



JUL 3 1 2001

Memorandum

Date *Michael Mangano*
From Michael F. Mangano
Acting Inspector General

Subject Follow-up Audit of Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System (A-01-00-00506)

To Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's (OIG) final audit report entitled, "Follow-up Audit of Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System." The objectives of our review were to: (1) quantify potential duplicate payments made to prospective payment system (PPS) hospitals for nonphysician outpatient services rendered within the diagnosis related group (DRG) payment window during Calendar Years (CY) 1997 and 1998; and (2) determine whether selected PPS hospitals were in compliance with the terms of the settlement agreements entered into with the Department of Justice (DOJ) and OIG.

Under inpatient PPS, Medicare fiscal intermediaries (FI) reimburse hospitals a predetermined amount for services furnished to Medicare beneficiaries based on the illness and its classification under a DRG. Payment for inpatient services includes nonphysician outpatient services rendered on the day of admission or during an inpatient stay, diagnostic services rendered up to 3 days before the day of admission, and admission related nondiagnostic services rendered up to 3 days before the day of admission. Accordingly, a duplicate payment is made when such nonphysician outpatient services are paid separately.

This follow-up report is the sixth in a series of OIG audit reports regarding the DRG payment window. Our previous five audit reports identified significant overpayments to PPS hospitals as a result of noncompliance with the DRG payment window. Consequently, OIG initiated a joint project with the Centers for Medicare and Medicaid Services (CMS)¹ and DOJ to recover the overpayments identified. To date, DOJ collected approximately \$73 million from 2,800 PPS hospitals which entered into settlement agreements with DOJ and OIG for noncompliance with the DRG payment window between November 1990 and December 1996.

¹ Formerly the Health Care Financing Administration.

For CYs 1997 and 1998, we identified approximately \$5 million, nationwide, in potential duplicate payments for nonphysician outpatient services rendered within the DRG payment window. This is significantly less than the \$27 million in potential duplicate payments identified for the 3-year period covered by our last audit report.² We believe that hospitals' compliance with OIG and DOJ settlement agreements contributed to this significant reduction in potential duplicate payments. In this regard, our analysis showed that none of the hospitals in our current review received a material overpayment.

With respect to the \$5 million of potential duplicate payments identified through our current computer applications, we found that payments continued to be made as a result of problems at hospitals, FIs, and within CMS' Common Working File (CWF) system.

At hospitals, we noted that: (1) hospitals' claims submission edits used to identify outpatient services provided within the DRG payment window were bypassed as a result of clerical errors; (2) outpatient providers were unaware that the patient was an inpatient at another PPS hospital; and/or (3) data exchanges between inpatient and outpatient departments of the same PPS hospital were not always effective.

At CMS and FIs, we determined that improper payments were made by FIs because: (1) the necessary edits within the CWF system were not sufficient, not activated, or were nonexistent during CYs 1997 and 1998; and/or (2) prepayment edits at the FIs to prevent duplicate payments for nonphysician outpatient services within the DRG payment window were manually overridden.

Accordingly, we recommended that CMS: (1) review the CWF system to ensure that all edits are sufficient, alerts are activated as edits, and edits are developed to address all legislative requirements; (2) review FIs' edit systems override procedures to ensure that all manual overrides are properly authorized and correct; (3) continue to cooperate with OIG and DOJ to recover potential overpayments from hospitals contacted by DOJ as a result of our prior review; (4) encourage FIs to continue educating providers on the requirements of the DRG payment window; and (5) require FIs to initiate recovery of the \$5 million in potential overpayments and report, by provider, the amounts recovered. We will coordinate with CMS to provide the overpayment information directly to FIs.

The CMS, in its comments (see APPENDIX), concurred with our recommendations. Specifically, CMS stated that they: (1) will review the CWF edits to verify that the edits are sufficient to stop improper payments under the 3-day rule; (2) have established a workgroup

²“Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System” (A-01-95-00508)

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to assess potential vulnerabilities in the existing duplicate claim edits; (3) will continue to cooperate with OIG and DOJ and collect potential overpayments based on the prior OIG review; (4) will issue a program memorandum regarding continued contractor education of providers on the requirement of the DRG payment window; and (5) will ensure FIs recover any overpayments resulting from violations of the 3-day rule.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-00-00506 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**FOLLOW-UP AUDIT OF IMPROPER
MEDICARE PAYMENTS TO HOSPITALS
FOR NONPHYSICIAN OUTPATIENT
SERVICES UNDER THE INPATIENT
PROSPECTIVE PAYMENT SYSTEM**



