Hospitalizations With Observation Services and the Medicare Part A Complex Appeals Process at Three Academic Medical Centers

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Hospitalists and other providers must classify hospitalized patients as *inpatient* or *outpatient*, the latter of which includes all *observation* stays. These orders direct hospital billing and payment, as well as patient out-of-pocket expenses. The Centers for Medicare & Medicaid Services (CMS) audits hospital billing for Medicare beneficiaries, historically through the Recovery Audit program. A recent U.S. Government Accountability Office (GAO) report identified problems in the hospital appeals process of Recovery Audit program audits to which CMS proposed reforms. In the context of the GAO report and CMS's proposed improvements, we conducted a study to describe the time course and process of complex Medicare Part A audits and appeals reaching Level 3 of the 5-level appeals process as of May 1, 2016 at 3 academic medical centers. Of 219 appeals reaching Level 3, 135 had a decision—96 (71.1%) successful for the hospitals. Mean total time since date of service was 1663.3 days, which includes mean days between date of service and audit (560.4) and total days in appeals (891.3). Government contractors were responsible for 70.7% of total appeals time. Overall, government contractors and judges met legislative timeliness deadlines less than half the time (47.7%), with declining compliance at successive levels (discussion, 92.5%; Level 1, 85.4%; Level 2, 38.8%; Level 3, 0%). Most Level 1 and Level 2 decision letters (95.2%) cited time-based (24-hour) criteria for determining inpatient status, despite 70.3% of denied appeals meeting the 24-hour benchmark. These findings suggest that the Medicare appeals system merits process improvement beyond current proposed reforms. *Journal of Hospital Medicine* 2017;12:251-255.

Hospitalists and other inpatient providers are familiar with hospitalizations classified *observation*. The Centers for Medicare & Medicaid Services (CMS) uses the "2-midnight rule" to distinguish between outpatient services (which include all observation stays) and inpatient services for most hospitalizations. The rule states that "inpatient admissions will generally be payable … if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation."[1]

Hospitalization under inpatient versus outpatient status is a billing distinction that can have significant financial consequences for patients, providers, and hospitals. The inpatient or outpatient observation orders written by hospitalists and other hospital-based providers direct billing based on CMS and other third-party regulation. However, providers may have variable expertise writing such orders. To audit the correct use of the visit-status orders by hospital providers, CMS uses recovery auditors (RAs), also referred to as recovery audit contractors.[2,3]

Historically, RAs had up to 3 years from date of service (DOS) to perform an audit, which involves asking a hospital for a medical record for a particular stay. The audit timeline includes 45 days for hospitals to produce such documentation, and 60 days for the RA either to agree with the hospital's billing or to make an "overpayment determination" that the hospital should have billed Medicare Part B (outpatient) instead of Part A (inpatient).[3,4] The hospital may either accept the RA decision, or contest it by using the pre-appeals discussion period or by directly entering the 5-level Medicare administrative appeals process.[3,4] Level 1 and Level 2 appeals are heard by a government contractor, Level 3 by an administrative law judge (ALJ), Level 4 by a Medicare appeals council, and Level 5 by a federal district court. These different appeal types have different deadlines (Appendix 1). The deadlines for hospitals and government responses beyond Level 1 are set by Congress and enforced by CMS,[3,4] and CMS sets discussion period timelines. Hospitals that miss an appeals deadline automatically default their appeals request, but there are no penalties for missed government deadlines.

Recently, there has been increased scrutiny of the audit-and-appeals process of outpatient and inpatient status determinations.[5] Despite the 2-midnight rule, the *Medicare Benefit Policy Manual* (*MBPM*) retains the passage: "Physicians should use a 24-hour period as a benchmark, i.e.,

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Additional Supporting Information may be found in the online version of this article.

