the agency in an efficient and productive way to finalize the audit and appreciates the agency's willingness to consider our concerns about the substance and the process related to this audit.

Very truly yours,

Shayla Robinson

Shayla Robinson
Corporate Compliance Officer
Jefferson Regional Medical Center

[18] See 81 Fed. Reg. 7667 (February 12, 2016).

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330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov