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November 2026 | A-05-23-00004

Mayo Clinic Rochester Generally Complied With Medicare Requirements

REPORT HIGHLIGHTS

November 2026 | A-05-23-00004

Mayo Clinic Rochester Generally Complied With Medicare Requirements

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 Mayo Clinic Rochester (the Hospital) because it submitted a substantial number of inpatient and outpatient claims that we had identified as high risk for erroneous billing.

What OIG Found

- Of the 100 inpatient and outpatient claims that we reviewed totaling $6,226,249, the Hospital complied with Medicare billing requirements for 92 claims. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 8 claims, resulting in overpayments of $34,013 from January 1, 2020, through December 31, 2021 (audit period).

- We estimated that, of $115.6 million Medicare paid the Hospital during the audit period, the Hospital received overpayments of $150 thousand for selected types of inpatient and outpatient services that did not comply with Medicare requirements.

- 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 made three recommendations, including that the Hospital refund to the Federal government $150 thousand in estimated overpayments. The full recommendations are in the audit report.

The Hospital disagreed with most of our findings and the related recommended refund amounts and did not indicate concurrence or nonconcurrence with our recommendations.

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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 Mayo Clinic Rochester (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 a Federal prospective payment rate for each of the 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]

[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. IRFs are excluded from this definition and are not paid under the inpatient PPS, and 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.

The HCPCS includes the American Medical Association's Current Procedural Terminology (CPT®) codes for physician services and CMS-developed codes for certain nonphysician services.[6, 7, 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
    - Hospital-acquired conditions and present on admission indicators
    - Claims paid in excess of billed charges
    - Same day discharge and readmission
    - DRGs for severe malnutrition

[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 CERT data analysis, we identified 10 DRGs that are most at risk for billing errors: 149, 312, 313, 518, 519, 520, 742, 743, 947, and 948.

- Resumption of home health services[10]

- Outpatient claims with bypass modifiers [11]

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 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

MACs may reopen a claim for good cause within 4 years from the date of the initial determination or redetermination.[12] National Government Services (NGS), the Hospital's MAC, 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.[13] A provider is presumed to be

[10] Resuming home health services means that an enrollee who previously received home health services begins receiving the services again after a period of hospitalization.

[11] A bypass modifier refers to a two-digit 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).

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

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.

Mayo Clinic Rochester

The Hospital is a 1,265-bed short-term, acute-care hospital, located in Rochester, Minnesota. According to CMS's National Claims History (NCH) data, Medicare paid the Hospital approximately $5.1 billion for 192,671 inpatient and 793,697 outpatient claims during the audit period.

HOW WE CONDUCTED THIS AUDIT

Our audit covered roughly $116 million in Medicare payments made to the Hospital for 11,673 claims in the risk areas identified above.[15] We selected for review a stratified random sample of 100 claims (70 inpatient, 15 IRF, and 15 outpatient) with Medicare payments totaling about $6.2 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 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 scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 92 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 8 claims, resulting in overpayments of $34,013. Figure 1

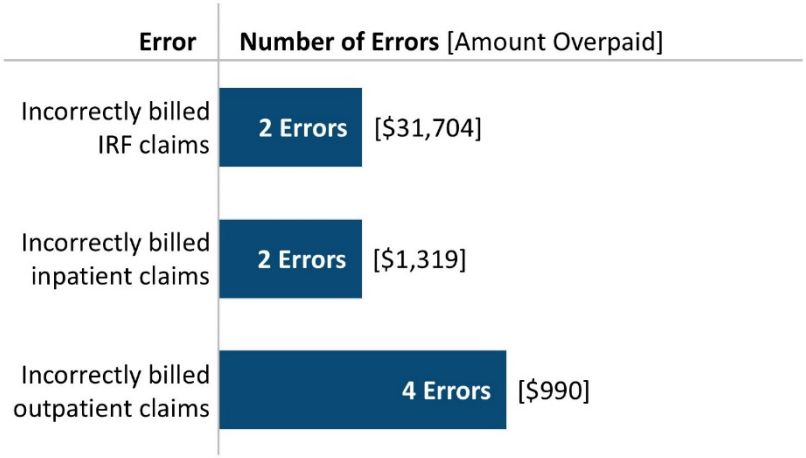
[14] Section 1870; 78 Fed. Reg. 74230, 74445 (Dec. 10, 2013); *Medicare Financial Management Manual*, chapter 3, §§ 70.3 and 80.

[15] The total Medicare payments were $115,642,106.

[16] The total Medicare payments were $6,226,249.

provides a breakdown of the error types, number of claims in error and the associated overpayments.

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 that contained errors.

