Memorandum

Date JUL 6 1994

From June Gibbs Brown
Inspector General

Subject Expansion of the Diagnosis Related Group Payment Window (A-01-92-00521)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Expansion of the Diagnosis Related Group Payment Window." The objectives of our review were (1) to determine if the necessary controls are in place to preclude payment of nonphysician outpatient services in light of the Omnibus Budget Reconciliation Act of 1990; and (2) to examine whether it would be reasonable and appropriate to expand the payment window to encompass a longer period to include all admission related services, i.e. preadmission diagnostic services.

Under the prospective payment system (PPS), Medicare fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). Under current regulations, separate payments for nonphysician outpatient services rendered within 72 hours of the day of an inpatient admission are not permitted. We estimate that approximately $8.6 million in improper billings and subsequent payments for nonphysician outpatient services were made to hospitals under PPS for the period November 1990 through December 1991. We also identified approximately $4.1 million in improperly charged beneficiary coinsurance and deductible related to the improper payments.

Our analysis indicated that improper billings were made by hospitals primarily because of clerical errors and misinterpretation of the regulations. The FIs cited clerical errors and insufficient or nonexistent edits in their and in the Common Working File (CWF) claims processing systems.

Based on our review, we are recommending that the Health Care Financing Administration (HCFA): (1) require providers to delay submitting claims for nonphysician outpatient services until such time as the DRG payment window has expired and the providers ensure the beneficiary has not become an inpatient; (2) begin recovery action, through the FIs, for the estimated $8.6 million in potential improper payments; (3) ensure applicable coinsurance and deductible are

refunded to Medicare beneficiaries; (4) develop a CWF edit to prevent improper payments associated with the composite rate for dialysis treatment; and (5) require suspected duplicate claims to be returned by the FIs to providers rather than sending them to the CWF system for further processing.

In response to our recommendations in the draft report addressing current laws and regulations, HCFA concurs with Recommendations 2 and 3. The HCFA had some concern with Recommendation 4. The HCFA did not concur with Recommendations 1 and 5.

In replying to HCFA comments, we point to the fact that the Office of Inspector General has issued three prior reports on the compliance with laws and regulations. To this end, over $100 million in improper payments were recovered since the inception of PPS. We acknowledge HCFA's past efforts to educate providers on the proper billing procedures for nonphysician outpatient services. It is apparent from this review, however, that this education process is not working. As such, the best means to correct this problem is to not allow providers to submit a bill until such time as the DRG payment window has expired and providers are ensured the beneficiary has not become an inpatient.

In addition to reviewing the compliance with current regulations, we also wanted to determine if it would be reasonable and appropriate to expand the DRG payment window to encompass a longer period. For the period November 1990 through December 1991, we have identified an estimated $83.5 million in admission related nonphysician outpatient services rendered 4 to 7 days immediately before an inpatient admission. The corresponding beneficiary coinsurance and deductible are estimated to be $37.7 million. Since the intent of PPS has always been to include related services under one prospective payment, it would seem appropriate that the DRG payment window encompass a longer period. As such, we are recommending that HCFA consider proposing a legislative change to expand the DRG payment window to at least the 7 days immediately before the day of admission.

The HCFA did not concur with our recommendation to expand the current DRG payment window citing potentially negligible savings to the Medicare program. As our review showed, a significant number of admission related services are being rendered outside the current 72-hour window. We believe that the $83.5 million in program savings and the $37.7 million in savings to the beneficiaries are not negligible and further consideration should be given to this recommendation.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-01-92-00521 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EXPANSION OF THE DIAGNOSIS RELATED GROUP PAYMENT WINDOW

JUNE GIBBS BROWN
Inspector General

JULY 1994
A-01-92-00521

SUMMARY

Under the prospective payment system (PPS), Medicare fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). As PPS was implemented by the Health Care Financing Administration (HCFA), separate payments for nonphysician outpatient services provided on the day before admission to the same hospital or during an inpatient stay, exclusive of the day of discharge, are not permitted. Effective January 1, 1991, the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), section 4003, expanded the DRG payment window to 72 hours immediately preceding the day of the patient's admission.

The objectives of our review were (1) to determine if the necessary controls are in place to preclude payment of nonphysician outpatient services in light of OBRA '90; and (2) to examine whether it would be reasonable and appropriate to expand the payment window to encompass a longer period to include all admission related services, i.e. preadmission diagnostic services.

Based on the completion of a series of computer matches of general-care hospital inpatient claims data to nonphysician outpatient claims data for the period November 1990 through December 1991 and a validation of the results, we:

- estimate that about $8.6 million[1] in improper payments for nonphysician outpatient services were made to hospitals under PPS, and

- estimate that Medicare beneficiaries were charged about $4.1[1] million for the coinsurance and deductible applicable to the improper payments.

Our analysis showed that improper billings were made primarily because of clerical errors and misinterpretation of the regulation. Clerical errors and insufficient or nonexistent edits at the FIs and in the Common Working File (CWF) were cited by the FIs as reasons for improper payments.

We have addressed the compliance with Medicare laws and regulations regarding the DRG payment window in three prior reports (see Appendix I). In our last report, HCFA did not believe that billing instructions needed to be reinforced since prior instructions were not shown to be ineffective. The results of this review, and especially the providers' responses as to why claims were submitted for payment, clearly indicate that new billing instructions are warranted. As such, we recommend that HCFA issue new instructions to require providers to delay submitting claims for nonphysician outpatient services until such time as the DRG payment window has expired and the

[1] These figures have been updated using responses received since the issuance of the draft report.

provider ensures the beneficiary has not become an inpatient. We also recommend that HCFA, through the FIs, begin recovery actions for potential improper payments and ensure that applicable coinsurance and deductible are refunded to Medicare beneficiaries.

In response to our recommendations in the draft report addressing current laws and regulations, HCFA concurs with recommendations for recovering the improper payments. The HCFA had some concern with our recommendation for a specific system edit. Finally, HCFA did not concur with our recommendations for procedural changes in new billing instructions and in claims processing.

In replying to HCFA nonconcurrences, we point to the fact that the Office of Inspector General (OIG) has issued three prior reports on the compliance with laws and regulations. To this end, over $100 million in improper payments were recovered since the inception of PPS. We acknowledge HCFA's past efforts to educate providers on the proper billing procedures for nonphysician outpatient services. It is apparent from this review, however, that this education process is not working. As such, the best means to correct this problem is to not allow providers to submit a bill until such time as the DRG payment window has expired and the provider is ensured the beneficiary has not become an inpatient.

With respect to our second objective on the reasonableness of expanding the DRG payment window, our computer applications identified $91.8 million of nonphysician outpatient services rendered 4 to 7 days before the day of admission. Based on a review of medical records of a statistical sample, we estimate that $83.5 million[2] or 91 percent of these services were either scheduled prior to the admission or resulted in an inpatient admission. Corresponding beneficiary coinsurance and deductible are estimated to be $37.7 million.[2] Since it has been HCFA's longstanding policy to treat nonphysician outpatient services related to an admission as inpatient services and since our analysis indicates that common medical practice has preadmission testing (PAT) being rendered well in advance of the admission, we believe that HCFA should consider proposing legislation to expand the DRG payment window to encompass a longer period, i.e., at least 7 days.