Received: August 11, 2016; **Revised:** November 8, 2016; **Accepted:** November 10, 2016

2017 Society of Hospital Medicine DOI 10.12788/jhm.2720

they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis."[6] Auditors often cite "medical necessity" in their decisions, which is not well defined in the *MBPM* and can be open to different interpretation. This lack of clarity likely contributed to the large number of status determination discrepancies between providers and RAs, thereby creating a federal appeals backlog that caused the Office of Medicare Hearings and Appeals to halt hospital appeals assignments[7] and prompted an ongoing lawsuit against CMS regarding the lengthy appeals process.[4] To address these problems and clear the appeals backlog, CMS proposed a "$0.68 settlement offer."[4] The settlement "offered an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount)"[8] and paid out almost $1.5 billion to the third of eligible hospitals that accepted the offer.[9] CMS also made programmatic improvements to the RA program.[10]

Despite these efforts, problems remain. On June 9, 2016, the U.S. Government Accountability Office (GAO) published *Medicare Fee-for-Service: Opportunities Remain to Improve Appeals Process*, citing an approximate 2000% increase in hospital inpatient appeals during the period 2010–2014 and the concern that appeals requests will continue to exceed adjudication capabilities.[11] On July 5, 2016, CMS issued its proposed rule for appeals reform that allows the Medicare Appeals Council (Level 4) to set precedents which would be binding at lower levels and allows senior attorneys to handle some cases and effectively increase manpower at the Level 3 (ALJ). In addition, CMS proposes to revise the method for calculating dollars at risk needed to schedule an ALJ hearing, and develop methods to better adjudicate similar claims, and other process improvements aimed at decreasing the more than 750,000 current claims awaiting ALJ decisions.[12]

We conducted a study to better understand the Medicare appeals process in the context of the proposed CMS reforms by investigating all appeals reaching Level 3 at Johns Hopkins Hospital (JHH), University of Wisconsin Hospitals and Clinics (UWHC), and University of Utah Hospital (UU). Because relatively few cases nationally are appealed beyond Level 3, the study focused on most-relevant data.[3] We examined time spent at each appeal Level and whether it met federally mandated deadlines, as well as the percentage accountable to hospitals versus government contractors or ALJs. We also recorded the overturn rate at Level 3 and evaluated standardized text in de-identified decision letters to determine criteria cited by contractors in their decisions to deny hospital appeal requests.

METHODS

The JHH, UWHC, and UU Institutional Review Boards did not require a review. The study included all complex Part A appeals involving DOS before October 1, 2013 and reaching Level 3 (ALJ) as of May 1, 2016.

Our general methods were described previously.[2] Briefly, the 3 academic medical centers are geographically diverse. JHH is in region A, UWHC in region B, and UU in region D (3 of the 4 RA regions are represented). The hospitals had different Medicare administrative contractors but the same qualified independent contractor until March 1, 2015 (Appendix 2).

For this paper, time spent in the discussion period, if applicable, is included in appeals time, except as specified (Table 1). The term *partially favorable* is used for UU cases only, based on the *O'Connor Hospital* decision[13] (Table 1). Reflecting ambiguity in the *MBPM*, for time-based encounter length of stay (LOS) statements, JHH and UU used time between admission order and discharge order, whereas UWHC used time between decision to admit (for emergency department patients) or time care began (direct admissions) and time patient stopped receiving care (Table 2). Although CMS now defines when a hospital encounter begins under the 2-midnight rule,[14] there was no standard definition when the cases in this study were audited.

We reviewed de-identified standardized text in Level 1 and Level 2 decision letters. Each hospital designated an analyst to search letters for *Medicare Benefit Policy Manual chapter 1*, which references the 24-hour benchmark, or the *MBPM* statement regarding use of the 24-hour period as a benchmark to guide inpatient admission orders.[6] Associated paragraphs that included these terms were coded and reviewed by Drs. Sheehy, Engel, and Locke to confirm that the 24-hour time-based benchmark was mentioned, as per the *MBPM* statement (Table 2, Appendix 3).

Descriptive statistics are used to describe the data, and representative de-identified standardized text is included.

RESULTS

Of 219 Level 3 cases, 135 (61.6%) concluded at Level 3. Of these 135 cases, 96 (71.1%) were decided in favor of the hospital, 11 (8.1%) were settled in the CMS $0.68 settlement offer, and 28 (20.7%) were unfavorable to the hospital (Table 1).

Mean total days since DOS was 1,663.3 (536.8) (mean [SD]), with median 1708 days. This included 560.4 (351.6) days between DOS and audit (median 556 days) and 891.3 (320.3) days in appeal (median 979 days). The hospitals were responsible for 29.3% of that time (260.7 [68.2] days) while government contractors were responsible for 70.7% (630.6 [277.2] days). Government contractors and ALJs met deadlines 47.7% of the time, meeting appeals deadlines 92.5% of the time for Discussion, 85.4% for Level 1, 38.8% for Level 2, and 0% for Level 3 (Table 1).