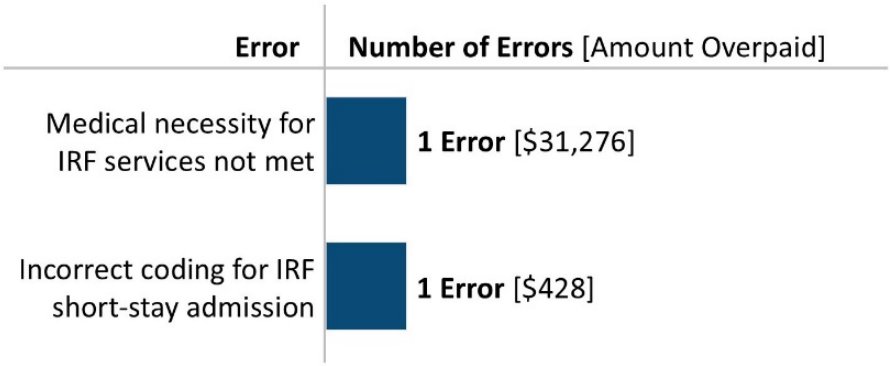
On the basis of our sample results, we estimate that the Hospital received overpayments of at least $150,665 for the audit period.[17] See Appendix B for statistical sampling methodology, Appendix C for sample results and estimates, and Appendix D for the results of our audit by risk area.

INCORRECTLY BILLED INPATIENT REHABILITATION FACILITY CLAIMS

For 2 of the 15 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. These errors resulted in overpayments totaling $31,704. Figure 2 provides a breakdown of the error types, number of claims in error and the associated overpayments.

[17] 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.

Figure 2: Inpatient Rehabilitation Facility Billing Errors



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.[18] During the COVID-19 Public Health Emergency, 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 1 of the 15 selected IRF claims, the Hospital incorrectly billed Medicare Part A for an enrollee stay that did not meet Medicare criteria for acute inpatient rehabilitation. Although the enrollee was admitted for inpatient rehabilitation services and required physical and occupational therapies for decreased mobility and function after surgery, the medical necessity requirements were not met because the enrollee's condition was not complex enough to require a rehabilitation physician to oversee interdisciplinary care. The overpayment associated with this claim totaled $31,276.

Incorrect Coding for Inpatient Rehabilitation Facility Short-Stay Admission

CMS classifies enrollees into mutually exclusive CMGs based on factors such as impairment, age, comorbidities, and functional capabilities (42 CFR § 412.620(a)).[19] Each CMG is assigned a

[18] (42 CFR § 412.622(a)(3)(i-iv))

[19] A CMG is a patient classification system used to group patients with similar clinical and resource utilization characteristics. This is used to determine reimbursement rates and for analyzing patient populations in various healthcare settings, including IRFs.

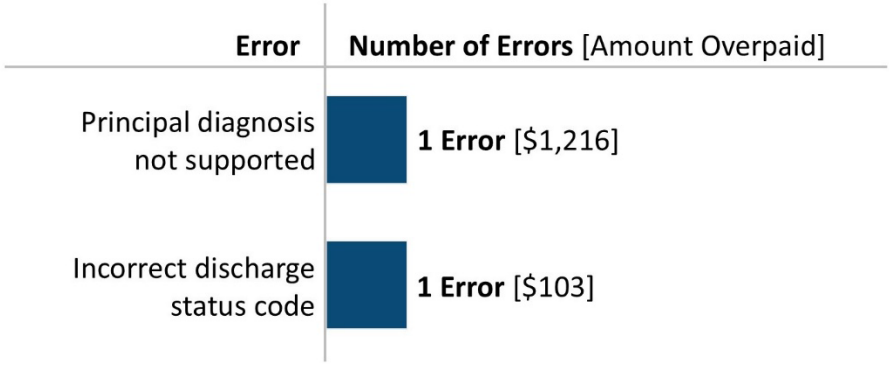
weight that reflects the expected resource use, which determines the payment amount; a separate weight applies to short-stay cases (42 CFR §§ 412.620(b)(1) and(2)). IRFs must include a revenue code and a Health Insurance PPS (HIPPS) Rate Code on Part A inpatient claims to identify the CMG classification (the *Manual*, chapter 3, § 140.3). For stays of 3 days or fewer—regardless of clinical condition or whether the patient dies—IRFs must report HIPPS Code A5001 (the *Manual*, chapter 3, § 140.2.4).

For 1 of the 15 selected IRF claims, the enrollee was appropriately admitted but transferred to critical care neurology after their condition worsened. The stay lasted 1 day, and the hospital did not use the required A5001 short-stay code, which is reimbursed at a lower rate. This resulted in an overpayment of $428.

INCORRECTLY BILLED INPATIENT CLAIMS

For 2 of the 70 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 overpayments totaling $1,319. Figure 3 provides a breakdown of the error types, number of claims in error and the associated overpayments.

Figure 3: Inpatient Billing Errors



Principal Diagnosis 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 1 of the 70 selected inpatient claims, the Hospital submitted a claim to Medicare that had a diagnosis code that was not supported by the medical record. The enrollee was admitted to the Hospital with a principal diagnosis code for "Diffuse large B-cell Lymphoma, extranodal and

solid organ sites" when the actual cause of admission was pneumonia.[20, 21] The incorrectly coded claim resulted in $1,216 in DRG overpayments to the Hospital.

