

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NORIDIAN HEALTHCARE
SOLUTIONS, LLC,
INAPPROPRIATELY PAID
HOSPITALS' MEDICARE CLAIMS
SUBJECT TO THE POSTACUTE
CARE TRANSFER POLICY IN
JURISDICTION 2**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Gloria L. Jarmon
Deputy Inspector General

November 2013
A-09-13-02035

Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Noridian Healthcare Solutions inappropriately paid Medicare claims subject to the postacute care transfer policy, resulting in overpayments to 73 hospitals totaling \$1.1 million over 4 years. The hospitals improperly coded claims as discharges to home or certain types of health care institutions rather than as transfers to postacute care.

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews identified Medicare overpayments to hospitals that did not comply with Medicare's postacute care transfer policy. These hospitals transferred inpatients to certain postacute care settings but claimed the higher reimbursement associated with discharges to home. In those reports, we recommended that the Centers for Medicare & Medicaid Services (CMS) provide education to make hospitals aware of the transfer policy and require Medicare contractors to implement system edits to prevent and detect postacute care transfers that are miscoded as discharges. CMS generally concurred with our recommendations. However, in recent OIG reviews of hospitals' compliance with Medicare billing requirements and a review of Medicare claims subject to the postacute care transfer policy in Jurisdiction 1, we identified overpayments to hospitals that did not comply with the policy.

The objective of this review was to determine whether Noridian Healthcare Solutions, LLC (Noridian), the Medicare contractor for Jurisdiction 2, appropriately paid hospitals' Medicare claims subject to the postacute care transfer policy.

BACKGROUND

Medicare's postacute care transfer policy distinguishes between discharges and transfers of beneficiaries from hospitals under the inpatient prospective payment system. Consistent with the policy, Medicare makes full Medicare Severity Diagnosis-Related Group (MS-DRG) payments to hospitals that discharge inpatients to their homes or certain types of health care institutions, such as hospice settings. In contrast, for specified MS-DRGs, Medicare pays hospitals that transfer inpatients to certain postacute care settings, such as home health care and skilled nursing facilities, a per diem rate for each day of the stay, not to exceed the full MS-DRG payment for a discharge. Therefore, the full MS-DRG payment is either higher than or equal to the per diem payment dependent on the patient's length of stay in the hospital. CMS requires hospitals to include a two-digit patient discharge status code on all inpatient claims to identify a beneficiary's status at the conclusion of an inpatient stay. Whether Medicare pays for a discharge or a transfer depends on the patient discharge status code.

In 2004, CMS implemented Common Working File (CWF) edits to identify transfers improperly coded as discharges. Specifically, if a postacute care claim is processed and paid before a corresponding inpatient claim is processed, prepayment edits for inpatient claims are designed to reject the incoming inpatient claim. However, if an inpatient claim is processed and paid before a corresponding postacute care claim is processed, postpayment edits are designed to (1) adjust the claim automatically by canceling the original inpatient claim and (2) identify the

overpayment. In both instances, the hospital may submit an adjusted claim with the appropriate discharge status code to receive the per diem payment.

Our review covered approximately \$4.6 million in Medicare Part A payments for 315 claims with specified MS-DRGs in which beneficiaries were transferred to postacute care and with dates of service during the period June 2009 through August 2012. These claims were submitted by 73 short-term acute-care hospitals in Jurisdiction 2.

WHAT WE FOUND

Noridian inappropriately paid 315 Medicare claims subject to the postacute care transfer policy. Noridian confirmed that hospitals used incorrect patient discharge status codes on their claims, indicating that the patients were discharged to home or certain types of health care institutions rather than transferred to postacute care. Of these claims, 95 percent were followed by claims for home health services, and 5 percent were followed by claims for services in other postacute care settings. Consequently, Noridian overpaid the hospitals by \$1,137,346.

Noridian made these overpayments because the CWF edits related to postacute care transfers were not working properly. Noridian did not receive the automatic adjustments that identify overpayments on inpatient claims. In addition, the CWF edits that were specifically related to transfers to home health care erroneously calculated the number of days between the dates of service on the inpatient claim and the home health claim.

CMS published a change request, effective July 1, 2013, to notify Medicare contractors that CMS had corrected the calculation of the number of days in the edits related to transfers to home health care.