**JULY 2001
A-01-00-00506**

EXECUTIVE SUMMARY

BACKGROUND

Under the inpatient prospective payment system (PPS), Medicare fiscal intermediaries (FI) reimburse hospitals a predetermined amount for services furnished to Medicare beneficiaries based on the illness and its classification under a diagnosis related group (DRG). To curb the unbundling of services which occurred since the introduction of PPS, the DRG payment window was expanded to include services rendered up to 3 days prior to admission. As such, separate payments are not allowed for:

- any nonphysician outpatient services rendered on the day of admission or during an inpatient stay;
- diagnostic services rendered up to 3 days before the day of admission; and
- admission related nondiagnostic services rendered up to 3 days before the day of admission.

These nonphysician outpatient services are deemed to be inpatient services and are included in the inpatient payment. Accordingly, a duplicate payment is made when such nonphysician outpatient services are paid separately.

This follow-up report is the sixth in a series of Office of Inspector General (OIG) audit reports regarding the DRG payment window. Our previous five audit reports identified significant overpayments to PPS hospitals as a result of noncompliance with the DRG payment window. Consequently, OIG initiated a joint project with the Centers for Medicare and Medicaid Services (CMS)¹ and the Department of Justice (DOJ) to recover the overpayments identified.

OBJECTIVE

The objectives of our review were to: (1) quantify potential duplicate payments made to PPS hospitals for nonphysician outpatient services rendered within the DRG payment window during Calendar Years (CY) 1997 and 1998; and (2) determine whether selected PPS hospitals were in compliance with the terms of the settlement agreements entered into with DOJ and OIG.

¹ Formerly the Health Care Financing Administration.

SUMMARY OF FINDINGS

To date, DOJ collected approximately \$73 million from 2,800 PPS hospitals which entered into settlement agreements with DOJ and OIG. These settlement agreements, which covered services rendered during the period November 1990 through December 1996, also required the hospitals to establish controls to prevent and/or detect the submission of duplicate claims for nonphysician outpatient services rendered within the DRG payment window.

Our review showed that the amount of potential duplicate payments for nonphysician outpatient services rendered within the DRG payment window decreased significantly from \$27 million for the 3-year period covered by our last audit report,¹ to \$5 million, nationwide, for CYs 1997 and 1998. Further, none of the hospitals in our current review received a material overpayment. We believe that hospitals' compliance with OIG and DOJ settlement agreements contributed to this significant reduction in potential duplicate payments.

However, with respect to the \$5 million of potential duplicate payments identified through our current computer applications, we noted that some problems still exist at hospitals, CMS, and FIs. At hospitals, we noted that: (1) hospitals' claims submission edits used to identify outpatient services provided within the DRG payment window were bypassed as a result of clerical errors; (2) outpatient providers were unaware that the patient was an inpatient at another PPS hospital; and/or (3) data exchanges between inpatient and outpatient departments at the same PPS hospital were not always effective.

At FIs and CMS, we determined that improper payments were made by FIs because: (1) the necessary edits within CMS' Common Working File (CWF) system were not sufficient, not activated, or were nonexistent during CYs 1997 and 1998; and/or (2) prepayment edits to prevent duplicate payments by FIs were manually overridden.

RECOMMENDATIONS

Accordingly, we recommended that CMS:

- Ø review the CWF system to ensure that all edits are sufficient, alerts are activated, and edits are developed to address all legislative requirements;
- Ù review FIs' edit systems override procedures to ensure that all manual overrides are properly authorized and correct;
- Ù continue to cooperate with OIG and DOJ to recover potential overpayments from hospitals contacted by DOJ as a result of our prior review;

¹ "Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System" (A-01-95-00508)

- Ū encourage FIs to continue educating providers on the requirements of the DRG payment window; and
- Œ require FIs to initiate recovery of the \$5 million in potential overpayments and report, by provider, the amounts recovered. We will coordinate with CMS to provide the overpayment information directly to FIs.