Incorrect Discharge Status Code

Hospitals receive the full inpatient PPS payment when an inpatient is formally discharged from 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 if an inpatient with a qualifying DRG is discharged to post-acute care, such as IRF services, skilled nursing facility services, or home health services, 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 1 of the 70 selected inpatient claims, a code for a discharge to home/self-care was used when the enrollee was discharged to home with home health care. The incorrectly coded claim resulted in $103 in a discharge status code overpayment to the Hospital.

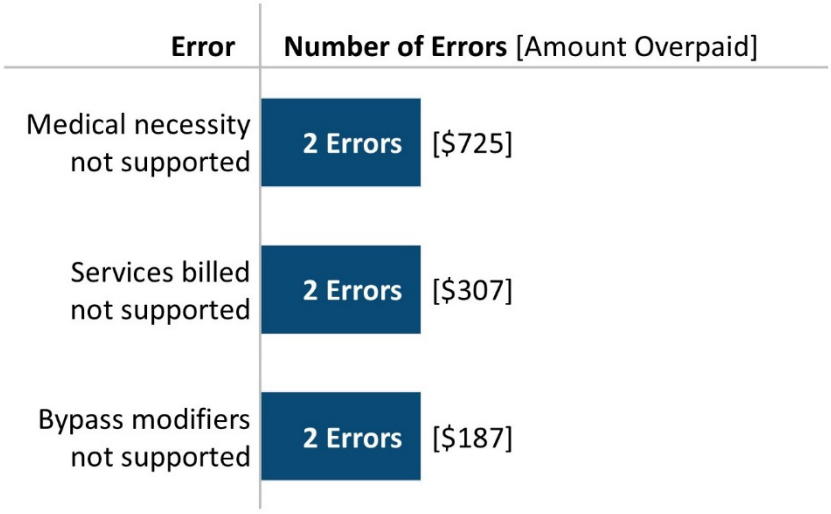
INCORRECTLY BILLED OUTPATIENT CLAIMS

For 4 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 $990. Figure 4 provides a breakdown of the error types, number of claims in error and the associated overpayments.

[20] Diffuse large B-cell Lymphoma is an aggressive cancer of the white blood cells.

[21] "The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the hospital enters the principal diagnosis." The *Manual*, chapter 25, § 75.6, FL 67 – Principal Diagnosis Code.

Figure 4: Outpatient Billing Errors*



* One claim had an error in more than one error category, which resulted in the total number of outpatient errors exceeding 4 outpatient claims. We only counted each outpatient claim once for overpayment estimation purposes.

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 2 of the 15 selected outpatient claims, the medical record did not include any clinical information supporting the medical necessity of the services billed. Overpayments associated with these claims totaled $725.

Services Billed Not Supported

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§§ 1815(a) and 1833(e)).

For 2 of the 15 selected outpatient claims, the documentation did not support that the services billed were rendered. Overpayments associated with these claims totaled $307.

Bypass Modifiers Not Supported

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

Modifier 59 is used to identify procedures and services, other than evaluation and management services, that are not normally reported together but are appropriate to report separately 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 cases) not ordinarily encountered or performed on the same day by the same individual. (*Medicare National Correct Coding Initiative Policy Manual*, chapter 1, section E).[22]

For 2 of 15 selected outpatient claims, the Hospital incorrectly billed Medicare Part B using HCPCS codes appended with modifier 59 that were not separate from other services or procedures billed on the same claim. Overpayments associated with these two claims totaled $187.

Unsupported Modifier
Our medical reviewer determined one claim was incorrectly billed using modifier 59, which was used to unbundle a biopsy from a lesion that was completely excised during the same operative session.

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

The 8 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 medical necessity, 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.

[22] *The responsibility for the content of any "National Correct Coding Policy" included in this product is with the Centers for Medicare and 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.*

RECOMMENDATIONS

- We recommend that the Hospital refund to the Federal government the estimated $150,665 in overpayments for incorrectly billed claims, excluding amounts presumed to be unrecoverable under the Section 1870 waiver of liability provision.[23, 24]

- 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 medical necessity of inpatient and outpatient services, IRF admissions and documentation requirements, and billing and coding inpatient and outpatient services.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital disagreed with most of our findings and the related recommended refund amounts and did not indicate concurrence or nonconcurrence with our recommendations.

The Hospital disagreed with OIG's findings regarding the inpatient principal diagnosis error, IRF medical necessity error, and outpatient medical necessity errors. It did not contest the findings related to the inpatient discharge status code error, IRF short-stay HIPPS code error requirement, or outpatient modifier 59 errors.

Regarding the Two-Midnight Rule findings in the draft report, the Hospital disagreed with our determinations for the three claims. Subsequent to issuance of our draft report, we removed the Two-Midnight Rule findings. Therefore, we have not summarized the Hospital's comments in this section. We summarized the Hospital's remaining comments below.

[23] OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC 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 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.

[24] NGS 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.

After considering the Hospital's comments and additional information that our medical reviewer evaluated, we revised our findings from 11 to 8 inpatient and outpatient claims and reduced the associated recommended refund amount to $150,665 for the final report, but we made no change to our second or third recommendation.

The Hospital's full comments are included as Appendix E.

