

## Report in Brief

Date: September 2023  
Report No. A-09-23-03016

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

Prior OIG audits identified over \$563 million in overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (transfer policy). These hospitals transferred patients to certain post-acute-care settings, such as skilled nursing facilities (SNFs), but claimed the higher reimbursements associated with discharges to home. Because compliance with the transfer policy has been an issue over a long period, we conducted this followup audit to evaluate whether Medicare properly paid acute-care hospitals' claims subject to that policy for those claims with dates of service from January 1, 2019, through December 31, 2022 (audit period).

Our objective was to determine whether Medicare properly paid acute-care hospitals' inpatient claims subject to the transfer policy.

### How OIG Did This Audit

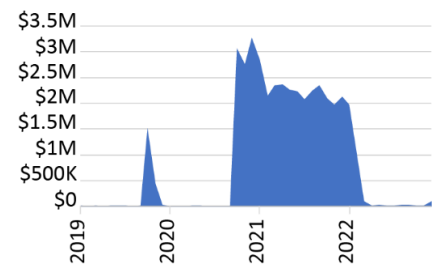
Our audit covered \$198 million in Medicare Part A payments for 12,133 inpatient claims subject to the transfer policy. We first identified specific inpatient claims for our audit period that had a patient discharge status code indicating a discharge to home or certain types of health care institutions. We used the Medicare enrollee information and service dates from those claims to identify services furnished in post-acute-care settings that began: (1) on the same date as the inpatient discharge (e.g., SNF claims) or (2) within 3 days of the inpatient discharge (i.e., home health claims).

## Medicare Improperly Paid Acute-Care Hospitals for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy Over a 4-Year Period, but CMS's System Edits Were Effective in Reducing Improper Payments by the End of the Period

### What OIG Found

For our audit period, Medicare improperly paid \$41.4 million to acute-care hospitals for inpatient claims subject to the transfer policy. These hospitals improperly billed these claims by using the incorrect discharge status codes. Specifically, they coded these claims as discharges to home (6,338 claims) or to certain types of health care institutions (5,795 claims), such as facilities that provide custodial care, rather than as transfers to post-acute care. Medicare makes the full Medicare Severity Diagnosis-Related Group (MS-DRG) payment to an acute-care hospital that discharges an inpatient to home or certain types of health care institutions, but pays an acute-care hospital that transfers an enrollee to post-acute care a per diem rate for each day of the enrollee's stay in the hospital. The total overpayment of \$41.4 million represented the difference between the amount of the full MS-DRG payments and the amount that would have been paid if the per diem rates had been applied.

These improper payments were made because CMS's system edits were not effective in detecting inpatient claims subject to the transfer policy in October and November 2019 and from October 2020 through March 2022. However, after CMS fixed the edits in April 2022, improper payments significantly decreased through the end of the audit period (i.e., through December 2022).



### What OIG Recommends and CMS Comments

We recommend that CMS: (1) direct the Medicare contractors to recover from acute-care hospitals the portion of the \$41.4 million in identified overpayments for our audit period that are within the 4-year reopening period and (2) instruct the Medicare contractors to notify appropriate providers so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule.

CMS concurred with both of our recommendations and provided information on actions that it planned to take to address our recommendations, including directing its Medicare contractors to recover the identified overpayments.