The CMS, in its comments (see APPENDIX), concurred with our recommendations. Specifically, CMS stated that they: (1) will review the CWF edits to verify that the edits are sufficient to stop improper payments under the 3-day rule; (2) have established a workgroup to assess potential vulnerabilities in the existing duplicate claim edits; (3) will continue to cooperate with OIG and DOJ and collect potential overpayments based on the prior OIG review; (4) will issue a program memorandum regarding continued contractor education of providers on the requirement of the DRG payment window; and (5) will ensure FIs recover any overpayments resulting from violations of the 3-day rule.

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INTRODUCTION

BACKGROUND

Under the inpatient prospective payment system (PPS), fiscal intermediaries (FI) reimburse hospitals a predetermined amount for services furnished to Medicare beneficiaries based on the illness and its classification under a diagnostic related group (DRG). To curb the unbundling of services which occurred since the introduction of PPS, the DRG payment window was expanded to include not only services rendered during an inpatient stay, but services rendered up to 3 days prior to admission as well. As such, separate payments are not allowed for:

- any nonphysician outpatient services rendered on the day of admission or during an inpatient stay;
- diagnostic services rendered up to 3 days before the day of admission; and
- admission related nondiagnostic services rendered up to 3 days before the day of admission.

These nonphysician outpatient services are deemed to be inpatient services and are included in the inpatient DRG payment. Accordingly, a duplicate payment is made when such nonphysician outpatient services are paid separately.

This follow-up report is the sixth in a series of Office of Inspector General (OIG) audit reports regarding the DRG payment window. Our previous five audit reports identified significant overpayments to PPS hospitals as a result of noncompliance with the DRG payment window. Consequently, OIG initiated a joint project with the Centers for Medicare and Medicaid Services (CMS)¹ and the Department of Justice (DOJ) to recover the overpayments identified. To date, DOJ collected approximately \$73 million from 2,800 PPS hospitals which entered into settlement agreements with DOJ and OIG for noncompliance with the DRG payment window between November 1990 through December 1996.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objectives of our review were to: (1) quantify potential duplicate payments made to hospitals for nonphysician outpatient services rendered within the DRG payment window during Calendar Years (CY) 1997 and 1998; and (2) determine whether selected PPS hospitals were in compliance with the terms of the settlement agreements entered into with DOJ and OIG.

¹ Formerly the Health Care Financing Administration

We limited consideration of the internal control structure to claims submissions for outpatient services as our review did not require an understanding or assessment of the complete internal control structure at the hospitals selected for site visits. In this regard, we concluded that our consideration of the internal control structure at FIs and CMS could be conducted more efficiently by expanding substantive testing, thereby placing limited reliance on FIs' and CMS' internal control structure.

Accordingly, to accomplish our objectives, we:

- reviewed criteria applicable to payment for nonphysician outpatient services rendered within the DRG payment window;
- performed a computer match using CMS' National Claims History (NCH) File to identify the universe of paid nonphysician outpatient service claims from PPS hospitals with dates of service: 1) corresponding to 3 days prior to an inpatient admission in which the inpatient provider rendered the outpatient services; 2) including the date of inpatient admission on which the inpatient provider rendered the outpatient services; or 3) during an inpatient stay (excluding the date of discharge) in which the inpatient provider or a different provider rendered the outpatient services during CYs 1997 and 1998;
- reviewed a judgmental sample of 64 claims, valued at \$57,778, paid to 10 hospitals in Connecticut, Maine, and Massachusetts to validate the results of our computer match (these claims were processed by 3 FIs);
- reviewed the claims submission process at the 10 hospitals to determine their compliance with the requirements of their settlement agreements;
- requested Associated Hospital Services of Maine, Mutual of Omaha, and CMS to review the claims paid by them to determine why those claims were paid; and
- followed up on the recommendations made in our prior audit.

Our field work was performed from December 1999 to September 2000 at the Office of Audit Services' regional office in Boston, Massachusetts and the CMS central office in Baltimore, Maryland.

Our draft report was issued to CMS on January 24, 2001. The CMS' response to the draft report and technical comments, are appended to this report (see APPENDIX) and addressed on page 7.

FINDINGS AND RECOMMENDATIONS

Our review showed that, to date, DOJ collected \$73,112,225 from 2,800 PPS hospitals which entered into settlement agreements with DOJ and OIG for noncompliance with the DRG payment window between November 1990 and December 1996. These settlement agreements also required hospitals to establish controls to prevent and/or detect the future submission of duplicate claims for nonphysician outpatient services rendered within the DRG payment window.

