DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

APR 11 2005

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Acting Inspector General

SUBJECT: Review of Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2001 and 2002 (A-04-04-03000)

The attached final report provides the results of our nationwide review of hospital compliance with Medicare's postacute care transfer policy. Consistent with the policy, Medicare pays the full diagnosis-related group (DRG) payment to a hospital that discharges an inpatient to home. In contrast, for specified DRGs, Medicare pays a hospital that transfers an inpatient to certain postacute care settings, such as a skilled nursing facility or home health care, a per diem rate for each day of the stay, not to exceed the full DRG payment for a discharge.

Our previous audits identified Medicare overpayments to transferring hospitals that did not comply with the postacute care transfer policy. In response to our recommendations, the Centers for Medicare & Medicaid Services (CMS) recently implemented edits in the Common Working File to detect postacute care transfers improperly coded as discharges. Those edits were effective January 1, 2004, and thus were not in place during our current audit period.

Our objective was to determine whether acute care hospitals complied with Medicare's postacute care transfer policy during fiscal years (FYs) 2001 and 2002.

Hospitals did not always comply with the transfer policy. Of 400 claims sampled, 381 were improperly coded as discharges to home rather than transfers to postacute care. Potential overpayments to hospitals for these claims totaled $1,034,588. The potential overpayments occurred because some hospitals did not have the necessary controls to ensure the accuracy of discharge status codes, and CMS lacked adequate payment system edits to prevent these overpayments. As a result, we estimate that Medicare overpaid hospitals approximately $72.4 million in FYs 2001 and 2002.

We recommend that CMS:

- instruct the fiscal intermediaries to recover, as appropriate, the $1,034,588 in potential overpayments identified in our sample;

- instruct the fiscal intermediaries to review the remaining claims in our sampling universe and identify and recover additional overpayments estimated at $71.3 million; and

- monitor hospitals that have a high number of claims adjusted as a result of the recently implemented system edits and perform followup reviews, as appropriate, at specific hospitals.

In response to our draft report, CMS agreed to implement the first and last recommendations. In regard to the second recommendation, CMS said that it was working on a strategy to identify and collect the remaining overpayments. We will assist CMS by providing a complete list of all claims in the sampling universe, sorted by fiscal intermediary.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at george.reeb@oig.hhs.gov. Please refer to report number A-04-04-03000 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HOSPITAL COMPLIANCE WITH MEDICARE'S POSTACUTE CARE TRANSFER POLICY DURING FISCAL YEARS 2001 AND 2002

APRIL 2005
A-04-04-03000

Office of Inspector General

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EXECUTIVE SUMMARY

BACKGROUND

Medicare's postacute care transfer policy distinguishes between discharges and transfers of beneficiaries from inpatient hospitals under the prospective payment system (PPS). Consistent with the policy, Medicare pays the full diagnosis-related group (DRG) payment to a hospital that discharges an inpatient to his or her home. In contrast, for specified DRGs, Medicare pays a hospital that transfers an inpatient to certain postacute care settings, such as a skilled nursing facility or home health care, a per diem rate for each day of the stay, not to exceed the full DRG payment for a discharge.

Previous Office of Inspector General (OIG) audits identified Medicare overpayments to transferring hospitals that did not comply with the postacute care transfer policy. In response to our recommendations, the Centers for Medicare & Medicaid Services (CMS) recently implemented edits in the Common Working File to detect transfers improperly coded as discharges. Those edits were effective January 1, 2004, and thus were not in place during our current audit period.

OBJECTIVE

Our objective was to determine whether acute care hospitals complied with Medicare's postacute care transfer policy during fiscal years (FYs) 2001 and 2002.

SUMMARY OF FINDING

Hospitals did not always comply with the transfer policy. Of 400 claims sampled, 381 were improperly coded as discharges to home rather than transfers to postacute care. Potential overpayments to hospitals for these claims totaled $1,034,588.

Some hospitals did not have the necessary controls to ensure the accuracy of discharge status codes, and CMS lacked adequate payment system edits to prevent these overpayments. As a result, we estimate that Medicare overpaid hospitals approximately $72.4 million in FYs 2001 and 2002.

RECOMMENDATIONS

We recommend that CMS:

- instruct the fiscal intermediaries to recover, as appropriate, the $1,034,588 in potential overpayments identified in our sample;

- instruct the fiscal intermediaries to review the remaining claims in our sampling universe and identify and recover additional overpayments estimated at $71.3 million; and

- monitor hospitals that have a high number of claims adjusted as a result of the recently implemented system edits and perform followup reviews, as appropriate, at specific hospitals.