Expanding the DRG payment window to at least 7 days before the day of admission would be consistent with industry practice and could achieve savings of up to $83.5 million to the Medicare program and additional savings to the beneficiaries. A certain source of program savings would also be derived from a reduction in administrative costs of processing fewer outpatient claims. The extent to which savings would accrue to the Medicare program, and ultimately the beneficiary, depends upon whether the Congress or HCFA: (1) believe that these services have already been accounted for when the base year costs were determined or (2) believe that folding in these services would result in a significant distortion in the inpatient operating costs to

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[2] These figures have been updated using responses received since the issuance of the draft report.

warrant an adjustment to the payment rate. In either case, since the intent of PPS has always been to include related services under one prospective payment, it would seem appropriate that HCFA should consider proposing legislation to expand the DRG payment window to encompass a longer period. Accordingly, we recommend that HCFA consider proposing a legislative change to expand the DRG payment window to at least the 7 days immediately before the day of admission.

The HCFA did not concur with our recommendation to expand the current DRG payment window citing potentially negligible savings to the Medicare program. As our review showed, a significant number of admission related services are being rendered outside the current 72-hour window. We believe that the $83.5 million in program savings and the $37.7 million in savings to the beneficiaries are not negligible and further consideration should be given to this recommendation.

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INTRODUCTION

BACKGROUND

Section 1886(d) of the Social Security Act, enacted by the Social Security Amendments of 1983, Public Law (P.L.) 98-21, established PPS. For inpatient services furnished to Medicare beneficiaries, Medicare FIs reimburse hospitals a predetermined amount, depending on the illness and its classification under a DRG. As implemented by HCFA, separate payments for nonphysician outpatient services (such as radiology, other diagnostic tests, and laboratory tests) provided on the day before admission to the same hospital or during an inpatient stay, exclusive of the day of discharge are not permitted. This is referred to as the 24-hour rule. Separate charges were not allowed because HCFA's longstanding policy is to consider these nonphysician outpatient services as inpatient services. As such, the costs of the nonphysician outpatient services have been included in the inpatient operating costs in developing the predetermined PPS rates used to pay claims for each DRG billed.

Effective January 1, 1991, the OBRA '90, P.L. 101-508, section 4003, extends the DRG payment window to preclude payment of nonphysician outpatient services up to 72 hours immediately preceding the day of admission. This amendment applies to:

- any nonphysician outpatient services rendered on the day before, the day of, or during an inpatient stay at a PPS hospital regardless of whether the services are admission related[3] (effective for services furnished before October 1, 1991); or

- diagnostic nonphysician outpatient services rendered up to 72 hours before the day of admission (effective for services furnished after January 1, 1991); or

- nondiagnostic nonphysician outpatient services rendered up to 72 hours before the day of admission and are admission related (effective for services furnished after October 1, 1991). This last provision of OBRA '90 was not implemented by HCFA until July 1992.

Section 3670 of the Medicare Intermediary Manual requires FIs to develop a system to prevent duplicate payment of nonphysician outpatient services. If a duplicate payment has been made, FIs should initiate appropriate recovery action and instruct the provider to refund to the beneficiary any coinsurance and deductible collected. As a supplement to the FIs' processing systems, the CWF is a prepayment validation system designed to avoid improper payment through a comparison of Part A and Part B claims data. These

[3] Services are considered admission related if they are furnished in connection with the principal diagnosis that necessitates the inpatient admission.

prepayment edits are designed to eliminate costly adjustment processing and overpayment recovery activities. In January 1991, CWF edits were revised to address the provisions of OBRA '90.

SCOPE

Our audit was made in accordance with generally accepted government auditing standards. The objectives of our review were to (1) determine if the necessary controls are in place to preclude payment of nonphysician outpatient services in light of OBRA '90; and (2) examine whether it would be reasonable and appropriate to expand the payment window to encompass a longer period to include all admission related services, i.e., preadmission diagnostic services. Our audit covered the period November 1990 through December 1991.

As part of our examination, we obtained an understanding of the internal control structure surrounding the processing of claims for nonphysician outpatient services. We concluded, however, that our consideration of the internal control structure could be conducted more efficiently by expanding substantive audit tests, thereby placing limited reliance on the hospitals' and FIs' internal control structure.

Accordingly, to accomplish Objective 1, we:

- reviewed applicable laws and regulations, Medicare and FI manuals, and HCFA's directives.

- examined the Arkansas and CWF claims processing systems by testing several transactions with expected results.

- performed several computer applications using HCFA's Medicare Part A paid claims file. We matched general-care hospital inpatient claims data to nonphysician outpatient claims data for the audit period and identified 74,301 potential improper payments for nonphysician outpatient services valued at $13,333,340.

- employed a multistage statistical sampling approach (see Appendix II). Our primary sampling unit consisted of 8 FIs from a population of 56 FIs with potential improper payments for nonphysician outpatient services. The secondary sampling unit consisted of 50 claims at each of these FIs (a total of 400 claims valued at $74,823).

- requested that the FIs, along with their hospitals, submit documentation (billing histories, hospital bills, medical records, etc.) to us for each of the 400 claims randomly selected in our sample. We also requested that both the FI and hospitals provide us with information as to why the claims were submitted and paid and to what extent improvements have been made to prevent improper payments from recurring.

- used a variable appraisal program to estimate the dollar impact of improper payments in the total population, as well as the estimated dollar impact of unnecessary charges to beneficiaries for coinsurance and deductibles.

To accomplish Objective 2, we:

- researched and evaluated the current law on the DRG payment window.

- performed several computer applications using HCFA's Medicare Part A paid claims file. We matched general-care hospital inpatient claims data to nonphysician outpatient claims data for the audit period and identified nonphysician outpatient services rendered 4 to 15 days before the day of admission.

- limited our review to nonphysician outpatient services rendered 4 to 7 days before the day of admission because of the volume of services, 654,648 claims valued at $91,821,785, and the likelihood of these services being admission related.

- used the same primary sampling units noted above in Objective 1. The secondary sampling unit consisted of 50 claims at each of these FIs (a total of 400 claims valued at $58,814).

- requested that the FIs, along with their hospitals, submit documentation (billing histories, hospital bills, medical records, etc.) to us for each of the 400 claims randomly selected in our sample. We also requested that the hospitals make a confirmation about whether these services were admission related.

- used a variable appraisal program to estimate the dollar value of admission related services rendered 4 to 7 days before the day of admission.

In completing our review of the sample, we established a reasonable assurance on the authenticity and accuracy of the data. Our audit was not directed towards assessing the completeness of the file from which the data was obtained.

Our audit included all PPS hospitals nationwide except those hospitals in Maryland and U.S. Territories which did not participate in PPS through the period covered by our audit. With respect to Objective 2, we limited our population to those services with a single date of service.

For those items tested, we found no instances of noncompliance except for the matters discussed in the FINDINGS AND RECOMMENDATIONS section of this report. Regarding the items not tested, nothing came to our attention to cause us to believe that untested items would produce different results. For example, an outpatient claim could have a range of dates of service which are outside and within the DRG payment window. The payment for services within the DRG payment window would be improper.

Our field work was performed from March 1993 through August 1993 at the HCFA central office in Baltimore, Maryland; Blue Cross of Massachusetts, Braintree, Massachusetts; selected Massachusetts hospitals; and the Office of Audit Services' office in Boston, Massachusetts.

The draft report was issued to HCFA on March 1, 1994. The HCFA's written comments, dated May 4, 1994, are appended to this report (see Appendix V) and addressed on page 13.