Our review showed that the amount of potential duplicate payments for nonphysician outpatient services rendered within the DRG payment window decreased significantly from \$27 million for the 3-year period covered by our last audit report² to \$5 million, nationwide, for CYs 1997 and 1998. Further, none of the hospitals in our current review received a material overpayment. Under PPS, FIs reimburse hospitals a predetermined amount for services furnished to Medicare beneficiaries based on the illness and its classification under a DRG. Nonphysician outpatient services rendered on the day of admission or during an inpatient stay; diagnostic services rendered up to 3 days before the day of admission; and admission related nondiagnostic services rendered up to 3 days before the day of admission are deemed to be inpatient services and are included in the inpatient payment. Accordingly, a duplicate payment is made when such nonphysician outpatient services are paid separately.

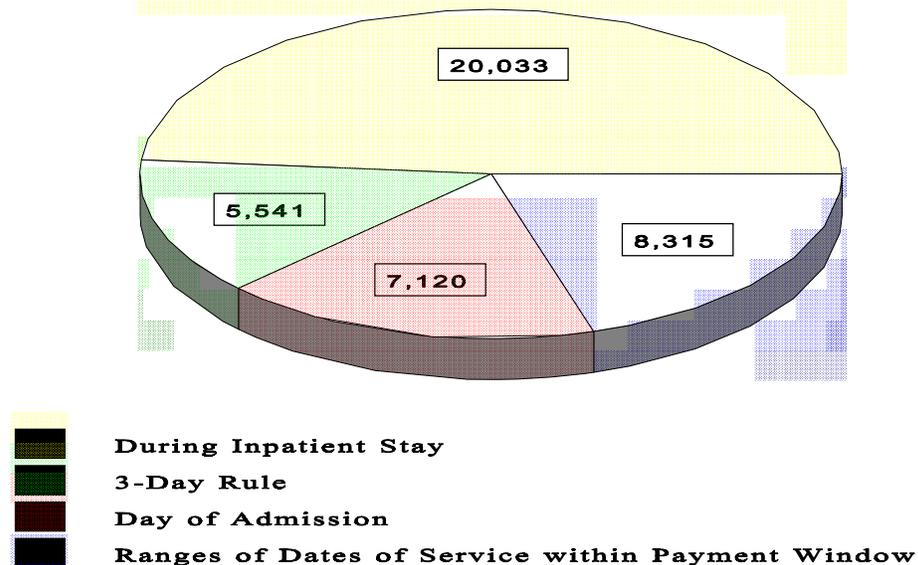
Specifically, Medicare Intermediary Manual (MIM) section 3670 states that a duplicate payment may occur when claims are submitted for nonphysician outpatient services rendered: (1) on the day of admission to the same hospital; or (2) during an inpatient stay at the same or another provider. Further, MIM section 3610.3 states that separate payments are not allowed for diagnostic services rendered up to 3 days before the day of admission, and admission related nondiagnostic services rendered up to 3 days before the day of admission. In addition, MIM section 3670 requires that FIs develop systems to prevent duplicate payments for nonphysician outpatient services provided during the DRG payment window.

POTENTIAL DUPLICATE PAYMENTS

We conducted a computer match comparing inpatient and outpatient data for CYs 1997 and 1998 from CMS' NCH File to determine if the necessary controls were in place to prevent duplicate payments for nonphysician outpatient services rendered during the DRG payment window. We identified 41,009 claims valued at \$5,042,207 which, based on our validation testing, were for nonphysician outpatient services provided within the DRG payment window. These claims fell into one of four categories:

²“Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System” (A-01-95-00508)

Categories of Claims with Potential Overpayments



As a means of validating the results of our computer applications, and to identify the cause of potential overpayments, we selected 10 hospitals in the States of Connecticut, Maine, and Massachusetts for review. At each of the hospitals, we reviewed a number of claims and the supporting documentation to determine whether payments for nonphysician outpatient services were appropriate. Based on the results of our review of claims at the 10 hospitals, we believe that the \$5 million identified by our computer applications represent potential duplicate payments. These potential duplicate payments may have occurred because of problems at hospitals, FIs, and/or within CMS' Common Working File (CWF) system.