INPATIENT CODING ISSUES

Hospital Comments

The Hospital did not concur that the principal diagnosis was unsupported for one claim identified in the audit report. The Hospital suggested that our medical reviewer relied on the admitting diagnosis rather than the condition established after study to be chiefly responsible for occasioning the admission. The Hospital provided the definition of the principal diagnosis from Section II of the Federal Fiscal Year 2022 *ICD-10-CM Official Guidelines for Coding and Reporting*: "The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set as 'that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.'" For the other inpatient claim finding, the Hospital did not contest that the incorrect discharge status code was used.

Office of Inspector General Response

Our medical reviewer relied on the same definition in Section II cited by the Hospital above and determined the condition "which occasioned the patient's inpatient admission" was not what was billed. For this sample item, we maintain that the sample item was coded with a diagnosis code with complication or comorbidity that was not supported and is an error.

INPATIENT REHABILITATION FACILITY CLAIMS

Hospital Comments

On one claim, the Hospital disagreed **"**that the post-surgical physical and occupational therapy needs reflected decreased mobility and function that were not sufficiently complex to warrant rehabilitation physician oversight and that recovery and monitoring allegedly could have been managed by a non-rehabilitation physician." In addition, the Hospital stated that "the combination of complex pain management, functional instability, and comorbidity oversight required physician-level judgment and could not be safely or effectively managed in a less intensive setting." Finally, the Hospital stated that the medical record, when viewed in its entirety, supports the medical necessity and satisfies the requirements of 42 CFR § 412.622(a)(3).

Office of Inspector General Response

Regarding the IRF sample claim, 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. We maintain that the post-surgical physical and occupational therapy needs reflected decreased mobility and function that were not sufficiently complex to warrant rehabilitation physician oversight and that recovery and monitoring could have been managed by a non-rehabilitation physician.

OUTPATIENT CLAIMS

Hospital Comments

The Hospital contended that the medical records sufficiently support the medical necessity of the services. However, the Hospital did not contest the finding related to the use of a Part B modifier for two of the outpatient claims reviewed.

Office of Inspector General Response

As a result of our medical reviewer's opinion, we maintain the medical records provided did not sufficiently support the medical necessity of the services. Based on additional documentation provided by the Hospital, we repriced the sampled claim, incorporated the repriced amount into our revised estimate and reduced the recommended recovery amount.

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). These tools are typically used by hospitals and reviewers to assess the appropriateness of inpatient and other levels of care. CMS did not require that the contractor use a specific tool, nor does CMS or the OIG endorse any specific tool.[25]

In prior hospital compliance audits, in response to findings that claims did not meet Medicare inpatient admission requirements, several auditees noted that their documentation submitted to support audited claims met the criteria in InterQual® or Milliman (the predecessor to the current MCG Care Guidelines) screening tools.[26]

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

[26] For example, see *Medicare Hospital Provider Compliance Audit: Lake Hospital System (A-05-19-00024)* and *Medicare Hospital Provider Compliance Audit: St. Vincent Hospital (A-05-18-00040)*.

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 the 70 inpatient claims selected in our sample. For 15 of those claims, our independent medical review contractor found that the admissions did not meet InterQual® criteria.

Claims Associated With Inpatient Rehabilitation Facility Regulations

An enrollee's medical record at the IRF must contain an "individualized" overall Plan of Care (POC) that is "developed by a rehabilitation physician with input from the interdisciplinary team [(IDT)] within 4 days of the patient's admission to the IRF" (42 CFR §§ 412.622(a)(4)(ii)(A) and (B)).

For all 15 of the selected IRF claims, documentation supported that a rehabilitation physician developed the POC, but it did not support that the POCs were individualized or created with input from the IDT. Although CMS requires that an enrollee's medical record at the IRF must contain a POC that is developed by a rehabilitation physician and is individualized, CMS requirements do not explain what "developed by" or "individualized" means or what should be documented. During the audit period, the requirements associated with the "developed by" and "individualized" terminology are unclear and may lead to an increased risk that the enrollee's specific needs were not adequately addressed. In addition, there is an increased risk of financial loss to and inefficiency in the Medicare program.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $115,642,106 in Medicare payments to the Hospital for 11,673 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims (70 inpatient, 15 IRF, and 15 outpatient) with payments totaling $6,226,249.[27] 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 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 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 70 inpatient claims, 15 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 February 2023 to March 2026.

[27] 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 (*Medicare Program Integrity Manual*, 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 2 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 11,673 claims with a total paid amount of $115,642,106
- Selected a stratified random sample of 100 claims (70 inpatient, 15 IRF, and 15 outpatient) with payments totaling $6,226,249
- 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 overpayment to the Hospital 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 11,673 Medicare paid claims in 9 risk areas totaling $115,642,106 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 December 8, 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 DRG Codes, Inpatient Claims Billed with High-Severity Level DRG Codes, Inpatient Claims Billed for Hospital Acquired Conditions and Present on Admission Indicators, Inpatient Claims Paid In Excess of Billed Charges, Inpatient Claims Covering Same Day Discharge and Readmission, Inpatient Claims Billed with Severe Malnutrition, Inpatient Claims with Acute Care to Home Health Services, Outpatient Claims Billed with Bypass Modifiers.