FINDINGS AND RECOMMENDATIONS

Since the inception of PPS in 1983, improper billings and subsequent payments have been made despite regulations which prohibit separate billing and payment for nonphysician outpatient services furnished to Medicare beneficiaries in conjunction with an inpatient stay. This problem was brought to HCFA's attention in three separate OIG reports and, based on recovery actions relative to those reports, over $100 million in improper payments have been recovered. Notwithstanding the corrective actions taken by HCFA, the problem still, to a lesser degree, persists.

For the period November 1990 through December 1991, we completed a series of computer matches using HCFA's Medicare Part A paid claims file containing general-care hospital inpatient claims data and nonphysician outpatient claims data. We identified 74,301 potential improper payments for nonphysician outpatient services valued at about $13.3 million (see Appendix III). These claims were submitted by 4,660 hospitals to 56 FIs. Based on a statistical projection, we estimate that about $8.6 million in improper payments for nonphysician outpatient services were made to hospitals for the audit period.[4] In addition to the improper payments to hospitals, we estimate that Medicare beneficiaries were charged approximately $4.1 million for the coinsurance and deductible share relative to the improper payments.

The OBRA '90 expands the DRG payment window to 72 hours before admission. The intent of this provision is to prevent hospitals from receiving separate payment for outpatient nonphysician services that are already included in the inpatient DRG rate. This is commonly referred to as unbundling. In this regard, our computer applications noted above also included an identification of nonphysician outpatient services rendered 4 to 15 days before the day of admission; however, we focused our review on those services rendered 4 to 7 days before the day of admission due to volume and the likelihood of these services being admission related. As such, we identified 654,648 claims for potentially admission related services valued at about $91.8 million (see Appendix IV). Our review indicates that it is common medical practice for patients to have PATs well in advance of an anticipated admission. Our review also indicates that other medical procedures or deteriorating medical conditions often result in admissions. Based on a statistical projection, we estimate that about $83.5 million in payments for nonphysician outpatient services were admission related. As such, consideration should be given to expanding the payment window to at least 7 days immediately before the day of admission.

[4] The $4.7 million difference between our estimate and the actual value of the population pertains to proper payments, improper payments previously corrected by the FIs, and no responses received (treated as proper payments for estimation purposes).

VALIDATION AND IDENTIFICATION OF POTENTIAL IMPROPER PAYMENTS

To validate our data and to estimate potential improper payments, we employed a multistage statistical sampling approach. In this regard, a primary sampling unit was an FI and a secondary sampling unit was a claim for nonphysician outpatient services. We selected 8 FIs from a population of 56 FIs and 50 claims were selected from the population of claims at each of the 8 FIs for a total of 400 claims (see Appendix II for details of the methodology for statistical sample selection).

We provided each FI with its sample claims. For each of the 400 claims, we requested that the FIs with their hospitals, submit documentation (billing histories, hospital bills, medical records, etc.) in order for us to determine the appropriateness of the payment. We also requested that both the hospitals and the FIs provide us with information as to why the claims were submitted and paid and what improvements have been made to prevent this situation from recurring. Figure 1 shows the breakdown of our analysis of the 400 claims.

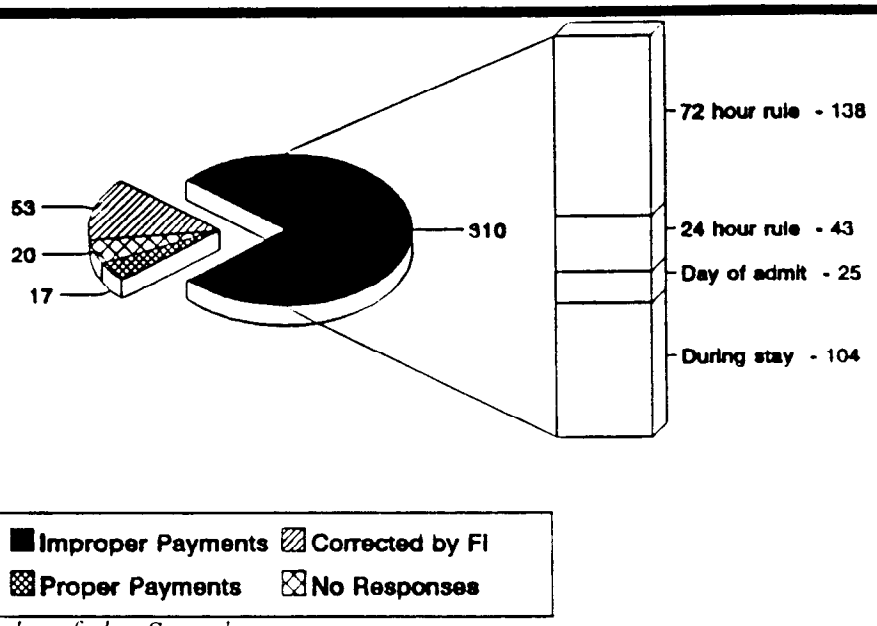

Figure 1 - Results of the Sample

As a result of reviewing the 400 claims with a dollar value of $74,823 and extrapolating the result of the statistical sample over the population using standard statistical methods, we found the following:

- A total of 310 claims valued at $47,402 were improperly paid. The estimated dollar impact of improper payments in the universe is $8,610,128 with a precision of this estimate at the 90 percent confidence level of ± 16.64 percent.

- A total of 243 of the 310 claims involved unnecessary payments of $22,029 by beneficiaries for the coinsurance and deductible share of the improperly paid claims. The estimated dollar impact on the beneficiaries is $4,148,039 with a precision of this estimate at the 90 percent confidence level of ± 16.59 percent.

Based on the responses from the eight FIs and the hospitals involved in the sample, we believe that the improper payments were the result of inadequate controls at the hospital and at the FI levels. The hospitals cited clerical error, hospital billing systems not designed to handle the DRG payment window, different providers of services during an inpatient stay, different intermediaries handling the inpatient and outpatient claims, problems associated with using a manual system to identify nonphysician outpatient services to be included with inpatient stay, separate billing departments, and misinterpretation of the regulation as reasons for improper billings. The FIs cited clerical errors, insufficient or nonexistent intermediary edits, and insufficient CWF edits as reasons for improper payments.

Through discussions with and written responses from hospitals, we have noted improvements made over time. In some instances hospitals are holding outpatient claims for several days before submitting them for payment. This enables the hospitals to, either manually or through an automated process, verify if the beneficiary has or has not been admitted to the hospital.

We tested the Arkansas and CWF claims processing systems during March 1993 with several transactions for nonphysician outpatient services with expected results. All claims with one exception were denied for payment. The one claim which was approved for payment pertained to the payment of the composite rate for a dialysis treatment during an inpatient stay. The Provider Reimbursement Manual, part I, section 2702.1 states, "The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day; the composite rate is not paid." Even though the errors associated with this type of claim appear to be insignificant, a CWF edit should still be developed to address this situation.

As noted above, when the test transactions were processed by both the Arkansas and CWF systems in sequence, all test transactions were processed correctly, except for the one type involving composite rates. However, we found that the FI's Arkansas system alone did not stop, for further processing, some claims that were suspected duplicates. Instead, these transactions were sent to the CWF system for further processing. Section 3670 of the Medicare Intermediary Manual requires FIs to develop a system to prevent duplicate payment of nonphysician outpatient services when the dates of service match those of an inpatient stay. We believe that once suspected duplicate claims are identified at the FI level, the FI should immediately return these claims to the provider to avoid potential duplicate payment and the additional and unnecessary processing costs by the CWF system.