At hospitals, we found that the improper hospital billings may have occurred because: (1) hospitals' claims submission edits used to identify outpatient services provided within the DRG payment window were bypassed as a result of clerical errors; (2) outpatient providers were unaware that the patient was an inpatient at another PPS hospital; and/or (3) data exchanges between inpatient and outpatient departments at the same PPS hospital were not always effective.

At FIs and within CMS' CWF system, payment errors may have occurred because:

- FI personnel manually overrode prepayment edits, which would have prevented erroneous payments; and/or
- CMS did not fully implement the improvements OIG recommended, and to which CMS agreed, in our prior report.

The CMS officials stated that they believed the new edits in CWF had been fully implemented and were designed to prevent erroneous payments. However, upon further review of our sampled claims, they stated that, in some cases, it appeared that either edits had not been created which would address billing situations not currently covered by active edits, or alerts had been issued but never activated as edits. For example, OIG was informed that alert number 7545 was never activated as an edit to prevent certain duplicate payments from being made.

COMPLIANCE WITH SETTLEMENT AGREEMENTS

This follow-up report is the sixth in a series of OIG audit reports regarding the DRG payment window. Our previous five reports identified significant overpayments to PPS hospitals as a result of noncompliance with the DRG payment window. Consequently, OIG initiated a joint project with CMS and DOJ to recover the overpayments identified. To date, DOJ collected approximately \$73 million from 2,800 PPS hospitals which entered into settlement agreements with DOJ and OIG for noncompliance with the DRG payment window between November 1990 and December 1996.

The settlement agreements required the hospitals to establish either a pre-submission or post-submission claims review to ensure compliance with the DRG payment window. In this regard, hospitals electing to use a pre-submission review had to select one of the following options:

- install and maintain computer software that permits the identification of occasions of nonphysician outpatient services rendered within the applicable time period of an inpatient admission;
- implement a routine manual claims review (by appropriately trained individuals who are familiar with Medicare billing policies) to determine the appropriateness of billing an outpatient service; or
- implement and maintain a process to identify a patient's admission to the institution as an inpatient prior to the submission of a claim for nonphysician outpatient services rendered to that patient at that institution.

Hospitals which elected to use a post-submission review agreed to:

- establish a testing process which examined previously submitted outpatient service claims for correctness within 60 days of submission;
- inform their FI of the testing process;
- advise and reimburse the FI for any overpayments in accordance with current Medicare requirements; and

- reimburse the beneficiary for the amount of any applicable deductibles or copayments within 30 days of the identification of the duplicate claim.

We judgmentally selected hospital settlement agreements for review and found that all of those hospitals were substantially in compliance with the requirements of their agreements. We, therefore, believe that the hospitals' systems of internal controls over nonphysician outpatient claims submission provide reasonable assurance that duplicate claims for nonphysician outpatient services within the DRG payment window are not submitted to FIs for reimbursement.

Further, our analysis of payment data indicated that the majority of hospitals, nationwide, received less than \$10,000 in potential duplicate payments. In addition, we also noted that, nationwide, payments for nonphysician outpatient services within the DRG payment window decreased from \$27 million for the 3-year period covered by our last audit report, to \$5 million for the 2-year period covered by our current review. We believe that the process of requiring hospitals to comply with the terms of their settlement agreements directly led to this significant reduction in potential duplicate payments.

CONCLUSION

Nationwide, hospitals claimed and were reimbursed approximately \$5 million in potential duplicate payments for nonphysician outpatient services rendered within the DRG payment window during CYs 1997 and 1998. We recognize that this is a substantial decrease in potential duplicate payments from the \$27 million identified in our last audit report. However, we believe that further improvements can be made regarding this issue as reflected by our recommendations.

RECOMMENDATIONS

We recommended that CMS:

- Ø review the CWF system to ensure that all edits are sufficient, alerts are activated, and edits are developed to address all legislative requirements;
- Ù review FIs' edit systems override procedures to ensure that all manual overrides are properly authorized and correct;
- Ù continue to cooperate with OIG and DOJ to recover potential overpayments from hospitals contacted by DOJ as a result of our prior review;
- Ù encourage FIs to continue educating providers on the requirements of the DRG payment window; and,

- require FIs to initiate recovery of the \$5 million in potential overpayments and report, by provider, the amounts recovered. We will coordinate with CMS to provide the overpayment information directly to the FIs.