Table 1: Risk Areas

Medicare Risk Area	Frame Size	Value of Frame
1. IRF Claims	154	$4,870,299
2. Inpatient Claims Billed with High CERT Error DRG Codes	1,071	18,398,081
3. Inpatient Claims Billed with High-Severity Level DRG Codes	1,225	28,440,501
4. Inpatient Claims Billed Hospital Acquired Conditions Present on Admission	966	18,493,724
5. Inpatient Claims Paid in Excess of Billed Charges	101	6,766,715
6. Inpatient Claims Billed with Same Day Discharge and Readmit	10	192,127
7. Inpatient Claims Billed with Severe Malnutrition	307	20,118,352
8. Inpatient Claims Billed for Resuming Home Health	28	556,632
9. Outpatient Claims Billed with Bypass Modifiers	7,811	17,805,675
Total	**11,673**	**$115,642,106**

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random 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 8, separated by paid amount;[28] and stratum 5 includes all outpatient claims from risk area 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 1	154	$4,870,299	15
2	Inpatient Risk Areas 2–8, High Dollar Claims	71	15,920,178	15
3	Inpatient Risk Areas 2–8, Moderate Dollar Claims	574	27,433,133	20
4	Inpatient Risk Areas 2–8, Low Dollar Claims	3,063	49,612,821	35
5	Outpatient Claim Risk Area 9	7,811	17,805,675	15
	Total	**11,673**	**$115,642,106**	**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.

[28] Paid claims greater than $100,000 are in stratum 2, paid claims greater than or equal to $30,000 and less than or equal to $100,000 are in stratum 3, and paid claims less than $30,000 are in stratum 4.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of 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 Overpayments in Sample
1	154	$4,870,299	15	$472,926	2	$31,704
2	71	15,920,178	15	4,083,001	0	0
3	574	27,433,133	20	927,652	1	1,216
4	3,063	49,612,821	35	578,082	1	103
5	7,811	17,805,675	15	164,588	4	990
Total	**11,673**	**$115,642,106**	**100**	**$6,226,249**	**8**	**$34,013**

Table 4: Estimates of Overpayments in the Sampling Frame for the Audit Period

Limits Calculated for a 90-Percent Confidence Interval

Point estimate	$885,017
Lower limit	$150,665
Upper limit	$1,619,370

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 Overpayments in Sample
IRF Claims	15	$472,926	2	$31,704
IRF Total	**15**	**$472,926**	**2**	**$31,704**
Inpatient Billed with High CERT Error DRG Codes	20	$428,182	-	-
Inpatient Billed with High-Severity Level DRG Codes	19	569,788	-	-
Inpatient Severe Malnutrition	17	3,667,144	1	$1,216
Inpatient Paid in Excess of Charges	7	797,740	-	-
Inpatient Claims for Hospital Acquired Conditions and Present on Admission Indicators	6	117,176	-	-
Inpatient for Resuming Home Health Services	1	8,705	1	103
Inpatient Totals	**70**	**$5,588,735**	**2**	**$1,319**
Outpatient With Bypass Modifiers	15	$164,588	4	$990
Outpatient Totals	**15**	**$164,588**	**4**	**$990**
Inpatient and Outpatient Totals	**100**	**$6,226,249**	**8**	**$34,013**

* 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: AUDITEE COMMENTS

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200 First Street SW
Rochester, Minnesota 55905
507-284-2511
mayoclinic.org

April 28, 2026

Dept of Health and Human Services
Office of the Inspector General
Attn: James M. Barton, Acting Regional Inspector General, Audit Services
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

SUBMITTED ELECTRONICALLY

RE: Mayo Clinic Response to Audit Project A-05-23-00004 Report

Dear Mr. Barton:

This letter serves as Mayo Clinic's response to the report from the Office of the Inspector General (OIG), received March 31, 2026. The report's findings comprise a sampling of claims from across inpatient, inpatient rehabilitation, and outpatient settings billed by Mayo Clinic Hospital in Rochester, Minnesota between January 2020 and December 2021.

We previously shared with the OIG several significant concerns about the original audit results. We are grateful that the OIG took some of those concerns seriously and made changes based on our feedback. However, those changes were not clearly communicated to us, and we do not fully understand the current rationale for the remaining denials reflected in the report. Mayo Clinic respectfully contests many of the findings alleging overpayment for these claims and responds to the allegations of non-compliance for the claims in question as follows:

I. Response to Alleged Non-Compliance for Billed Inpatient Claims

OIG asserts that five of the inpatient claims reviewed were incorrectly billed in this matter, resulting in a net overpayment of $53,153. As the basis for its conclusion, OIG alleges that each of these five claims had any of the following errors:

- Lack of reasonableness of the patient staying for two midnights – 3 claims
- Unsupported discharge status code – 1 claim
- Unsupported DRG codes – 1 claim

A. The three patients' medical condition clearly satisfied the expectation that a hospital stay would span two midnights, which justifies inpatient admission.