FURTHER EXPANSION OF THE DRG PAYMENT WINDOW

In October 1990, the House Committee on the Budget proposed legislation to expand the DRG payment window to 72 hours given the estimated program savings. The Congressional Budget Office estimated that this expansion would realize program savings of $710 million for the period 1991 through 1995. The OBRA '90 was signed into law by the President in November 1990 with an effective date of the DRG payment window provisions of January 1, 1991. The purpose of the OBRA '90 provisions was to curb further unbundling of hospital services which has occurred since the inception of PPS. Our objective was to examine whether it would be reasonable and appropriate to expand the payment window to encompass a longer period to include all admission related services.

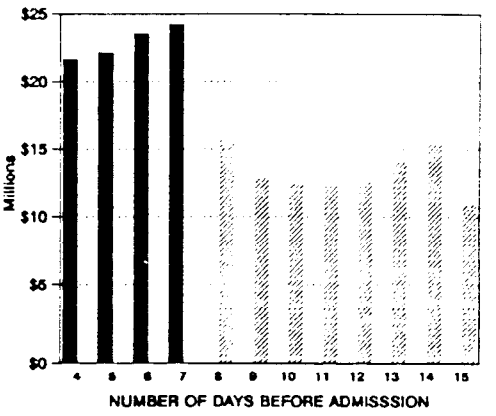

Figure 2 - Potential Admission Related Nonphysician Outpatient Services

We developed computer applications which identified nonphysician outpatient services rendered 4 to 15 days before the day of admission for the period November 1990 through December 1991. We refined our data to include only those claims which contained at least one diagnostic service (based on revenue center code). We arrayed the data by Medicare paid amount and by the number of days before the day of admission. It is evident that the majority of nonphysician outpatient services were rendered on days 4 through 7 (654,648 claims valued at about $91.8 million) (see Figure 2). A closer examination of the claims showed that the use of principal diagnosis codes in identifying admission related services is not always reliable. Therefore, we concluded that services rendered 4 to 7 days before the day of admission are more likely to be admission related. We also concluded that some services will not be admission related. In this respect, we estimated based on statistical sampling techniques that about $83.5 million of the $91.8 million were admission related services because of either being scheduled prior to the admission or resulting in an inpatient admission.

EXAMINATION OF THE DIAGNOSIS CODES

To validate the relationship of the nonphysician outpatient services to the subsequent admission, we attempted to rely on the diagnosis codes. Section 3610.3 of the Medicare Intermediary Manual states, "Services are considered related if they are furnished in connection with the principal diagnosis that necessitates the inpatient admission." As such, we tried to use the diagnosis codes to identify those claims where the principal diagnosis codes on both the outpatient and inpatient claims were exact. This analysis

showed that very few outpatient claims contained the same diagnosis as the inpatient claim. We found in our survey work that:

- oftentimes, no correlation exists between outpatient and inpatient diagnosis codes even though the services are admission related; and
- in the cases where the diagnosis codes matched, it was not always principal to principal, i.e., we noted principal to secondary, secondary to secondary, etc.

To demonstrate these points, consider the following cases:

CASE	TYPE OF CLAIM DATE OF SERVICE	DIAGNOSIS CODE AND DESCRIPTION	SERVICES RENDERED
A	Outpatient claim 7/16/91	Principal: 426.9 - Conduction disorder, unspecified	PATs: Lab, chest x-ray, EKG/ECG
	Inpatient claim 7/22/91	Principal: 996.01 - Mechanical complication due to pacemaker Secondary: 443.9 - Peripheral vascular disease, unspecified Tertiary: 786.66 - Swelling, mass, or lump in chest	
B	Outpatient claim 8/23/81	Principal: 600 - Hyperplasia of prostate Secondary: 602.8 - Other specified disorder of prostate	PATs: Lab, chest x-ray, EKG/ECG
	Inpatient claim 8/28/91	Principal: 598.9 - Postoperative urethral stricture Secondary: 600 - Hyperplasia of prostate	

In Case A, the hospital clearly indicated in the medical records that these nonphysician outpatient services were PAT, yet there is no correlation among the diagnosis codes. In Case B, the hospital indicated that these nonphysician outpatient services were also PAT and the diagnosis codes were the same. However, the principal diagnosis code on the outpatient claim matched the secondary diagnosis code on the inpatient claim.

REVIEW OF THE STATISTICAL SAMPLE

Since we were unable to rely on the outpatient diagnosis code in identifying admission related services, we employed a multistage statistical sampling approach. In this regard, a primary sampling unit was an FI and a secondary sampling unit was a claim for nonphysician outpatient services. We selected 50 claims from the population of claims at each of the 8 FIs for a total of 400 claims.

We provided each FI with its sample claims. For each of the 400 claims, we requested that the FIs with their hospitals, submit documentation (billing histories, hospital bills, medical records, etc.) in order for us to determine if the nonphysician outpatient services were admission related. We also requested the hospitals to confirm whether or not the services were admission related or not.

Our analysis of the sample of 400 claims (see Figure 3) showed:

- that 88 claims were for PAT for a scheduled admission;
- that 186 claims were for services related to the admission because (a) routine tests produced results which warranted an admission; (b) the beneficiary was treated in the emergency room, discharged to his/her home, and was admitted several days later due to a deteriorating condition; or (c) the beneficiary underwent an ambulatory surgical procedure and was later admitted due to complications;

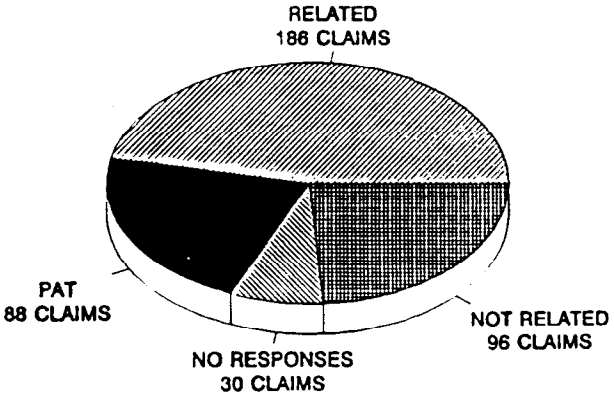

Figure 3 - Results of the Sample

- that 96 claims were for services which were not related to the admission; and
- no responses for 30 claims (these claims were considered not related to an admission for estimation purposes).

With respect to PAT, we requested hospitals to provide to us their preadmission policies, if any. Based on responses and discussions with hospital officials, it is common medical practice to conduct PAT anywhere from 1 to 14 days before admission. In some cases, certain diagnostic services can be performed up to 30 days before admission. This time frame allows surgeons and anesthesiologists to review the results to make the determination on whether to proceed with the surgery, cancel the surgery, or conduct

more tests. We also identified a private insurance plan which considers outpatient diagnostic services provided within 7 days before an admission to be part of that admission for payment purposes.

As a result of reviewing the 400 claims with a dollar value of $58,814 and extrapolating the result of the statistical sample over the population using standard statistical methods, we found that a total of 274 claims valued at $44,424 were admission related. The estimated amount of admission related services in the universe is $83,474,516 with a precision of this estimate at the 90 percent confidence level of ± 32.95 percent.

ADJUSTMENTS TO DRG PAYMENT RATE

When the current payment window was enacted, the Congress made no provisions in OBRA '90 to require an adjustment to the DRG payments to account for any additional services rendered up to 72 hours. We did note, however, in a Conference Agreement that the conferees did not expect an adjustment to be made until Fiscal Year 1993 when data would be available. The HCFA determined that estimated savings derived from OBRA '90 are, "...less than one-half of one percent of total Medicare funding to hospital...." To date, HCFA has made no adjustment to reflect the effects of the 72-hour DRG payment window.