AUDITEE'S COMMENTS AND OIG'S RESPONSE

Auditee's Comments

The CMS, in its comments (see APPENDIX), concurred with our recommendations. Specifically, CMS stated they: (1) will review the CWF edits to verify that the edits are sufficient to stop improper payments under the 3-day rule; (2) have established a workgroup to assess potential vulnerabilities in the existing duplicate claim edits; (3) will continue to cooperate with OIG and DOJ and collect potential overpayments based on the prior OIG review; (4) will issue a program memorandum regarding continued contractor education of providers on the requirement of the DRG payment window; and (5) will ensure FIs recover any overpayments resulting from violations of the 3-day rule.

The HCFA also provided technical comments to our draft report.

OIG'S Response

We appreciate CMS' comments and concurrence with our recommendations. With respect to CMS' comments regarding OIG's interpretation and definition of the DRG window, we offer the following clarifications. First, our computer match was designed to identify only those services rendered by the same provider during the 3 days prior to admission and the day of admission. Our computer match for services rendered during an inpatient stay, excluding the day of discharge, was designed to identify services rendered by the same, as well as different providers. Second, we did, in fact, use 3 days when defining the DRG window and performing our computer extract.

Based on CMS' comments regarding our first recommendation, we would also like to clarify that CMS' review of the CWF system edits should include duplicate payment edits for outpatient services rendered on the day of admission and during inpatient stays, as well as those violating the 3-day rule.

With respect to CMS' technical comments, we offer the following:

- We have replaced "72 hours" with "3 days" throughout the report.
- We included section 1862(a)(14) of the Social Security Act as part of the DRG payment window as Congress indicated in its Joint Explanatory Statement of the Committee Conference for expansion of the DRG payment window that outpatient services may not be billed on behalf of an inpatient of a hospital.

- We do not believe that a discussion of materiality is relevant as these duplicate payments are easily identifiable and preventable, regardless of their percentage of the total payments made by Medicare to hospitals in a given period.
- As previously stated, we believe that the DRG payment window includes the period during an inpatient stay, as well as the 3 days prior to the day of admission.

APPENDIX



DATE: MAY -9 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan 
Acting Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: *Follow-up Audit of Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System*
(A-01-00-00506)

Thank you for the opportunity to comment on the above-referenced report. The Health Care Financing Administration (HCFA) is committed to the fiscal integrity of the Medicare program. In recent years HCFA, together with OIG and the Department of Justice (DOJ), has been particularly successful in reducing duplicate payments to hospitals for outpatient services rendered by the hospital, or an entity wholly-owned and operated by the hospital, to a patient within 3 days of an inpatient admission (diagnostic-related group (DRG) window).

As OIG notes, improper DRG window payments have declined from \$27 million over a 3-year period covered in a previous audit to \$5 million in 1997-98 (the period discussed in this report). This estimate may be high, since it appears OIG may have interpreted the DRG window too broadly when extending outpatient services rendered by one hospital within 3 days of a patient's admission, to another hospital, without specifying whether the first hospital was wholly-owned and operated by the second (Draft Report, p. 4).

Moreover, OIG may have underestimated the duplicate payments by applying a 72-hour test, when the statute specifies 3 days and implementing regulations have interpreted the statute as meaning 3 calendar days. Using the 72-hour criteria instead of 3 days, some duplicate payments may have been missed. For example, if a patient received outpatient services at 1:00 a.m. on the first of the month, and was admitted to the same hospital at 11:00 p.m. on the fourth of the month (94 hours later), HCFA regulations would require payment for the outpatient services to be bundled into the payment for the inpatient admission. In a HCFA final rule, published in the February 11, 1998, *Federal Register*, the 1983 statute creating the prospective payment system (PPS) for acute care hospitals incorporated long-standing Medicare policy that outpatient services provided to a patient who was then admitted to the same hospital by midnight of the succeeding day were deemed to be inpatient services, to be included in the Part A payment. The law was subsequently amended to phase-in a 3-day payment window.

Effective October 1, 1991, Medicare policy does not provide for separate payment under Part B for any outpatient diagnostic services, whether or not related to the admission, or

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any other outpatient services related to the admission, when rendered by the admitting hospital, or an entity that is wholly-owned or operated by the admitting hospital, during the 3 days immediately preceding the date of admission.

With these reservations in mind, we offer our comments regarding OIG's specific recommendations in the report.