All "redetermination" (level 1 appeals letters) received at UU and UWHC, and all "reconsideration" (level 2 appeals letters) received by UU, UWHC, and JHH contained standardized time-based 24–hour benchmark text directly or referencing the MBPM containing such text, to describe criteria for inpatient status (Table 2 and Appendix 3).[6] In total, 417 of 438 (95.2%) of Level 1 and Level 2 appeals results letters contained time-based 24-hour benchmark criteria for

TABLE 1. Complex Part A Appeals Reaching Administrative Law Judge (Level 3) at 3 Academic Medical Centers

	Academic Medical Center			
	JHH (n = 21)	UU (n = 116)	UWHC (n = 82)	Total (N = 219)
Total Time in Days Since Date of Service (mean, SD)[a]	2,377.9 (117.9)	1,391.1 (487.9)	1,865.3 (392.6)	1,663.3 (536.8)
Time between Date of Service (Discharge Date) and Audit	946.5 (105.8)	499.1 (357.6)	548.2 (323.0)	560.4 (351.6)
Time between Audit and Denial	394.5 (20.0)	120.6 (18.8)	108.2 (43.5)	142.2 (88.0)
Time between Denial and Appeal/Contested Denial[b]	49.3 (17.7)	97.9 (26.0)	34.3 (7.2)	69.4 (36.6)
Time in Appeals	987.6 (15.5)	673.5 (257.2)	1,174.7 (174.7)	891.3 (320.3)
Time in Appeals Attributable to Hospital (%)	26.6%	31.9%	27.7%	29.3%
Government Contractor Compliance with Deadlines (number, %)				
Discussion (30 day contractor deadline)[c]	9/9 (100%)	2/2 (100%)	75/82 (91.5%)	86/93 (92.5%)
Level 1 (60)	12/21 (57.1%)	95/116 (81.9%)	80/82 (97.6%)	187/219 (85.4%)
Level 2 (60)	18/21 (85.7%)	4/116 (3.4%)	63/82 (76.8%)	85/219 (38.8%)
Level 3 (90)	0/21 (0%)	0/116 (0%)	0/82 (0%)	0/219 (0%)
All Levels	39/72 (54.2%)	101/350 (28.9%)	218/328 (66.5%)	358/750 (47.7%)
Level 3 Appeals with ALJ Decisions or Settlement[d] Prior to ALJ Decision (number, %)	0/21 (0%)[f]	116/116 (100%)	19/82 (23.2%)	135/219 (61.6%)
Favorable/Partially Favorable Decisions for Hospital[e]	n/a	83/116 (71.6%)	13/19 (68.4%)	96/135 (71.1%)
CMS Settlement Prior to ALJ Decision	n/a	11/116 (9.5%)	0/19 (0%)	11/135 (8.1%)
Unfavorable Decisions for Hospital	n/a	22/116 (19.0%)	6/19 (31.6%)	28/135 (20.7%)

[a]Indicates total time (days) between date of service (defined as day of discharge) and Level 3 decision or settlement. For cases still awaiting Level 3 decision, indicates total time between date of service and censor date of 5/1/2016.

[b]Reflects most accurate timepoint at each institution where contested denial started for purposes of this study. At UWHC, this was Discussion for 79 cases and Level 1 appeal for 3; for UU and JHH, this was Level 1. Discussion request date could not be used for 14 cases because MAC demand letter (official start of payment denial) was received after the hospital's Discussion request. For these 14 cases, the Appeal/Contested Denial date is the Level 1 Appeal letter date even though Discussion was used. All timepoints used were based on dates on level appeal results/decision letters.

[c]As Discussion is optional, not all cases went through Discussion. All UWHC cases, 9 JHH cases, and 2 UU cases had Discussion. All cases reaching Level 3 went through Level 1 and 2.

[d]Settlement refers to the Centers for Medicare and Medicaid Services "$0.68 on the dollar" settlement offer in 2014. For purposes of this study, included settlement cases were waiting for an ALJ hearing at the time of the settlement. Of the three hospitals, only UU accepted the settlement.

[e]52 of the 83 favorable decisions at UU are considered 'partially favorable' and are the result of legal negotiation for Part B payment at the ALJ level based on the O'Connor case. In some individual cases, UU argued for full inpatient payment, but also requested that the judge consider partial payment for the medically necessary hospitalization based on the Medicare Appeal Council's decision In re O'Connor Hospital.13 Argued on a legal basis only, the ALJ awarded UU partial payment under Part B. UU considers these 52 decisions to be favorable (noted as "partially favorable" to distinguish).