WHAT WE RECOMMEND

We recommend that Noridian:

- recover \$1,137,346 in identified overpayments;
- educate Jurisdiction 2 hospitals on the importance of reporting the correct patient discharge status codes on transfer claims, especially when home health services have been ordered; and
- work with the CWF maintenance contractor to ensure that it receives the automatic adjustments identifying overpayments on inpatient claims.

NORIDIAN COMMENTS

In written comments on our draft report, Noridian concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews identified Medicare overpayments to hospitals that did not comply with Medicare's postacute care transfer policy. These hospitals transferred inpatients to certain postacute care settings but claimed the higher reimbursement associated with discharges to home. In those reports, we recommended that the Centers for Medicare & Medicaid Services (CMS) provide education to make hospitals aware of the transfer policy and require Medicare contractors to implement system edits to prevent and detect postacute care transfers that are miscoded as discharges. CMS generally concurred with our recommendations. However, in recent OIG reviews of hospitals' compliance with Medicare billing requirements and a review of Medicare claims subject to the postacute care transfer policy in Jurisdiction 1, we identified Medicare overpayments to hospitals that did not comply with the policy. (Appendix A contains a list of the previously issued OIG reports on hospitals' submissions of Medicare claims subject to the postacute transfer policy.)

OBJECTIVE

Our objective was to determine whether Noridian Healthcare Solutions, LLC (Noridian), the Medicare contractor for Jurisdiction 2, appropriately paid hospitals' Medicare claims subject to the postacute care transfer policy.

BACKGROUND

Medicare's Inpatient Prospective Payment System

The Social Security Act (the Act) established the inpatient prospective payment system (IPPS) for inpatient hospital services provided to Medicare beneficiaries (§§ 1886(d) and (g)). Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. A hospital inpatient is considered discharged from a hospital when the patient is formally released from or dies in the hospital.

CMS's payment rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which a beneficiary's stay is assigned. The MS-DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Postacute Care Transfer Policy

Section 4407 of the Balanced Budget Act of 1997, P.L. No. 105-33, added section 1886(d)(5)(J) to the Act to establish the Medicare postacute care transfer policy. This provision and its implementing regulations (42 CFR § 412.4(c)) state that a postacute care transfer occurs when a beneficiary whose hospital stay was classified within specified MS-DRGs is discharged from an IPPS hospital in one of the following situations:

- The beneficiary is admitted on the same day to a hospital or hospital unit that is not reimbursed under the IPPS.
- The beneficiary is admitted on the same day to a skilled nursing facility.
- The beneficiary receives home health services from a home health agency, the services are related to the condition or diagnosis for which the beneficiary received inpatient hospital services, and the services are provided within 3 days of the beneficiary's hospital discharge date.

Medicare makes the full MS-DRG payment to a hospital that discharges an inpatient to home or certain types of health care institutions, such as hospice settings. In contrast, Medicare pays a hospital that transfers an inpatient to postacute care a per diem rate for each day of the stay, not to exceed the full MS-DRG payment that would have been made if the inpatient had been discharged to home. Therefore, the full MS-DRG payment is either higher than or equal to the per diem payment dependent upon the patient's length of stay in the hospital.

CMS requires hospitals to include a two-digit patient discharge status code on all inpatient claims to identify a beneficiary's status at the conclusion of an inpatient stay. Whether Medicare pays for a discharge or a transfer depends on the patient discharge status code.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare claims submitted for hospital services. The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse.

Medicare Claim Processing Systems

Medicare contractors use the Fiscal Intermediary Standard System (FISS) to process inpatient claims submitted by hospitals in their designated jurisdictions. After being processed through the FISS, and before payment, all claims are sent to CMS's Common Working File (CWF) system for verification, validation, and payment authorization. Once the CWF has processed a claim, it electronically transmits information to the contractor regarding potential errors on the claim. Both the FISS and CWF contain edits to prevent and detect overpayments.