OIG Recommendation

HCFA should review the Common Working File (CWF) system to ensure that all edits are sufficient, alerts are activated, and edits are developed to address all of the legislative requirements set forth by the Omnibus Budget Reconciliation Act of 1990.

HCFA Response

We concur. HCFA will review CWF edits to verify that the edits are sufficient to stop improper payments under the 3 day window rules. Upon completion of the review, HCFA will determine if there is a need to develop new edits or change existing edits, and whether to take any further action.

OIG Recommendation

HCFA should review fiscal intermediaries' (FIs') edit systems override procedures to ensure that all manual overrides are properly authorized and correct.

HCFA Response

We concur. Prior to Y2K, HCFA initiated actions to ensure that contractors could not alter the duplicate claim edits coded in the Medicare standard claims processing system. Currently, HCFA has established a workgroup to assess the potential vulnerabilities in the existing duplicate claim edits. From this analysis, we will determine appropriate actions to reduce program risks.

HCFA requires contractors to implement edits based on local medical review policy (LMRP) in order to automatically review claims. LMRPs are developed to address identified vulnerabilities, and the edits seek to reduce inappropriate payments. Contractors are further required to review the effectiveness of edits quarterly and to delete or supplement as necessary.

Additionally, HCFA performs national contractor performance evaluations (CPEs) to ensure contractors' adherence to program safeguards. We will consider incorporating a review of the systems override procedures into our CPE strategy.

OIG Recommendation

HCFA should continue to cooperate with OIG and DOJ to recover potential overpayments from hospitals contacted by DOJ as a result of our prior review.

HCFA Response

We concur. HCFA will continue to cooperate with OIG and DOJ and collect potential overpayments from hospitals based on the OIG prior review.

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OIG Recommendation

HCFA should encourage FIs to continue educating providers on the requirement of the DRG payment window.

HCFA Response

We concur. HCFA will issue a program memorandum regarding continued contractor education of providers on the requirement of the DRG payment window. The program memorandum is currently being developed.

OIG Recommendation

HCFA should require FIs to initiate recovery of the \$5 million in potential overpayments and report, by provider, and amounts recovered. We will coordinate with HCFA to provide the overpayment information directly to the FIs.

HCFA Response

We concur that the FIs should recover any overpayments resulting from a violation of the 3-day DRG window, but we request that OIG review the data on the amounts of overpayments in light of the above comments regarding HCFA's interpretation of the window. When the final report is issued, OIG will furnish the data necessary (provider numbers, claims information, health insurance claim numbers, etc.) for the Medicare contractors to initiate and complete recovery action. At that time, we will forward the final report and information needed by the Medicare contractors to effectuate recovery of the overpayments to the regional offices for appropriate action. We will also identify an OIG contact if any questions arise. We appreciate OIG's offer to provide HCFA with the detailed claims information to assist in the recovery process.

In the past, OIG has agreed to furnish provider-specific home health agency reports to the regional home health intermediaries in order to eliminate delays in recouping overpayments. We are pleased that similar arrangements for advising the Medicare FIs will be followed when this report is issued in final.

Technical Comments

In addition, HCFA offers the following technical comments regarding OIG's report:

1. As noted above, the OIG report repeatedly refers to the DRG window as the 72-hour period before an inpatient admission. However, as explained in 63 F.R. 6864, dated February 11, 1998, the DRG window is 3 calendar days prior to the date of admission. Therefore, each time "72 hours" is mentioned in the report, it should be replaced with "3 days."
2. OIG includes section 1862(a)(14) of the Social Security Act as part of the "DRG payment window." However, section 1862(a)(14) is a separate provision. The DRG payment window (i.e., a 3-day payment window) provision of inpatient PPS is section 1886(a)(4) alone.

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3. On page ii of the Executive Summary, the report should provide a sense of perspective, namely that the amount of potential improper payments represents X percent of the \$Y billion in payments for inpatient hospital services during the time period in question.
4. The background sections of both the Executive Summary and the draft report should define the 3-day payment window provision as follows:
 - a. Separate payments are not allowed for: (1) diagnostic services rendered by the admitting hospital, or by an entity wholly-operated by the hospital (or by another entity under arrangements with the hospital), up to 3 days before the day of admission; and (2) admission-related nondiagnostic services rendered by the admitting hospital, or by an entity wholly-owned or wholly-operated by the hospital (or by the entity under arrangements with the hospital), up to 3 days before the day of admission.