We have demonstrated the magnitude of nonphysician outpatient services rendered 4 to 7 days before an admission. It cannot be determined whether the cost of the services which make up the $83.5 million has already been taken into consideration. These services may be of the type that were once performed on the day before, the day of, or during an inpatient admission and are now being performed 4 to 7 days before an admission. If so, the cost of these services has been taken into consideration. The timing of these services may have remained unchanged since the inception of PPS. Hospitals may have always performed PATs well in advance of an admission. If so, these services may have never entered into the determination of the payment rate.

Expanding the DRG payment window to at least 7 days before the day of admission would be consistent with industry practice and could achieve savings of up to $83.5 million to the Medicare program and additional savings to the beneficiaries. A definite savings to the Medicare program would also come from the reduction in administrative costs of processing fewer outpatient claims. The extent to which savings would accrue to the Medicare program depends upon whether the Congress or HCFA: (1) believe that these services have already been accounted for when the base year costs were determined or (2) believe that folding in these services would result in a significant distortion in the inpatient operating costs to warrant an adjustment to the payment rate. In either case, since the intent of PPS has always been to include related services under one prospective payment, it would seem appropriate for HCFA to consider proposing legislation to expand the DRG payment window to encompass a longer period.

Whenever program savings are attained, corresponding savings to the beneficiary are also achieved. In times when beneficiaries are choosing between health care and other

necessities of life, reductions in health care related costs are welcomed. In reviewing our sample, we found 218 of the 274 claims for admission related services involved beneficiary coinsurance and deductible of $20,804. Extrapolated to the universe, beneficiary coinsurance and deductible relating to admission related services is $37,734,679 with a precision of this estimate at the 90 percent confidence level of ± 25.98 percent. By expanding the DRG payment window and folding nonphysician outpatient services into the DRG payment, beneficiaries will no longer be responsible for Part B coinsurance and deductible. They will, however, continue to be responsible for inpatient coinsurance and deductible.

CONCLUSIONS

For the period November 1990 through December 1991, approximately $8.6 million in improper billings and payments for nonphysician outpatient services were made by providers and FIs, respectively. In addition, Medicare beneficiaries paid about $4.1 million in coinsurance and deductibles for claims that should not have been processed for payment. We have noted problems with billing and claims processing, as well as improvements. Our March 1993 review of test transactions of the CWF system and the FI's Arkansas system found two problems that need to be corrected. We found that the CWF system did not prevent payment of claims involving the composite rate for dialysis treatment. Also, the Arkansas system did not stop suspected duplicate claims at the FI level, but allowed them to be further processed by the CWF system at additional expense. Yet, the fact that these claims are being submitted for payment is a clear indication that past billing instructions have not been effective. Although some providers are still submitting improper claims, we found instances where hospitals are holding outpatient claims for several days before submitting them for payment. This practice enables the hospitals to verify if the beneficiary has or has not been admitted to the hospital. We believe that HCFA should expand this practice by requiring hospitals to delay the submission of these claims until the DRG payment window has expired.

In addition to the above, we tried to determine if it would be reasonable and appropriate to expand the DRG payment window to encompass a longer period. The HCFA's longstanding policy has been to treat nonphysician outpatient services related to an admission as inpatient services. Our analysis of nonphysician outpatient services rendered 4 to 15 days before admission indicates the majority of these services were rendered on days 4 through 7. Based on statistical sampling techniques, we estimate that about $83.5 million in admission related services were provided on days 4 through 7. This analysis suggests that it is becoming more common to perform admission related services during the 7 days prior to hospital admission. In view of this, consideration should be given to expanding the DRG payment window beyond 72 hours.

As indicated, this was our fourth review in the area of compliance with the DRG payment window. As such, we have been able to accumulate potential improper payments for nonphysician outpatient services into a national data base. We would be more than willing to work with HCFA in using this data base to profile providers who have continually submitted improper claims at which specific attention could be directed.

RECOMMENDATIONS

We recommend that HCFA, with respect to the improper payments:

1. Issue new instructions to require providers to delay submitting claims for nonphysician outpatient services until such time as the DRG payment window has expired and the provider ensures the beneficiary has not become an inpatient.

2. Provide FIs with our computer tapes to begin recovery action of the estimated $8.6 million in potential improper payments.

3. Require FIs to instruct providers to refund the coinsurance and deductible portion of the improper payments. The FIs should monitor this especially in the instances where the beneficiaries are responsible for these payments.

4. Develop a CWF edit to prevent improper payments associated with the composite rate for dialysis treatments rendered during an inpatient stay.

5. Require suspected duplicate claims to be returned by the FIs to providers rather than sending them to the CWF system for further processing.

Finally, with respect to the expansion of the DRG payment window:

6. Propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission.

HCFA COMMENTS

In response to the draft report (see Appendix V), HCFA concurred with recommendations to recover the potential improper payments of $8.6 million and to ensure beneficiaries are refunded the $4.1 million in coinsurance and deductibles. With respect to our recommendation to implement a CWF edit to address claims for dialysis services rendered during an inpatient stay, HCFA had some concern regarding the implementation of this recommendation. Finally, HCFA's nonconcurrence with the remaining recommendations are summarized as follows:

Recommendation 1

The HCFA believes a delay in submitting claims would not be beneficial to the providers because it would delay payment for every outpatient claim.

Recommendation 4

The HCFA expressed concern regarding this recommendation. The HCFA stated that while CWF does not currently match end stage renal disease (ESRD) composite rate claims against inpatient stays, it could implement such an edit in the future with more definitive edit criteria from the OIG. The HCFA believes the DRG window should be applied to ESRD dialysis services paid under the composite rate, because these services are essentially life support services and, as such, would always be related to one or more secondary diagnosis on the inpatient claim, and not directly related to the reason for admission. The HCFA also stated it would like to discuss with the OIG the nature of the suggested CWF edit and asked for examples as to what the OIG considers inappropriate inpatient/outpatient service mix for ESRD beneficiaries.

Recommendation 5

The HCFA believes processing through CWF is necessary for making the proper determination on the appropriateness of a claim. The HCFA also feels that it would not be cost effective or efficient for the FIs to implement.

Recommendation 6

The HCFA does not support initiating a legislative proposal to expand the DRG payment window beyond the current 72 hours since the potential savings would be negligible.

OIG RESPONSE

Recommendation 1

As we noted in our report, improper billings and subsequent payments have been made since the inception of PPS. The OIG has identified over $100 million in improper payments in three prior reports. It is apparent that providers have not followed appropriate billing procedures. We recognize past efforts by HCFA to educate providers to proper billing procedures; however, this alone is not working. As such, the best means to correct this problem is to not allow providers to submit a bill until such time as the DRG payment window has expired and the provider is ensured the beneficiary has not become an inpatient.

Recommendation 4

To address HCFA's concern, we have clarified the recommendation to state "Develop a CWF edit to prevent improper payments associated with the composite rate for dialysis treatments rendered during an inpatient stay." Regardless of the reason for an admission, dialysis services rendered during an inpatient stay would be included in the

DRG payment and should not be billed separately. Further, the OIG agrees it would be beneficial to discuss the nature of the suggested CWF edit and would provide an example of such an edit to HCFA staff.

Recommendation 5

We acknowledge HCFA's position on this recommendation. We note, however, that the implementation of Recommendation 1 would significantly curtail the number of improper claims being submitted to the FIs.