[f]JHH is a Periodic Interim Payment (PIP) program, which likely delayed the start of RA audits and the subsequent appeals process timeline.

NOTE: Abbreviations: ALJ, administrative law judge; CMS, Centers for Medicare & Medicaid Services; DOS, date of service; JHH, Johns Hopkins Hospital; MAC, Medicare administrative contractor; PIP, periodic interim payment; SD, standard deviation; UU, University of Utah Hospital; UWHC, University of Wisconsin Hospitals and Clinics.

inpatient status despite 154 of 219 (70.3%) of denied cases exceeding a 24-hour LOS.

DISCUSSION

This study demonstrated process and timeliness concerns in the Medicare RA program for Level 3 cases at 3 academic medical centers. Although hospitals forfeit any appeal for which they miss a filing deadline, government contractors and ALJs met their deadlines less than half the time without default or penalty. Average time from the rendering of services to the conclusion of the audit-and-appeals process exceeded 4.5 years, which included an average 560 days between hospital stay and initial RA audit, and almost 900 days in appeals, with more than 70% of that time attributable to government contractors and ALJs.

Objective time-based 24-hour inpatient status criteria were referenced in 95% of decision letters, even though LOS exceeded 24 hours in more than 70% of these cases, suggesting that objective LOS data played only a small role in contractor decisions, or that contractors did not actually audit for LOS when reviewing cases. Unclear criteria likely contributed to payment denials and improper payments, despite admitting providers' best efforts to comply with Medicare rules when writing visit-status orders. There was also a significant cost to hospitals; our prior study found that navigating the appeals process required 5 full-time equivalents per institution.[2]

At the 2 study hospitals with Level 3 decisions, more than two thirds of the decisions favored the hospital, suggesting the hospitals were justified in appealing RA Level 1 and Level 2 determinations. This proportion is consistent with the 43% ALJ overturn rate (including RA- and non-RA-derived appeals) cited in the recent U.S. Court of Appeals for the DC Circuit decision.[9]

This study potentially was limited by contractor and hospital use of the nonstandardized LOS calculation during the study period. That the majority of JHH and UU cases cited

TABLE 2. Sample Time-Based Text Excerpts From Level 1 and Level 2 Decision Letters, Number of Letters That Included Time-Based Text, and Number of Cases That Exceeded 24 Hours,[a] for Appeals Reaching Level 3 at 3 Academic Medical Centers

	Academic Medical Center		
Measure	JHH (n = 21)	UWHC (n = 82)	UU (n = 116)
Exceeded 24-hour LOS,[b] n (%)	13 (61.9%)	72 (87.8%)	69 (59.5%)
Level 1 (MAC)	No time-based text in decision letters	Our review of the records was based on the Internet-Only Manuals (IOM) Pub 100-2 *Medicare Benefit Policy Manual* Chapter 1 Section 10[c] and 100-8 *Medicare Program Integrity Manual* Chapter 6 Section 6.5. Inpatient care rather than outpatient care is required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. The patient's (or "beneficiary's") signs and symptoms must be severe enough to warrant the need for medical care and must be severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.	The records did not support more intensive monitoring or extended nursing or physician care that would require an inpatient stay. Observation hospital care rather than inpatient admission was appropriate…The requirements for observation care, appropriate for this patient, are the same as for inpatient care with the exception that inpatient care is considerably more intense in terms of resource utilization (eg, ICU/CCU) and/or duration (commonly more than two days), entailing more extensive resource utilization. The policies used to help make this decision were: • *Medicare Benefit Policy Manual,* Chapter 1, "Inpatient Hospital Services Covered Under Part A"[c] • *Medicare Claims Processing Manual*, Chapter 3, "Inpatient Hospital Billing" • *Medicare Program Integrity Manual*, Chapter 6, Section 6.5, "Medical Review of Inpatient Hospital Claims" and Chapter 3, Section 3.4.5.C "Complex Prepayment/Postpayment Review"
Level 1 letters with time-based standardized text, n (%)	0 (0%)	82 (100%)	116 (100%)
Level 2 (QIC)[d]	For inpatient hospital care, admitting physicians or other practitioners should use a 24-hour period as a benchmark, ie, they should order inpatient admission for patients who are expected to need such care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision whether to admit as an inpatient is a complex medical judgment, which includes consideration of a variety of factors, including: • The patient's medical history and current medical needs • The types of facilities available to inpatients and outpatients, the hospital's bylaws and admission policies, and the relative appropriateness of treatment in each setting • The severity of the signs and symptoms exhibited by the beneficiary • The medical probability of something adverse happening to the beneficiary • The need for diagnostic studies that are appropriately outpatient services to assist in assessing the need for inpatient admission • The availability of diagnostic procedures at the time when and at the location where the beneficiary presents (*Medicare Benefit Policy Manual*, Publication 100-2, Chapter 1, Section 10).		
Level 2 letters with time-based standardized text, n (%)	21 (100%)	82 (100%)	116 (100%)