On January 1, 2004, CMS implemented CWF edits¹ to identify improperly coded hospital claims and instructed the Medicare contractors to automatically cancel hospital claims that had incorrect patient discharge status codes. On March 15, 2004, CMS revised these edits and established new criteria for an automatic claim cancellation. Specifically, if a postacute care claim is processed and paid before a corresponding inpatient claim is processed, prepayment edits for inpatient claims are designed to reject the incoming inpatient claim. However, if an inpatient claim is processed and paid before a corresponding postacute care claim is processed, postpayment edits

¹ The CWF edits operate generally in the same way for all types of postacute care transfers depending on the postacute care setting as specified in 42 CFR § 412.4(c).

are designed to (1) adjust the claim automatically by canceling the original inpatient claim and (2) identify the overpayment. In both instances, the hospital may submit an adjusted claim with the appropriate discharge status code to receive the per diem payment.

Noridian Healthcare Solutions, LLC

During our audit period, Noridian Healthcare Solutions, LLC (Noridian), was the Medicare contractor for Jurisdiction 2 hospitals in four States: Alaska, Idaho, Oregon, and Washington.²

HOW WE CONDUCTED THIS REVIEW

Our review covered \$4,600,157 in Medicare Part A payments for 315 claims with specified MS-DRGs in which beneficiaries were transferred to postacute care and with dates of service during the period June 2009 through August 2012. These claims were submitted by 73 short-term acute-care hospitals in Jurisdiction 2.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from Medicare payment files; we did not assess the completeness of the files. Through data analysis, we identified inpatient claims subject to the postacute transfer policy that were improperly coded as discharges to home or certain types of health care institutions.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our audit scope and methodology.

FINDINGS

Noridian inappropriately paid 315 Medicare claims subject to the postacute care transfer policy. Noridian confirmed that hospitals used incorrect patient discharge status codes on their claims, indicating that the patients were discharged to home or certain types of health care institutions rather than transferred to postacute care. Of these claims, 95 percent were followed by claims for home health services, and 5 percent were followed by claims for services in other postacute care settings. Consequently, Noridian overpaid the hospitals by \$1,137,346. Noridian made these overpayments because the CWF edits related to transfers to home health care, skilled nursing facilities, and non-IPPS hospitals were not working properly.

² Noridian is currently the Medicare contractor for hospitals in Jurisdiction F, which consolidated Jurisdictions 2 and 3 on August 22, 2011. Because Noridian was the Medicare contractor for Jurisdiction 2 hospitals, it is currently responsible for those hospitals under Jurisdiction F. Therefore, Noridian is responsible for collecting any overpayments and resolving any issues related to this audit.

FEDERAL REQUIREMENTS

Federal regulations state that for a beneficiary whose hospital stay was classified within one of the specified MS-DRGs, a discharge from an IPPS hospital to a qualifying postacute care setting is considered a transfer (42 CFR § 412.4(c)). The qualifying postacute care settings are (1) hospitals or hospital units that are not reimbursed under the IPPS,³ (2) skilled nursing facilities, and (3) home health care if services are provided within 3 days of the discharge.

CMS requires hospitals to include patient discharge status codes on all inpatient claims.⁴ When a beneficiary is transferred to a setting subject to the postacute care transfer policy, a specific discharge status code should be used, depending on the type of postacute care setting. For example, discharge status code 03 should be used when the beneficiary is transferred to a skilled nursing facility, discharge status code 06 should be used when a beneficiary is transferred to home for home health services, and discharge status code 62 should be used when a beneficiary is transferred to an inpatient rehabilitation facility.⁵ The Federal Register emphasizes that the hospital is responsible for coding the bill on the basis of its discharge plan for the patient. If the hospital subsequently determines that postacute care was provided, it is responsible for either coding the original bill as a transfer or submitting an adjusted claim.⁶

The *Medicare Financial Management Manual*, Pub. 100-06, chapter 7, section 10, states that the contractor must administer the Medicare program efficiently and economically and refers to the Medicare contractors' Statement of Work, which further states that the contractor must establish and maintain efficient and effective internal controls.

HOSPITALS IMPROPERLY CODED CLAIMS AS DISCHARGES TO HOME OR CERTAIN TYPES OF HEALTH CARE INSTITUTIONS RATHER THAN AS TRANSFERS TO POSTACUTE CARE

Noridian inappropriately paid 315 Medicare claims subject to the postacute care transfer policy during the period June 2009 through August 2012. Noridian confirmed that hospitals improperly coded these claims as discharges to home (287 claims) or to certain types of health care institutions (28 claims) rather than as transfers to postacute care by using the incorrect patient discharge status codes. Of these claims:

³ The Act refers to hospitals and hospital units that are not reimbursed under the IPPS as "not subsection (d) hospitals" (§ 1886(d)(5)(J)). The Act also identifies the hospitals and hospital units that are excluded from the term "subsection (d) hospitals," such as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term-care hospitals, and cancer hospitals (§ 1886(d)(1)(B)).