CMS COMMENTS

In response to our draft report, CMS agreed to implement the first and last recommendations. In regard to the second recommendation, CMS said that it was working on a strategy to identify and collect the remaining overpayments.

OIG RESPONSE

We will assist CMS in identifying the remaining claims with overpayments by providing a complete list of all claims in the sampling universe, sorted by fiscal intermediary.

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GLOSSARY OF ABBREVIATIONS AND ACRONYMS

CC	complications and comorbidities
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
DRG	diagnosis-related group
FY	fiscal year
OIG	Office of Inspector General
PPS	prospective payment system

INTRODUCTION

BACKGROUND

Postacute Care Transfer Policy

With the implementation of the Medicare inpatient PPS in 1983, a discharge was defined as a beneficiary's release from a PPS hospital to any setting other than another PPS hospital. A transfer was defined as a beneficiary's release from a PPS hospital and admission to another PPS hospital on the same day. Section 4407 of the Balanced Budget Act of 1997 expanded the definition of a transfer by establishing the Medicare postacute care transfer policy. Pursuant to section 1886(d)(5)(J) of the Social Security Act (the Act) and implementing regulations (42 CFR § 412.4(c)), a postacute care transfer is a situation in which a beneficiary whose hospital stay was classified within specified DRGs is released from a PPS hospital in one of the situations listed below.

- The individual is admitted on the same day to a hospital or hospital unit that is not reimbursed under the inpatient PPS.

- The individual is admitted on the same day to a skilled nursing facility.

- The individual is discharged to home under a written plan of care for the provision of home health services and receives those services within 3 days of the discharge date.

Appendix C lists the 10 DRGs subject to this policy during our audit period, as well as the DRGs currently subject to the policy.

Pursuant to 42 CFR §§ 412.4(e) and (f), Medicare pays the full DRG payment to the final discharging hospital, while a hospital that transfers a patient to postacute care receives a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged to home.

Prior OIG Reports and CMS Corrective Actions

Previous OIG audits identified Medicare overpayments due to noncompliance with the postacute care transfer policy.[1] Our recommendations in those reports called for education efforts to make hospitals aware of the policy, as well as the implementation of system edits at the fiscal intermediary level to detect and prevent postacute care transfers that are miscoded as discharges. CMS generally concurred with our recommendations and initiated collection efforts on the

[1]Previous audits include "Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross Blue Shield of Georgia" (A-04-00-01210), "Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options" (A-04-00-02162), "Implementation of Medicare's Postacute Care Transfer Policy" (A-04-00-01220), and "Compliance With Medicare's Postacute Care Transfer Policy for Fiscal Year 2000" (A-04-02-07005). These reports are available at http://oig.hhs.gov.

overpayments we identified. Effective with discharges occurring after September 30, 2003, CMS also expanded the postacute care transfer policy to incorporate additional DRGs.

CMS recently took steps to detect overpayments to hospitals for postacute care transfers. Effective January 1, 2004, CMS implemented edits in the Common Working File to detect improperly coded claims and instructed its fiscal intermediaries to modify their claims processing systems.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether acute care hospitals complied with Medicare's postacute care transfer policy during FYs 2001 and 2002.

Scope and Methodology

We focused on discharges from PPS hospitals for the 10 DRGs subject to the postacute care transfer policy for the 2-year period October 1, 2000, through September 30, 2002. We excluded discharges from Maryland hospitals because they are not reimbursed under PPS. We also excluded all claims for which the beneficiary's length of stay at the hospital would have resulted in full payment to the hospital regardless of a transfer to a postacute care setting.

Nationally, hospitals billed Medicare for 2.3 million discharges that occurred during FYs 2001 and 2002 within the 10 DRGs. To capture those discharges incorrectly coded as final discharges rather than transfers, our audit focused on the 159,819 claims with a patient discharge status code of "to home." For the 10 DRGs, the discharge code of "to home" is appropriate only if the patient is discharged from an inpatient PPS facility and (1) is not admitted on the same day to a non-PPS hospital or hospital unit or to a skilled nursing facility or (2) is not discharged to home under a written plan of care for the provision of home health services that are received within 3 days of the discharge date. By matching these discharges to claims for postacute care, we identified a population of 27,864 discharges that were followed by postacute care. (See Appendix A for a detailed description of how we developed these "matches.")