Recommendation 6

We believe that HCFA should reevaluate its position and propose legislation to expand the DRG payment window. The HCFA states that the amount of savings is negligible. This would be true if payment rates were adjusted to account for additional services. However, the HCFA states that an adjustment "would not be necessary" because preadmission tests were accounted for in the base year and thus rebundling would not distort the operating costs of inpatient hospital services. Accordingly, the $83.5 million in program savings and $37.7 million savings to the beneficiary in our opinion are significant.

To further illustrate our position on the need for an expanded window, we point to the January 12, 1994 Federal Register containing HCFA's interim final rule entitled ***Preadmission Services Included In Part A Payment.*** In the interim final rule, HCFA, in referring to the 72-hour window, states "This regulation will result in program savings from discontinuing separate payment under Part B...without an immediate, corresponding increase in the DRG payments under Part A. The estimated savings will be reduced if physicians [and, in our opinion, hospitals] elect to have preadmission services performed at a non-hospital site or more than 3 days before admission." It is not clear how HCFA can acknowledge program savings with the 72-hour window, yet believes savings would be negligible with a 7 day window. Further the interim final rule states, "... we do not anticipate that this new provision will cause a significant change in timing of services..." It is clear from our review that a significant number of admission related services are being rendered outside the current 72-hour payment window. An expanded window would not only achieve the savings HCFA estimated with a 72-hour window but also our estimated savings with an expanded window. Finally, the interim final rule states beneficiaries will receive benefit from a 72-hour window since they will no longer be paying the coinsurance and deductible on these services. We agree and point to the estimated savings of $37.7 million in coinsurance and deductibles associated with the admission related services rendered 4 to 7 days before admission.

Addressing HCFA's comment on the use of principal diagnosis, our analysis of the principal diagnosis code was twofold. First, we did not want to rely strictly on the principal diagnosis codes of both the outpatient and inpatient claims to determine if services rendered outside the current payment window were admission related. As our

report points out a one-for-one match of the diagnosis code was not practical. Secondly, we believe that since a one-for-one match is not reliable, some admission related nondiagnostic services rendered in the payment window could be inappropriately reimbursed.

Finally, with respect to HCFA's technical comments, we revised our final report to address these concerns.

APPENDICES

PRIOR OIG REPORTS ADDRESSING IMPROPER PAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES

CIN	TITLE	AUDIT PERIOD	AMOUNT RECOVERED
A-01-86-62024	Millions in Improper Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System	October 1, 1983 through January 31, 1986	$24.6 million
A-01-90-00516	Improper Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System	February 1, 1986 through November 30, 1987	$31 million
A-01-91-00511	Nationwide Review of Improper Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System	December 1, 1987 through October 31, 1990	$45.7 million

METHODOLOGY OF STATISTICAL SAMPLE SELECTION

To select a sample for validating our data and estimating the potential improper payments for nonphysician outpatient services, we employed a multistage sample based on probability-proportional-to-size weighted by dollar value at each intermediary. The sample was drawn from 56 FIs which processed 74,301 claims for nonphysician outpatient services (valued at $13.3 million) (See Appendix III). Thus, the primary sampling units consisted of 8 FIs and our secondary units consisted of 50 claims at each FI (a total of 400 claims).

To select our primary sample units, the following steps were conducted:

- for each FI, the number of claims and the value of these claims were determined,
- the 56 primary units were randomly assigned to 8 groups,
- one FI was then selected from each of the eight groups with chance of selection proportional to their respective dollar value within that group.

The following FIs were selected:

INTERMEDIARY	CLAIM COUNT	TOTAL AMOUNT PAID
BLUE CROSS OF ALABAMA	1,703	$269,665
BLUE CROSS OF CALIFORNIA	3,198	$837,455
BLUE CROSS OF MASSACHUSETTS	1,549	$245,252
BLUE CROSS OF MONTANA	180	$ 39,753
EMPIRE BLUE CROSS	5,885	$737,559
BLUE CROSS OF WESTERN PENNSYLVANIA	5,783	$787,554
BLUE CROSS OF TEXAS	2,435	$561,683
AETNA OF ILLINOIS	333	$ 48,545

The selection of secondary units was by a simple random sample of claims for nonphysician outpatient service. Fifty claims were selected from the population of claims at each of the 8 FIs.

To validate our data and estimate the amount of admission related services, we used the same FIs selected as noted above. The selection of secondary units was by a simple random sample of claims for nonphysician outpatient service. Fifty claims were selected from the following population of claims at each of the 8 FIs.

INTERMEDIARY	CLAIM COUNT	TOTAL AMOUNT PAID
BLUE CROSS OF ALABAMA	9,889	$1,306,736
BLUE CROSS OF CALIFORNIA	28,705	$6,725,604
BLUE CROSS OF MASSACHUSETTS	23,543	$2,892,876
BLUE CROSS OF MONTANA	2,200	$ 439,741
EMPIRE BLUE CROSS	61,805	$6,071,396
BLUE CROSS OF WESTERN PENNSYLVANIA	45,212	$4,643,317
BLUE CROSS OF TEXAS	18,107	$3,269,051
AETNA OF ILLINOIS	2,858	$ 380,696

Claims for which we have not received supporting documentation have been considered a zero error for estimation purposes.

All random selections were made using the Office of Audit Services Statistical Software dated October 1992.

SUMMARY BY INTERMEDIARY OF POTENTIAL IMPROPER
PAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES
NOVEMBER 1990 THROUGH DECEMBER 1991

INTERMEDIARY	PROVIDER COUNT	CLAIM COUNT	TOTAL PAID AMOUNT
00010-BC OF ALABAMA	95	1,703	$ 269,665
00020-BC OF ARKANSAS	75	1,039	125,187
00030-BC OF ARIZONA	50	662	325,425
00040-BC OF CALIFORNIA	277	3,198	837,455
00050-COLORADO HOSPITAL SERVICE	52	643	119,261
00060-BC OF CONNECTICUT	27	834	153,957
00070-BC OF DELAWARE	7	258	45,716
00090-BC OF FLORIDA	187	4,119	728,885
00101-BC OF GEORGIA	133	2,104	351,943
00121-HEALTH CARE SERVICE CORP ILLINOIS	161	1,658	395,731
00130-MUTUAL HOSPITAL INSURANCE INC INDIANA	113	2,436	371,728
00140-BC OF IOWA	123	1,011	186,031
00150-BC OF KANSAS	82	475	67,998
00160-BC OF KENTUCKY	96	1,149	178,255
00170-BC OF LOUISIANA	1	1	33
00180-ASSOCIATED HOSPITAL SERVICE OF MAINE	36	251	34,737
00190-BC OF MARYLAND	9	348	81,493
00200-BC OF MASSACHUSETTS	75	1,549	245,252
00210-BC OF MICHIGAN	149	2,978	466,276
00220-BC OF MINNESOTA	112	924	144,640
00230-BC OF MISSISSIPPI	83	758	95,588
00231-BC OF LOUISIANA	84	1,179	289,191
00241-BC OF HOSPITAL SERVICE OF MISSOURI	125	1,656	279,105
00250-BC OF MONTANA	29	180	39,753
00260-BC OF NEBRASKA	32	182	24,675
00270-NEW HAMPSHIRE/VERMONT HOSPITAL SERVICE	40	640	89,690

SUMMARY BY INTERMEDIARY OF POTENTIAL IMPROPER PAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES NOVEMBER 1990 THROUGH DECEMBER 1991