[a]There was no standard method of defining LOS at the time of these cases. At UWHC, LOS was time between emergency department decision to admit and time patient arrived on floor for direct admission; at JHH and UU, LOS was based on admit order. Discharge time was based on time patient stopped receiving care (UWHC) or on discharge order (JHH, UU). With this measurement method, LOS was shorter at JHH and UU than at UWHC.

[b]Of 219 cases, 154 (70.3%) exceeded the 24-hour benchmark; of 438 letters, 417 (95.2%) included time-based text.

[c]Referenced Chapter 1 contains text, "Physicians should use a 24-hour benchmark when deciding whether a beneficiary should be admitted as an inpatient. When a beneficiary is expected to need hospital care for 24 hours or more, the beneficiary should be admitted as an inpatient. Other patients should be admitted on an outpatient basis."

[d]The 3 hospitals had the same QIC for letters received in this study; therefore, Level 2 text was similar among hospitals.

NOTE: Abbreviations: CCU, cardiac/coronary care unit; ICU, intensive care unit; JHH, Johns Hopkins Hospital; LOS, length of stay; MAC, Medicare administrative contractor; QIC, qualified independent contractor; UU, University of Utah Hospital; UWHC, University of Wisconsin Hospitals and Clinics.

the 24-hour benchmark in their letters but nevertheless exceeded 24-hour LOS (using the most conservative definition of LOS) suggests contractors did not audit for or consider LOS in their decisions.

Our results support recent steps taken by CMS to reform the appeals process, including shortening the RA "look-back period" from 3 years to 6 months,[10] which will markedly shorten the 560-day lag between DOS and audit found in this study. In addition, CMS has replaced RAs with beneficiary and family-centered care quality improvement organizations (BFCC-QIOs)[1,8] for initial status determination audits. Although it is too soon to tell, the hope is that BFCC-QIOs will decrease the volume of audits and denials that have overwhelmed the system and most probably contributed to process delays and the appeals backlog.

However, our data demonstrate several areas of concern not addressed in the recent GAO report[11] or in the rule proposed by CMS.[12] Most important, CMS could consider an appeals deadline missed by a government contractor as a decision for the hospital, in the same way a hospital's missed deadline defaults its appeal. Such equity would ensure due process and prevent another appeals backlog. In addition, the large number of Level 3 decisions favoring hospitals suggests a need for process improvement at the Medicare administrative contractor and qualified independent contractor Level of appeals—such as mandatory review of Level 1 and Level 2 decision letters for appeals overturned at Level 3, accountability for Level 1 and Level 2 contractors with high rates of Level 3 overturn, and clarification of criteria used to judge determinations.

Medicare fraud cannot be tolerated, and a robust auditing process is essential to the integrity of the Medicare program. CMS's current and proposed reforms may not be enough to eliminate the appeals backlog and restore a timely and fair appeals process. As CMS explores bundled payments and other reimbursement reforms, perhaps the need to distinguish observation hospital care will be eliminated. Short of that, additional actions must be taken so that a just and efficient Medicare appeals system can be realized for observation hospitalizations.

Acknowledgments

For invaluable assistance in data preparation and presentation, the authors thank Becky Borchert, RN, MS, MBA, Program Manager for Medicare/Medicaid Utilization Review, University of Wisconsin Hospital and Clinics; Carol Duhaney, Calvin Young, and Joan Kratz, RN, Johns Hopkins Hospital; and Morgan Walker and Lisa Whittaker, RN, University of Utah.

Disclosure: Nothing to report.

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