Mayo Clinic does not concur with the OIG's recommendation. Mayo Clinic is certain that each of these hospital stays met the Two-Midnight Rule. The denials are inconsistent with both the law and the instructions found in the audit form the OIG used. Moreover, CMS has explicitly stated that total knee arthroplasty (TKA) patients who are to be discharged to a skilled nursing facility (SNF) merit inpatient admission. All three denials were TKA patients to be discharged to a SNF. All of the original denials cite InterQual as the primary basis for the denial, despite the fact that the OIG audit form states InterQual will

[*] Office of Inspector General Note—Section I.A is not applicable because the finding or issue to which the auditee referred is not included in this report.

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NOT be the basis of an "error." It appears that the OIG may no longer be relying on InterQual as the basis for the denial, but this leaves confusion about the OIG's rationale for denying the claims. The only reason that an inpatient hospital stay lasting more than two midnights should be denied is if the patient did not require hospital care. Nothing in the report suggests that the OIG felt that hospitalization was unnecessary. When a patient needs hospitalization for more than two midnights, 42 CFR 412.3 defines the patient as an inpatient.

As OIG well knows, under the Two-Midnight Rule, 42 C.F.R. § 412.3, inpatient admission is "appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights." Under that regulation, there are only two questions: 1) does the patient require hospital care, and 2) is the need for hospital care expected to last for two midnights? If the answer to each question is yes, the patient is properly admitted as an inpatient. Despite this long-standing regulation, it is unclear to Mayo Clinic exactly what rule OIG applied in evaluating these claims, as for all three patients the answer to both questions was "yes."

For each of the patients here, the physician expected the patient to need care over two or more midnights. The reasonableness of that expectation is validated by the fact that the patient actually received care across more than two midnights. Indeed, the shortest stay was three days, with two of the three patients having a stay of five or more days.

For a stay that lasts more than two days, unless there is an argument that the patient did not require hospital care at all (and no such argument has been made here), the stay qualifies for inpatient status because the physician **KNEW** that the stay would last beyond two midnights.

It is unclear to us exactly how much weight the OIG assigned to InterQual, and why the OIG ultimately denied the hospital stay. The initial audit documents placed great weight on InterQual. The final report conceded that proprietary tools like InterQual and MCG have no substantive regulatory authority and in no way equate with a failure to meet Medicare criteria; but continued reference to InterQual would seem to suggest that the agency gives the tool at least some practical (though unlawful) merit while carrying out these audits. The Two-Midnight Rule establishes a very straightforward test for patient status that depends solely on the length of time the physician expects the patient to require hospitalization. Nothing in the law, regulation, or even guidance supports the use of InterQual as a tool for reviewing admissions.

The other reason that the OIG denied care was that the patient was discharged to a SNF. The reviewer was particularly troubled that for some patients the wait for a SNF bed prolonged the hospital stay. The reviewer mistakenly believes that the fact a patient would be discharged to a Skilled Nursing Facility undercuts the admission. In fact, the opposite is true. In a discussion in the Federal Register, CMS recognized that the post-discharge plan should be a factor in the physician's decision to admit the patient: "We agree that the physician should take the beneficiaries' need for post-surgical services into account when selecting the site of care to perform the surgery. We would expect that Medicare beneficiaries who are selected for outpatient TKA would be less medically complex cases with few comorbidities **and would not be expected to require SNF care following surgery**." 82 FR 52356,52524, https://www.federalregister.gov/d/2017-23932/p-2018, (bold and underlining added). The implication of that statement is clear; when a patient receiving TKA will be discharged to a SNF, CMS believes that inpatient admission is appropriate. That alone is a sufficient reason to allow two of the three denials.

The auditor also often complained that the patient's hospital stay was prolonged by the wait for a SNF bed. Of note, all the hospital stays for the claims reviewed occurred during the designated COVID Public Health Emergency -- a time when finding a skilled nursing facility to accept a rehab patient was incredibly difficult. It is true that several of the patients stayed additional days in the hospital because of the need for

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rehabilitation care that was not available. For one claim, a patient who received a left total knee arthroplasty, the reviewer indicates that "her hospital course was prolonged over a weekend, secondary to finding skilled nursing facility placement." That is true, but the conclusion fails to consider that under CMS policy, days spent in the hospital waiting for a necessary admission to a SNF are properly considered medically necessary hospital days. Medicare's QIO Manual, chapter 7, section 7005 includes the following note: "In cases where the beneficiary requires a SNF level of care, the hospital cannot issue a notice of non-coverage if a SNF bed is not available. **Medicare pays hospitals for days awaiting placement until a SNF bed is available, and the medical record documentation indicates that SNF placement is actively being sought**" (bold added). CMS clearly acknowledges that when a patient needs a SNF bed that is not available they must stay in the hospital, and that time is a medically necessary hospital day.

At the time of admission with respect to the hospital stays in question, the admitting physician was acutely aware of the existence of COVID and the difficulty of finding skilled nursing facility placements. The physician anticipated a stay that would last more than two midnights. The reasonableness of this expectation is highlighted by the fact that the individuals all stayed more than two midnights, with two of the three staying five or more days.