We selected a stratified random sample of 400 claims from the 27,864 claims for discharges. For each sampled claim, we reviewed the Common Working File to verify patient admittance and discharge dates and the Medicare-paid amount and to determine whether the claim had been canceled. We considered canceled claims to be "nonerrors." Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from Medicare payment files. Our audit was not directed toward assessing the completeness of those files. We did not review the medical records from the PPS hospitals from which the patients were discharged to determine whether there was a written plan of care for the provision of home health services from a home health agency because the discharge code provided by the PPS hospitals indicated that home health services were not to be provided.

We used CMS's "Pricer" programs to calculate the correct payments to hospitals for discharges that were followed by postacute care treatment. To determine the hospital overpayment, we subtracted the OIG-calculated payment from the Medicare payment to the hospital. Based on our sample results, we projected the dollar amount and number of overpayments to hospitals. (See Appendix A for details on our data extraction and sampling methodology and Appendix B for the sampling projections.)

We conducted our audit in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATIONS

Hospitals did not always comply with Medicare's postacute care transfer policy found in 42 CFR § 412.4. Of 400 claims sampled, 381 were improperly coded as discharges to home rather than transfers to postacute care. Potential overpayments to hospitals for these claims totaled $1,034,588.

The potentially excessive payments occurred because some hospitals did not have the necessary controls to ensure the accuracy of discharge status codes and because CMS lacked adequate payment system edits. As a result, we estimate that Medicare overpaid hospitals approximately $72.4 million in FYs 2001 and 2002.

POSTACUTE CARE TRANSFER REQUIREMENTS

Medicare regulations (42 CFR § 412.4(e)) provide for the full DRG payment to a hospital that discharges an inpatient to home. In contrast, pursuant to 42 CFR § 412.4(f), a hospital that transfers an inpatient to one of three specified postacute settings is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged to home.

For hospital stays classified in any of 10 specified DRGs, a discharge from a PPS hospital to a qualifying postacute care setting is treated as a transfer case. The applicable postacute care settings are (1) a hospital or hospital unit that is not reimbursed under the inpatient PPS (a psychiatric hospital or unit, a rehabilitation hospital or unit, a children's hospital, a long-term-care hospital, or a cancer hospital); (2) a skilled nursing facility; and (3) home health care if services begin within 3 days of the discharge.

In Program Memorandum A-01-39, issued on March 22, 2001, CMS advised hospitals that the use of patient status code 01 (discharge to home) is appropriate for the 10 DRGs only when the patient is discharged from an inpatient facility and (1) is not admitted on the same day to a non-PPS inpatient facility or skilled nursing facility or (2) does not receive any home health services within 3 days of the date of discharge. In addition, the program memorandum instructed CMS's contractors that:

> As a result of these OIG reports, this Program Memorandum is requiring that you publish instructions in your next regularly scheduled provider bulletin, to hospitals and postacute care facilities, with respect to their responsibility for ensuring correct and appropriate discharge status coding on claims, according to the 10 Diagnosis Related Group (DRG) postacute care transfer provision in §1886(d)(5)(I) of the Social Security Act . . . .

CLAIMS IMPROPERLY CODED AS DISCHARGES RATHER THAN TRANSFERS

Hospitals improperly coded 381 of the 400 sampled claims as discharges to home rather than transfers to postacute care:

- Two hundred and thirty-two claims for discharges were followed by claims for home health services provided within 3 days of the discharge dates on the sampled claims. These erroneously coded claims resulted in $757,535 in potentially excess payments to the discharging hospitals.

- Eighty claims for discharges were followed by claims for skilled nursing services provided on the same days as the discharge dates on the sampled claims. These erroneously coded claims resulted in $118,646 in excess payments to the discharging hospitals.

- Sixty-nine claims for discharges were followed by claims for admissions to non-PPS hospitals or hospital units on the same days as the discharge dates on the sampled claims. These erroneously coded claims resulted in $158,407 in excess payments to the discharging hospitals.

The remaining 19 sampled claims included 12 canceled claims and 7 claims for discharges from non-PPS facilities, which were not subject to the postacute care transfer policy.