INTERMEDIARY	PROVIDER COUNT	CLAIM COUNT	TOTAL PAID AMOUNT
00280-HOSPITAL SERVICE PLAN OF NEW JERSEY	89	3,433	816,753
00290-NEW MEXICO BC	69	495	79,997
00308-EMPIRE BC	219	5,885	737,559
00310-NORTH CAROLINA BC	109	2,227	407,471
00320-BC OF NORTH DAKOTA	34	181	31,690
00332-HOSPITAL CARE CORP OHIO	176	4,162	781,521
00340-BC OF OKLAHOMA	75	656	141,843
00350-NORTHWEST HOSPITAL SERVICE OREGON	55	636	140,024
00351-BC OF IDAHO	34	223	29,764
00362-BC OF GREATER PHILADELPHIA	27	862	103,075
00363-BC OF WESTERN PENNSYLVANIA	148	5,783	787,554
00370-BC OF RHODE ISLAND	11	268	50,039
00380-BC OF SOUTH CAROLINA	62	897	173,324
00390-BC OF TENNESSEE	117	1,537	210,766
00400-BC OF TEXAS	242	2,435	561,683
00410-BC OF UTAH	26	215	40,526
00423-BC OF VIRGINIA	120	1,681	265,811
00430-BC OF WASHINGTON ALASKA	69	545	135,497
00441-BC HOSPITAL SERVICE INC WEST VIRGINIA	33	151	14,695
00450-ASSOCIATED HOSPITAL SERVICE IN WISCONSIN	124	2,280	274,319
00460-WYOMING HOSPITAL SERVICE	21	88	15,540
00468-COOPERATIVA DE SEGUROS DE VIDA DE PUERTO RICO	47	310	17,492
17120-HAWAII GUAM MEDICAL SERVICE ASSOCIATION	13	84	16,022
50333-TIC NEW YORK	24	408	58,014
51051-AETNA CALIFORNIA	114	1,124	293,550

SUMMARY BY INTERMEDIARY OF POTENTIAL IMPROPER PAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES NOVEMBER 1990 THROUGH DECEMBER 1991

INTERMEDIARY	PROVIDER COUNT	CLAIM COUNT	TOTAL PAID AMOUNT
51070-AETNA CONNECTICUT	23	548	111,058
51100-AETNA FLORIDA	4	78	22,109
51140-AETNA ILLINOIS	26	333	48,545
51390-AETNA PENNSYLVANIA	41	2,068	284,827
52280-MUTUAL OF OMAHA	255	2,773	734,602
TOTAL	4,660	74,301	$13,333,340

SUMMARY BY INTERMEDIARY OF POTENTIAL ADMISSION RELATED NONPHYSICIAN OUTPATIENT SERVICES RENDERED 4 TO 7 DAYS BEFORE THE DAY OF ADMISSION NOVEMBER 1990 THROUGH DECEMBER 1991

INTERMEDIARY	PROVIDER COUNT	CLAIM COUNT	TOTAL PAID AMOUNT
00010-BC OF ALABAMA	105	9,889	$ 1,306,736
00020-BC OF ARKANSAS	80	5,998	765,834
00030-BC OF ARIZONA	58	6,158	2,178,752
00040-BC OF CALIFORNIA	304	28,705	6,725,604
00050-COLORADO HOSPITAL SERVICE	66	6,298	914,493
00060-BC OF CONNECTICUT	28	8,057	1,000,643
00070-BC OF DELAWARE	7	1,758	239,494
00090-BC OF FLORIDA	195	26,060	4,139,556
00101-BC OF GEORGIA	149	12,152	1,798,529
00121-HEALTH CARE SERVICE CORP ILLINOIS	185	28,634	4,015,327
00130-MUTUAL HOSPITAL INSURANCE INC INDIANA	115	18,654	2,451,457
00140-BC OF IOWA	175	13,524	1,733,925
00150-BC OF KANSAS	129	5,570	815,270
00160-BC OF KENTUCKY	107	11,026	1,299,177
00170-BC OF LOUISIANA	5	6	330
00180-ASSOCIATED HOSPITAL SERVICE OF MAINE	40	5,273	521,794
00190-BC OF MARYLAND	10	1,544	369,007
00200-BC OF MASSACHUSETTS	76	23,543	2,892,876
00210-BC OF MICHIGAN	165	31,921	3,718,630
00220-BC OF MINNESOTA	153	8,356	1,088,538
00230-BC OF MISSISSIPPI	101	6,265	615,722
00231-BC OF LOUISIANA	102	5,972	1,425,000
00241-BC OF HOSPITAL SERVICE OF MISSOURI	139	15,066	2,191,360
00250-BC OF MONTANA	52	2,200	439,741
00260-BC OF NEBRASKA	74	2,117	281,110
00270-NEW HAMPSHIRE/VERMONT HOSPITAL SERVICE	41	5,318	601,447

SUMMARY BY INTERMEDIARY OF POTENTIAL ADMISSION RELATED NONPHYSICIAN OUTPATIENT SERVICES RENDERED 4 TO 7 DAYS BEFORE THE DAY OF ADMISSION NOVEMBER 1990 THROUGH DECEMBER 1991

INTERMEDIARY	PROVIDER COUNT	CLAIM COUNT	TOTAL PAID AMOUNT
00280-HOSPITAL SERVICE PLAN OF NEW JERSEY	89	13,934	2,174,744
00290-NEW MEXICO BC	35	2,401	282,810
00308-EMPIRE BC	221	61,805	6,071,396
00310-NORTH CAROLINA BC	115	17,110	2,449,959
00320-BC OF NORTH DAKOTA	47	1,236	212,858
00332-HOSPITAL CARE CORP OHIO	180	43,891	6,618,253
00340-BC OF OKLAHOMA	108	6,988	1,176,520
00350-NORTHWEST HOSPITAL SERVICE OREGON	64	6,771	1,150,302
00351-BC OF IDAHO	42	2,201	306,465
00362-BC OF GREATER PHILADELPHIA	27	6,413	653,499
00363-BC OF WESTERN PENNSYLVANIA	149	45,212	4,643,317
00370-BC OF RHODE ISLAND	12	5,895	643,181
00380-BC OF SOUTH CAROLINA	63	6,438	828,689
00390-BC OF TENNESSEE	135	14,823	1,820,177
00400-BC OF TEXAS	311	18,107	3,269,051
00410-BC OF UTAH	36	2,906	341,930
00423-BC OF VIRGINIA	139	19,629	2,431,755
00430-BC OF WASHINGTON ALASKA	87	6,611	1,229,355
00441-BC HOSPITAL SERVICE INC WEST VIRGINIA	52	2,133	209,747
00450-ASSOCIATED HOSPITAL SERVICE IN WISCONSIN	130	14,183	1,775,793
00460-WYOMING HOSPITAL SERVICE	27	842	166,723
00468-COOPERATIVA DE SEGUROS DE VIDA DE PUERTO RICO	53	6,415	327,376
17120-HAWAII GUAM MEDICAL SERVICE ASSOCIATION	18	1,249	242,479
50333-TIC NEW YORK	24	4,932	579,673
51051-AETNA CALIFORNIA	137	11,504	2,194,716

SUMMARY BY INTERMEDIARY OF POTENTIAL ADMISSION RELATED NONPHYSICIAN OUTPATIENT SERVICES RENDERED 4 TO 7 DAYS BEFORE THE DAY OF ADMISSION NOVEMBER 1990 THROUGH DECEMBER 1991

INTERMEDIARY	PROVIDER COUNT	CLAIM COUNT	TOTAL PAID AMOUNT
51070-AETNA CONNECTICUT	24	6,351	912,778
51100-AETNA FLORIDA	5	880	122,364
51140-AETNA ILLINOIS	26	2,858	380,696
51390-AETNA PENNSYLVANIA	42	12,781	1,469,385
52280-MUTUAL OF OMAHA	269	18,085	3,605,442
TOTAL	5,328	654,648	$91,821,785

DEPARTMENT OF HEALTH & HUMAN SERVICES

Financing Administration

Memorandum

Date MAY 4 1994

From Bruce C. Vladeck
Administrator

Subject Office of Inspector General (OIG) Draft Report: "Expansion of the Diagnosis Related Group Payment Window"(A-01-92-00521)

To June Gibbs Brown
Inspector General

We reviewed the above-subject draft report which examines the appropriateness of expanding the diagnosis related group payment window to encompass a longer period. Our specific comments are attached.