We also want to emphasize that if for any reason the OIG were to conclude that admission was not appropriate at the time it was ordered, by the time the patient was about to spend their second midnight in the hospital, inpatient admission was absolutely appropriate. Therefore, there cannot be any overpayment because the admission was correct once the patient required hospitalization for 3, 5 or even 6 days. (Mayo wants to be clear that we have no doubt that the admission was proper the moment it was written. We merely want to emphasize that if anyone disagrees, at some point admission was proper and inpatient hospital reimbursement was appropriate.)

We would like to offer a final observation that isn't relevant to this review, because all the admissions were appropriate. But, had some of the care only qualified for outpatient status, the proper calculation of an overpayment would be the difference between the DRG amount and the amount that would have been allowable as an outpatient. Considering that the reviewer readily acknowledges that the patients required hospital care, even accepting the reviewer's analysis, there should not have been a single zero in the "revised payment amount" column.

Finally, Mayo Clinic would like to note that there is something very misleading about characterizing a hospital stay that everyone agrees was both needed and received by the beneficiary as an "overpayment." The issues discussed above are highly technical and entirely unrelated to the value of the care received by the patient. While we readily agree that the OIG should review organizations to verify their compliance with regulatory requirements, the findings should be presented in a way that helps policymakers to understand the issue. When the OIG indicates that the government "overpaid" for services, any reasonable observer would conclude either a) that the services were not provided, b) should not have been provided, or c) were provided in such a deficient manner that they were effectively useless. That is not true here for any of these claims. The Medicare program (and Medicare beneficiaries) received exactly what they paid for.

In conclusion, each patient here met the Two-Midnight Rule. The reviewer applied the wrong standard when analyzing whether the patient was properly admitted.

B. Mayo Clinic does not contest the finding regarding the discharge status code.

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Mayo Clinic does not contest the finding related to the discharge code. The patient was discharged home with home health care supports, which should be reflected by a discharge status code of 06.

C. The allegation that the principal diagnosis code was unsupported is clearly erroneous.

Mayo Clinic does not concur with OIG that the DRG code was unsupported for the relevant inpatient claim. The reviewer is mistaken in its assertion that the agency's downgraded diagnosis would meet the ICD-10 definition of "principal diagnosis" under current coding guidelines. The OIG seems to believe that Mayo should have coded based on the ADMITTING diagnosis, that is, the reason that the patient came to the hospital. However, DRG are based on the PRINCIPAL diagnosis, the final diagnosis after the patient's condition has been reviewed.

The FFY 2022 ICD-10-CM Official Guidelines for Coding and Reporting (Official Coding Guidelines) are applicable to this admission. The Official Coding Guidelines are adopted as federal law under HIPAA and are required to be followed in all healthcare settings. Section II of the Official Coding Guidelines defines the principal diagnosis as follows:

> "The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as 'that condition established **after study** to be chiefly responsible for occasioning the admission of the patient to the hospital for care.'" (Bold and underlining added).

Section II clearly delineates the difference between the admitting diagnosis and the principal diagnosis. The admitting diagnosis is the reason for admission. The principal diagnosis is the condition "after study" that is "chiefly responsible for occasioning the admission to the hospital for care."

II. Response to Alleged Non-Compliance for Billed Inpatient Rehabilitation Facility (IRF) Claims

OIG asserts that two of the inpatient rehab claims reviewed were incorrectly billed in this matter, resulting in a net overpayment of $31,704. As the basis for its conclusion, OIG alleges the following errors:

- Documentation does not substantiate medical necessity for IRF-level care – 1 claim
- Documentation supported a short stay but HIPPS code A5001 was not correctly billed – 1 claim

A. OIG's allegation that IRF-level care was not medically necessary is clearly erroneous.

OIG asserts that the documentation for the relevant claim does not support a medical condition requiring the supervision and oversight of a rehabilitation physician under 42 C.F.R. § 412.622(a)(3). In support of this conclusion, OIG states that the post-surgical physical and occupational therapy needs reflected decreased mobility and function that were not sufficiently complex to warrant rehabilitation physician oversight and that recovery and monitoring allegedly could have been managed by a non-rehabilitation physician.

Mayo Clinic strongly disagrees with this characterization. The contemporaneous medical record demonstrates that, at the time of admission, the beneficiary's overall clinical condition required the active supervision and medical management of a rehabilitation physician and the coordination of an

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interdisciplinary inpatient rehabilitation team, consistent with the regulatory requirements for IRF admission.

The documentation reflects an acute post-operative decline in functional mobility, accompanied by significant biomechanical impairment and complex pain that materially interfered with safe ambulation and activities of daily living. Management of this condition required specialized physiatric leadership to integrate intensive physical and occupational therapy while simultaneously addressing pain control, mobility limitations, and functional recovery in a medically supervised setting.