INADEQUATE PAYMENT CONTROLS

The overpayments identified in our sample occurred because some hospitals did not have the necessary controls to ensure the accuracy of discharge status codes and because CMS lacked adequate payment system edits.

Hospitals' processes did not always ensure accurate discharge status codes. For example, some hospitals had high levels of human and computer system errors. Also, some hospitals' patient medical records contained conflicting information on whether the patient was being discharged to home or transferred to a postacute care setting.

In Program Memorandum A-03-065, dated August 1, 2003, CMS responded to recommendations in previous OIG reports by announcing new edits in the Common Working File to compare inpatient claims with postacute care claims. By establishing these edits, CMS attempted to detect overpayments to hospitals that discharged beneficiaries who subsequently received

postacute care within a specified period. These edits were effective January 1, 2004, and thus were not in place when the claims reviewed for this audit were processed.

POTENTIALLY EXCESSIVE MEDICARE DRG PAYMENTS

During FYs 2001 and 2002, hospitals erroneously coded 381 of 400 sampled claims as discharges to home and received potentially excessive DRG payments of $1,034,588. Based on the sample results, we estimate that hospitals erroneously coded 26,537 claims nationally. We also estimate that the Medicare program paid $72.4 million in potentially excessive DRG payments to PPS hospitals as a result of these erroneous codings.

RECOMMENDATIONS

We recommend that CMS:

- instruct the fiscal intermediaries to recover, as appropriate, the $1,034,588 in potential overpayments identified in our sample;

- instruct the fiscal intermediaries to review the remaining claims in our sampling universe and identify and recover additional overpayments estimated at $71.3 million; and

- monitor hospitals that have a high number of claims adjusted as a result of the recently implemented system edits and perform followup reviews, as appropriate, at specific hospitals.

CMS COMMENTS

In written comments on our draft report, CMS stated that it would direct the Medicare fiscal intermediaries to recover the $1,034,588 in overpayments. In regard to the remaining claims in our sampling universe, CMS said that it was working on a strategy to identify and collect additional overpayments. CMS also said that it intended to monitor hospitals that have a high frequency of miscoded claims and issue further program instructions to ensure compliance with the recently expanded postacute care transfer policy.

OIG RESPONSE

We will assist CMS in identifying the remaining claims with overpayments by providing a complete list of all claims in the sampling universe, sorted by fiscal intermediary.

APPENDIXES

SAMPLING METHODOLOGY

BACKGROUND

From CMS's National Claims History Standard Analytical Files, we obtained a list of final action files of inpatient data from PPS hospitals for the 10 DRGs for the period October 1, 2000, through September 30, 2002. This database contained 2,308,318 claims totaling approximately $25.2 billion. We reduced these 2,308,318 claims to 159,819 claims totaling approximately $1.2 billion by:

- including only claims with the patient status code "01- Discharge to Home,"
- eliminating claims from Maryland (not PPS),
- eliminating all records for which full payment was due and no overpayment could have occurred,
- eliminating all claims for which the Medicare payment amount equaled zero, and
- including only those claims that were final bills.

We then compared these claims with CMS's Standard Analytical Files database of Medicare claims to determine whether any of the claims were matched by:

- an admission to a non-PPS hospital, or unit of a hospital, on the day of discharge (i.e., "From Date" on claim 2 matches "Thru Date" on claim 1);
- an admission to a skilled nursing facility on the day of discharge (i.e., "From Date" on claim 2 matches "Thru Date" on claim 1); or
- treatment by a home health agency within 3 days of the day of discharge (i.e., "From Date" on claim 2 $\leq$ "Thru Date" on claim 1 + 3).

The resulting matches left a population of 14,086 claims totaling approximately $160.4 million for FY 2001, which comprised stratum 1 of our sample. The resulting matches left a population of 13,778 claims totaling approximately $148.7 million for FY 2002, which comprised stratum 2 of our sample.

OBJECTIVE

The objective of this sample was to quantify the overpayments resulting from qualified discharges erroneously coded as patient status code "01 - Discharge to Home."

POPULATION

The population consisted of 27,864 claims. We divided the population into two strata as follows:

- **FY 2001:** The population for stratum 1 was 14,086 claims for discharges in the 10 DRGs that were also classified as "Discharge to Home" by the discharging institution. These claims were for discharges during the period October 1, 2000, through September 30, 2001, and met other criteria that indicated they were likely to include overpayments. The claims totaled approximately $160.4 million.

- **FY 2002:** The population for stratum 2 was 13,778 claims for discharges in the 10 DRGs that were also classified as "Discharge to Home" by the discharging institution. These claims were for discharges during the period October 1, 2001, through September 30, 2002, and met other criteria that indicated they were likely to include overpayments. The claims totaled approximately $148.7 million.

SAMPLE UNIT

The sample unit was a DRG claim.

SAMPLE DESIGN

We used a stratified random sample with each stratum consisting of claims for discharges occurring in an FY.

SAMPLE SIZE

The sample size totaled 400 claims: 200 claims in stratum 1 from the population for FY 2001 and 200 claims in stratum 2 from the population for FY 2002.

ESTIMATION METHODOLOGY

Using the OIG, Office of Audit Services RAT-STATS 2003 Variable Appraisal Program for stratified samples, we projected the excessive payments to discharging hospitals resulting from erroneously coded claims. We calculated the erroneous payments by using the payment methods for the 10 DRGs as adopted under section 1886(d)(5)(J) of the Act.

We also used the OIG, Office of Audit Services RAT-STATS Attribute Appraisal Program for stratified samples to project the number of claims in error.

SAMPLE RESULTS AND PROJECTIONS

SAMPLE RESULTS

Stratum	Sample Size	Value of Sample	Number of Errors	Value of Errors
1 (FY 2001)	200	$2,809,846	188	$712,459
2 (FY 2002)	200	1,777,587	193	322,129
Total	**400**	**$4,587,433**	**381**	**$1,034,588**

VARIABLE PROJECTIONS

	Projected Value of Erroneous Claims for FYs 2001 & 2002
Point Estimate	$72,369,964
90-Percent Confidence Interval	
Lower Limit	$51,892,149
Upper Limit	$92,847,778

ATTRIBUTE PROJECTIONS

	Projected Number of Erroneous Claims for FYs 2001 & 2002
Point Estimate	26,537
90-Percent Confidence Interval	
Lower Limit	26,051
Upper Limit	27,022

DRGs SUBJECT TO THE POSTACUTE CARE TRANSFER POLICY

Section 1886(d)(5)(J)(iii)(I) of the Act gives the Secretary broad authority to select the DRGs based on a high volume of discharges and a disproportionate use of postacute care services. According to 42 CFR § 412.4(d), the 10 DRGs selected by the Secretary pursuant to this authority, for the period of this audit, were as follows:

DRG	Title
014	Intracranial Hemorrhage and Stroke With Infarction
113	Amputation for Circulatory System Disorders Excluding Upper Limb and Toe
209	Major Joint and Limb Reattachment Procedures of Lower Extremity
210	Hip and Femur Procedures Except Major Joint Age > 17 With Complications and Comorbidities (CC)
211	Hip and Femur Procedures Except Major Joint Age > 17 Without CC
236	Fractures of Hip and Pelvis
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC
429	Organic Disturbances and Mental Retardation
483	Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnoses

Effective October 1, 2003, the Secretary modified the list of DRGs and specified criteria to identify, on an ongoing basis, which DRGs will be accorded "qualified" DRG status. These criteria require that to be included in the policy, a DRG must have, for both of the 2 most recent years for which data are available, at least 14,000 postacute care transfer cases; at least 10 percent of its postacute care transfers occurring before the geometric mean length of stay; a geometric mean length of stay of at least 3 days; and, if a DRG is not already included in the policy, at least a 7-percent decline in its geometric mean length of stay during the most recent 5-year period. The modified list of DRGs that qualify under this policy is as follows:

DRG	Title
012	Degenerative Nervous System Disorders
014	Intracranial Hemorrhage and Stroke With Infarction
024	Seizure and Headache Age > 17 With CC
025	Seizure and Headache Age > 17 Without CC
088	Chronic Obstructive Pulmonary Disease
089	Simple Pneumonia and Pleurisy Age > 17 With CC
090	Simple Pneumonia and Pleurisy Age > 17 Without CC
113	Amputation for Circulatory System Disorders Excluding Upper Limb and Toe
121	Circulatory Disorders With Acute Myocardial Infarction and Major Complication, Discharged Alive

122 Circulatory Disorders With Acute Myocardial Infarction Without Major Complication, Discharged Alive
127 Heart Failure and Shock
130 Peripheral Vascular Disorders With CC
131 Peripheral Vascular Disorders Without CC
209 Major Joint and Limb Reattachment Procedures of Lower Extremity
210 Hip and Femur Procedures Except Major Joint Age > 17 With CC
211 Hip and Femur Procedures Except Major Joint Age > 17 Without CC
236 Fractures of Hip and Pelvis
239 Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy
277 Cellulitis Age > 17 With CC
278 Cellulitis Age > 17 Without CC
294 Diabetes Age > 35
296 Nutritional and Miscellaneous Metabolic Disorders Age > 17 With CC
297 Nutritional and Miscellaneous Metabolic Disorders Age > 17 Without CC
320 Red Blood Cell Disorders Age > 17
321 Kidney and Urinary Tract Infections Age > 17 With CC
395 Kidney and Urinary Tract Infections Age > 17 Without CC
429 Organic Disturbances and Mental Retardation
468 Extensive Operating Room Procedure Unrelated to Principal Diagnosis
483 Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnoses

Effective October 1, 2004, the Secretary deleted DRG 483 from the list and added the following DRGs that incorporate the cases formerly assigned to DRG 483.

541 Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses With Major Operating Room Procedure
542 Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses Without Major Operating Room Procedure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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DATE: FEB -8 2005

TO: Daniel R. Levinson
Acting Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Hospital Compliance with Medicare's Postacute Care Transfer Policy During Fiscal Years 2001 and 2002" (OAS-04-04-03000)

Thank you for the opportunity to review and comment on the above-referenced OIG draft report. The OIG has conducted a review of inpatient hospital compliance with the postacute care transfer policy for fiscal years 2001 and 2002. During this time period, claims for patients that were transferred to postacute facilities and that fell into one of ten diagnosis-related groups (DRGs) were subject to the postacute care transfer policy. Claims for these patients that are transferred to one of these postacute facilities should be identified by using discharge status codes that reflect the type of postacute care the patient is to receive. This transfer status initiates a per diem payment for the transferring hospital instead of the regular DRG payment. Because there is a strong financial incentive for hospitals to miscode these claims, the OIG has conducted several studies to ensure hospital compliance with the policy. In this most recent study, they have found that, of the claims in a small sample size of 400, 381 claims were erroneously coded, resulting in more than $1 million in overpayments to hospitals. Additionally, the OIG believes that more than 27,000 such miscoded claims may have resulted in additional overpayments of nearly $73 million to hospitals. The OIG report recommends that the Centers for Medicare & Medicaid Services (CMS) instruct fiscal intermediaries (FIs) to recover the identified $1,034,588 in overpayments, and to review the remaining 27,000 claims identified as possible problem claims and recover any moneys that were overpayments due to hospital errors in coding. Additionally, the OIG commends CMS for implementing new payment edits that will prevent overpayments for miscoded transfers to postacute care in the future.

OIG Recommendation

Instruct the fiscal intermediaries to recover the $1,034,588 in overpayments identified in our sample.

Page 2 – Daniel R. Levinson

CMS Response

We concur. CMS shall direct the Medicare FIs to recover the $1,034,588 in overpayments. This concurrence is based on CMS' review and concurrence of the OIG's findings of hospital non-compliance. This would include CMS' sample review of the universe of claims identified as overpayments.

OIG Recommendation

Instruct the fiscal intermediaries to review the remaining claims in our sampling universe and identify and recover additional overpayments estimated at $71.3 million.

CMS Response

We concur that where the remainder of claims is indicative of overpayments, FIs shall be directed to recover these overpayments. To reduce contractor costs and operational impacts in the identification of remaining and associated claims, we are currently working on a strategy to identify the remaining claims in the OIG's sampling universe. We will advise the FIs to furnish an initial (45 days from the date of instruction), interim (60 days from the initial report), and final report (60 days from the interim report) on their efforts.

OIG Recommendation

Monitor hospitals that have a high number of claims adjusted as a result of the recently implemented system edits and perform follow-up reviews, as appropriate, at specific hospitals.

CMS Response

As the report suggests, CMS intends to monitor hospitals that have a high frequency of miscoded claims as identified by the new Common Working File edits and to also issue further program instructions to ensure compliance with the recently expanded postacute care transfer policy.

We feel that the new edits we implemented based on past OIG reports will instruct providers how to correct their claims and ultimately pay correctly. We will happily work with the OIG should they discover that further editing is needed in the future.

We thank the OIG for conducting this audit and find their input very valuable.