Thank you for the opportunity to review and comment on this report. Please advise us if you agree with our comments on the report's recommendations at your earliest convenience.

Attachment

IG	✓
SAIG	✓
PDIG	✓
DIG-AS	✓
DIG-EI	
DIG-OI	
AIG-MP	
OGC/IG	
EXSEC	✓
DATE SENT	5-5

Comments of the Health Care Financing Administration (HCFA)
on the Office of Inspector General (OIG) Draft Report:
"Expansion of the Diagnosis Related Group Payment Window"
(A-01-92-00521)

OIG Recommendation #1

Issue new instructions to require providers to delay submitting claims for nonphysician outpatient services until such time as the DRG payment window has expired and the provider ensures the beneficiary has not become an inpatient.

HCFA Response

HCFA nonconcurs. Given the existing payment floor, we do not believe HCFA should request that providers hold claims for outpatient services. The delay in submitting claims would not be beneficial to providers because there would be a delay in payment for every Medicare outpatient claim.

Further, we are concerned that the impact of the proposed delays in billing will affect some providers' ability to qualify for Periodic Interim Payment. This will actually delay payment an additional 3 days under the current law, and would delay payment a total of 21 days minimum if the proposed legislative change in recommendation 6 is adopted. We maintain that the 13-day payment floor for electronic media claims (EMC) and 26 days for paper claims allow the requisite time for an inpatient admission to occur in most cases, and that it would be a burden on hospitals to be required to hold all outpatient claims.

OIG Recommendation #2

Provide FIs with OIG's computer tapes to begin recovery action of the estimated $7.9 million in potential improper payments.

HCFA Response

HCFA concurs. This recovery will be coordinated by the Division of Account Management and Collection in the Office of Contracting and Financial Management in the Bureau of Program Operations.

OIG Recommendation #3

Require FIs to instruct providers to refund the coinsurance and deductible portion of the improper payments. The FIs should monitor this especially in the instances where the beneficiaries are responsible for these payments.

HCFA Response

HCFA concurs. This is part of an FI's normal duties.

OIG Recommendation #4

Develop a CWF edit to prevent improper payments associated with the composite rate for dialysis treatment.

HCFA Response

We have some concern regarding this recommendation. While the Common Working File (CWF) does not currently match End-Stage Renal Disease (ESRD) composite rate claims against inpatient stays, we could implement such an edit in the future with more definitive edit criteria from the OIG. We do not believe the Diagnosis Related Group (DRG) window should be applied to ESRD dialysis services paid under the composite rate, because these services are essentially life support services and, as such, would always be related to one or more secondary diagnosis on the inpatient claim, and not directly related to the reason for the admission.

HCFA would like to discuss with the OIG the nature of the CWF edit they have suggested. Specifically, we need examples from the OIG as to what it considers inappropriate inpatient/outpatient service mix for ESRD beneficiaries.

OIG Recommendation #5

Require suspected duplicate claims to be returned by the FIs to providers rather than sending them to the CWF system for further processing.

HCFA Response

HCFA nonconcurs. The FI system edits detect a broad range of improper claims. These claims are returned to the provider for additional information and/or error correction and resubmittal. Including all suspected duplicate claims in this category of improper claims and returning them to the provider without further development would not be useful. A provider receiving these claims and believing them to be legitimate claims, would just resubmit them to the FIs where they would once again hit the same edit.

To implement the report's recommendation, FIs would have to manually develop these "suspected duplicates" or duplicate the related CWF edits in order to further develop every suspected duplicate. We do not believe this would be cost-effective or efficient since it would require additional personnel with associated costs.

Another factor to consider is the customer-oriented approach provided by the current system's CWF edit. To return these claims to the provider would require additional evaluation and processing by the provider, thus causing delay and forcing the provider to incur additional costs. The use of the CWF edit allows HCFA to make the proper decision in an inexpensive, fast, and non-hassling manner. Thus, we believe the FIs should continue to submit suspected duplicates to CWF for a definitive determination and deny and return to providers only those determined, through CWF, to be within the DRG window.

OIG Recommendation #6

HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission.

HCFA Response

HCFA nonconcurs. We do not support initiating a legislative proposal to expand the payment window from 3 to 7 days before admission, since we believe the potential savings that would accrue from such an expansion would be negligible. However, if such a proposal were to be made, it would not be necessary to change the Medicare prospective payment system (PPS) standardized amounts. We believe that in the PPS base year, only an insignificant volume of preadmission services were furnished in the fourth through seventh days and, thus, would now be rebundled under the report's proposal. It is our belief that the practice of unbundling inpatient testing into the preadmission period became widespread after the introduction of PPS, and that rebundling those costs would cause no distortion in the operating costs of inpatient hospital services.

Additional Comments

We wish to respond to the report's reservations about using the principal diagnosis to determine whether preadmission services are considered "related to the admission." In order to facilitate automated processing of these claims, we intentionally chose to rely on the principal diagnosis in developing instructions on the admission-relatedness of

nondiagnostic preadmission services (the payment window's admission-relatedness test does not apply to diagnostic services). We chose this approach precisely to avoid having to make the kind of exacting, case-by-case medical judgments that the report describes on page 10, which would necessitate having a medical reviewer manually evaluate narrative information on every claim. We believe such a procedure would expend an inordinate amount of operational resources on evaluating nondiagnostic services under the payment window, particularly since Congress' primary concern in enacting this provision clearly was to recapture inpatient diagnostic services that had been unbundled into the preadmission period.

We note, as background, that we consider routine dialysis services furnished during the preadmission period to be related to the subsequent admission (and, thus, subject to bundling under the payment window) only when the principal reason for the subsequent admission is renal dialysis (International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes V56.0, Extracorporeal Dialysis, or V56.8, Other Dialysis NEC (not elsewhere classifiable). PPS has established DRG 317, Admit for Renal Dialysis, precisely to accommodate admissions made for the specific purpose of obtaining dialysis on an inpatient basis.

Page 11 of the report cites 42 CFR section 413.40(g)(3) and notes that "To date, HCFA has made no adjustment to reflect the effects of the 72-hour DRG payment window." This implication is incorrect as the above regulation does not address HCFA's authority to make adjustment to PPS rates, but rather addresses HCFA's authority to make adjustments to a hospital's target amount for purposes of payment to hospitals that are excluded from PPS. Section 1886(d)(5)(I) of the Social Security Act prescribes a formula for calculating PPS rates and gives HCFA statutory authority to provide exceptions and adjustments to the amounts calculated. However, HCFA may not have general discretionary authority to adjust PPS rates to account for the DRG payment window that affects payments to all hospitals. The report should be revised to reflect this.