In addition, the beneficiary presented multiple active medical comorbidities (namely: chronic low-back pain and left lower extremity weakness; a history of PICC-line associated deep vein thrombosis; and ongoing treatment of myeloid leukemia, which had been pended for the patient's surgery) requiring ongoing physician monitoring during the rehabilitation course. These conditions increased the risk of medical complications during therapy participation and necessitated frequent reassessment, medication management, and coordination across disciplines. The combination of complex pain management, functional instability, and comorbidity oversight required physician-level judgment and could not be safely or effectively managed in a less intensive setting.

Contrary to OIG's implication, the absence of certain exemplar conditions (such as tracheostomy care or tube feeding) does not negate medical necessity for IRF-level care. CMS regulations do not restrict IRF admission to a narrow list of diagnoses or interventions. Rather, the governing standard is whether the beneficiary requires close medical supervision by a rehabilitation physician and an intensive, coordinated interdisciplinary rehabilitation program. That standard was met here.

OIG also suggests that the beneficiary's successful discharge to home undermines the medical necessity of the IRF stay. This position is inconsistent with CMS policy (*Medicare Benefit Policy Manual, 110.3)*. As CMS expressly recognizes, the goal of inpatient rehabilitation is to enable a safe return to the home when clinically appropriate. A successful discharge outcome is evidence of effective rehabilitation care—not proof that such care was unnecessary. The record demonstrates that the beneficiary achieved functional improvement precisely because of the intensive rehabilitation services and medical oversight provided during the IRF admission.

In focusing narrowly on selective documentation elements, OIG fails to account for the beneficiary's comprehensive clinical presentation and the integrated nature of inpatient rehabilitation care. When viewed in its entirety, the record clearly supports the medical necessity of IRF-level services and satisfies the requirements of 42 C.F.R. § 412.622(a)(3). Accordingly, Mayo Clinic disputes OIG's finding that the IRF stay was not medically necessary.

B. *Mayo Clinic does not contest the finding regarding the applicability of the A5001 HIPPS code.*

Mayo Clinic does not contest the finding for Sample 13 that a HIPPS code of A5001 was applicable for an IRF stay of less than three days. As noted above, the patient was discharged from the IRF within twenty-four hours.

III. Response to Alleged Non-Compliance for Billed Outpatient Claims

OIG asserts that four of the outpatient claims reviewed were incorrectly billed in this matter, resulting in a net overpayment of $2,127. As the rationale for the alleged overpayment, OIG cites that the documentation supplied does not substantiate the medical necessity of the service performed. Mayo Clinic disagrees with this

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characterization and contends that the medical records provided sufficiently support the medical necessity of the services.

Separately, Mayo Clinic does not contest the finding related to Part B modifier usage, for two of the outpatient claims reviewed.

VI. Concluding Remarks Related to OIG's Anciliary Observations

For the reasons stated herein, Mayo Clinic disagrees with many of the findings expressed by OIG in their report, the characterization as overpayments, and the related recommendation.

In the closing comments to their report, the OIG discusses "Other Matters" tangential to their recommendations. While OIG acknowledges these factors had no influence upon their final recommendations, we wish to comment on them briefly as object lessons for the industry, similarly situated provider organizations, and for CMS.

1. OIG, again, references that its independent medical review contractor applied a clinical screening tool (InterQual), and the review deemed many of the reviewed claims did not meet InterQual criteria. While OIG does repeatedly say in its conclusions that neither OIG nor CMS endorse a particular tool – and likewise that failure to meet such criteria does not reflect a failure to meet Medicare criteria – we cannot help but point out repeated references to these proprietary screening tools in the context of a billing-related audit tends to imbue the tool with a regulatory weight that it does not –cannot—lawfully have. These tools may have a particular limited utility in the context of workforce planning or a Hospital's utilization review program, and a provider organization's election to use them for those such purposes is within the permitted range of honest judgment; however, they have no role here, in the determination of appropriate patient status under Medicare criteria.
2. OIG advises CMS to advance further rulemaking under the IRF conditions of participation further defining terms such as "developed by" or "individualized" regarding the required plan of care for the admission to an IRF setting. Mayo Clinic believes that the operative regulatory text, as currently drafted, sufficiently articulates the expectations for the provider community. OIG's interpretation of the text discounts the reality of modern coordination between care team professionals. That coordination consists of conversations between team members working in close connection, such as those occurring between therapy providers and the physician documenting the plan of care and communicating through the integrated medical record. Members of the patient's care team access historical medical information, including encounters from each patient's recent acute hospitalization, which is substantively synthesized into the documented plan of care. The regulation as current, 42 CFR 412.622(a)(4)(ii)(A), explicitly requires that the patient's plan of care be developed ***with input from*** the interdisciplinary team (bold and italics added). The focus of the regulation is on the integration and synthesis of the multidisciplinary team perspective in the comprehensive care of the patient. In Mayo Clinic's view, this patient-focused approach is the appropriate standard, and a more prescriptive approach may chill or otherwise hamper the dynamic nature that care and collaboration occurs within modern healthcare settings.

Mayo Clinic appreciates the opportunity to be heard with regard to OIG's findings.

Sincerely,

Ryan D. Williams

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Ryan D. Williams
Legal Counsel | Mayo Clinic
200 First Street SW
Rochester, MN 55905

Cc: Tate Clark, OIG

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Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov