Report in Brief
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Inadequate Edits and Oversight Caused Medicare To Overpay More Than $267 Million for Hospital Inpatient Claims With Post-Acute-Care Transfers to Home Health Services

Why OIG Did This Audit

Prior OIG audits identified Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (transfer policy). CMS generally concurred with our recommendations, but subsequent analysis that we conducted indicated that CMS's system edits were still not properly designed and that hospitals may be using condition codes to bypass CMS's system edits to receive higher reimbursements for inpatients transferred to home health services.

Our objective was to determine whether Medicare properly paid acute-care hospital inpatient claims subject to the transfer policy when hospitals: (1) did not code the claims as a discharge to home with home health services when the beneficiary resumed home health services within 3 days of discharge, (2) applied condition code 43 indicating that the home health services were not provided within 3 days of discharge, or (3) applied condition code 42 indicating that the home health services were not related to the inpatient hospital services.

How OIG Did This Audit

For fiscal years 2016 and 2017, we identified 89,213 inpatient claims totaling $948 million at risk of overpayment because of the transfer policy. We selected a stratified sample of 150 claims, and an independent medical review contractor reviewed the medical records to assess the relatedness of the home health services to the hospital admission.

What OIG Found

Medicare improperly paid most inpatient claims subject to the transfer policy when beneficiaries resumed home health services within 3 days of discharge but the hospitals failed to code the inpatient claim as a discharge to home with home health services or when the hospitals applied condition codes 42 (home health not related to inpatient stay) or 43 (home health not within 3 days of discharge). Of the 150 inpatient claims in our sample, Medicare properly paid 3; however, it improperly paid 147 with $722,288 in overpayments. Medicare should have paid these inpatient claims using a graduated per diem rate rather than the full payment. Based on our sample results, we estimated that Medicare improperly paid $267 million during a 2-year period for hospital services that should have been paid a graduated per diem payment.

What OIG Recommends and CMS Comments

We recommend that CMS direct its Medicare contractors, for the claims that are within the 4-year reopening period, to: (1) recover a portion of the $722,288 in overpayments identified in our sample, (2) reprocess the remaining inpatient claims in our sample frame with an incorrect patient discharge status code or condition code 43 to recover a portion of the estimated $225.7 million in overpayments, and (3) analyze the remaining inpatient claims in our frame with condition code 42 and recover a portion of the estimated $40.6 million in potential overpayments. Also, we recommend that CMS correct its related system edits, improve its provider education related to the Medicare transfer policy, and use data analytics to identify hospitals disproportionally using condition code 42. Finally, we recommend that CMS consider reducing the need for clinical judgment when processing claims under the post-acute-care transfer policy by taking the necessary actions, including seeking legislative authority if necessary, to deem any home health service within 3 days of discharge to be "related."

CMS concurred with all but our last recommendation and described actions that it had taken or planned to take to address the recommendations. We maintain that CMS should further explore reducing the need for clinical judgment when processing claims under the post-acute-care transfer policy and revised our recommendation to have CMS consider this change.

The full report can be found at https://oig.hhs.gov/oas/reports/region4/41804067.asp.