⁴ *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 25, § 75.2.

⁵ *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 3, § 40.2.4; Program Memorandum, Transmittal No. A-01-39, Mar. 22, 2001, Change Request 1565; Medicare Learning Network's MLN Matters Number: SE0801; and MLN Matters Number: MM4046, Related Change Request 4046.

⁶ 63 Fed. Reg. 40954, 40980 (July 31, 1998). See also MLN Matters Number: SE0408.

- 298 claims were followed by claims for home health services provided within 3 days of the discharge date, resulting in \$1,071,798 of overpayments to the discharging hospitals;
- 13 claims were followed by claims for skilled nursing services provided on the same day as the discharge date, resulting in \$37,977 of overpayments to the discharging hospitals; and
- 4 claims were followed by claims for admissions to non-IPPS hospitals or hospital units on the same day as the discharge date, resulting in \$27,571 of overpayments to the discharging hospitals.

As a result, Noridian overpaid 73 hospitals by \$1,137,346. The overpayments represented the difference between the full MS-DRG payments and the per diem rates that should have been applied.

EDITS WERE NOT WORKING PROPERLY TO PREVENT OVERPAYMENTS TO HOSPITALS

Noridian overpaid the hospitals because the CWF edits related to transfers to home health care, skilled nursing facilities, and non-IPPS hospitals were not working properly. Noridian did not receive the automatic adjustments that identify overpayments on inpatient claims.

In addition, the CWF edits specifically related to transfers to home health care erroneously calculated the number of days between the dates of service on the inpatient claim and the home health claim. Rather than calculating the number of days between the inpatient and home health claims as 3 days after the date of discharge from the inpatient hospital, the edits erroneously calculated the number of days as 2 days after the date of discharge.

CMS published a change request, effective July 1, 2013, to notify Medicare contractors that CMS had corrected the calculation of the number of days in the edits related to transfers to home health care.

RECOMMENDATIONS

We recommend that Noridian:

- recover \$1,137,346 in identified overpayments;
- educate Jurisdiction 2 hospitals on the importance of reporting the correct patient discharge status codes on transfer claims, especially when home health services have been ordered; and
- work with the CWF maintenance contractor to ensure that it receives the automatic adjustments identifying overpayments on inpatient claims.

NORIDIAN COMMENTS

In written comments on our draft report, Noridian concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. Noridian's comments are included in their entirety as Appendix C.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Medicare Compliance Review of Community Regional Medical Center⁷</i>	A-09-12-02071	6/11/2013
<i>Palmetto GBA, LLC, Inappropriately Paid Hospitals' Medicare Claims Subject to the Postacute Care Transfer Policy in Jurisdiction 1</i>	A-09-12-02038	5/29/2013
<i>Medicare Compliance Review of Cedars-Sinai Medical Center for the Period January 1, 2008, Through June 30, 2011⁷</i>	A-09-12-02048	5/15/2013
<i>Medicare Compliance Review of California Pacific Medical Center, Pacific Campus, for Calendar Years 2009 and 2010⁷</i>	A-09-12-02027	1/10/2013
<i>Medicare Compliance Review of Hoag Memorial Hospital Presbyterian for Calendar Years 2008 Through 2011⁷</i>	A-09-12-02012	12/10/2012
<i>Medicare Overpaid Some Fiscal Year 2008 and 2009 Jurisdiction 4 Inpatient Rehabilitation Facility Claims That Did Not Comply With Transfer Regulations</i>	A-04-11-00078	4/24/2012
<i>Medicare Compliance Review of John Muir Medical Center, Walnut Creek, for Calendar Years 2008 Through 2010⁷</i>	A-09-11-02060	2/23/2012
<i>Medicare Compliance Review of University of California, San Diego, Medical Center for Calendar Years 2008 and 2009⁷</i>	A-09-11-02055	2/23/2012
<i>Medicare Compliance Review of University of California, San Francisco, Medical Center for Calendar Years 2008 and 2009⁷</i>	A-09-11-02034	9/21/2011
<i>Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2003 Through 2005</i>	A-04-07-03035	2/27/2009

⁷ The postacute care transfer issue was only one of the findings in this report.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered \$4,600,157 in Medicare Part A payments for 315 claims with specified MS-DRGs in which beneficiaries were transferred to postacute care and with dates of service during the period June 2009 through August 2012. These claims were submitted by 73 short-term acute-care hospitals in Jurisdiction 2.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from Medicare payment files; we did not assess the completeness of the files. Through data analysis, we identified inpatient claims subject to the postacute transfer policy that were improperly coded as discharges to home or certain types of health care institutions. We limited our review of Noridian's internal controls to those applicable to implementation of Medicare's postacute care transfer policy. We did not evaluate the medical records of the IPPS hospitals from which the beneficiaries in our review were discharged to determine whether there was a written plan of care for the provision of home health services.

We conducted our audit from July 2012 to July 2013 and performed fieldwork at Noridian in Fargo, North Dakota.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance;
- used CMS's National Claims History File to identify inpatient claims with specified MS-DRGs, during our audit period, for beneficiaries who received certain postacute care services after inpatient stays;
- used computer matching, data mining, and data analysis techniques to identify for review 315 claims coded as discharges to home or certain types of health care institutions;
- sent the 315 claims to Noridian officials to verify that the claims were miscoded and to determine the cause of the miscoding;
- interviewed Noridian officials and reviewed documentation provided by them to understand how they processed claims and to determine why Noridian made payments for the miscoded claims;

- used CMS’s PC Pricer to reprice each improperly paid claim to determine the transfer payment amount, compared the repriced payment with the actual payment, and determined the value of the overpayment;⁸ and
- discussed the results of our review with Noridian officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

⁸ CMS’s PC Pricer is software used to estimate Medicare payments. Because of timing differences in the data used to determine the payments, the estimated payments may not match exactly the actual claim payments.

APPENDIX C: NORIDIAN COMMENTS



900 42nd Street South
Fargo, ND 58103

November 6, 2013

Report Number: A-09-13-02035

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90-7th St, Suite 3-650
San Francisco, CA 94103

Dear Ms. Ahlstrand,

Noridian Healthcare Solutions, LLC (Noridian) has reviewed the draft report, entitled *Noridian Healthcare Solutions, LLC, Inappropriately Paid Hospitals' Medicare Claims Subject to the Postacute Care Transfer Policy in Jurisdiction 2*. Below are our comments and responses to the OIG's recommendations.

Noridian concurs with all of the recommendations.

The first OIG recommendation was that Noridian recover \$1,137,346 in identified overpayments for claims with specified MS-DRGs in which beneficiaries were transferred to postacute care and with dates of service during the period June 2009 through August 2012. Noridian has reviewed the OIG provided spreadsheet and finds that only \$14,299 remains uncollected.

The second OIG recommendation was that Noridian educate Jurisdiction 2 hospitals on the importance of reporting the correct patient discharge status codes on transfer claims, especially when home health services have been ordered. Noridian published an educational article on October 21, 2013 reminding providers of the importance of using the appropriate discharge status codes and explaining the payment methodology applied according to the discharge status used. The article also included a listing of the discharge status codes used to indicate a transfer case. https://www.noridianmedicare.com/cgi-bin/coranto/viewnews.cgi?id=EFIkFZAupFLGtWHCO&tmpl=part_a_viewnews&style=part_ab_viewnews

The third OIG recommendation was that Noridian work with the CWF maintenance contractor to ensure it receives the automatic adjustments identifying overpayments on inpatient claims. When CWF identifies an overlap claim or duplicate, CWF will send back an Informational Unsolicited Response (IUR) or a CWF edit/response to Noridian. Noridian will monitor/work the IUR or CWF edit to ensure the claims process correctly and overpayments are

A CMS Medicare Administrative Contractor

Noridian Healthcare Solutions, LLC



recovered, if appropriate. Noridian continues coordination with The Standard Fiscal Intermediary Systems (FISS) maintenance contractor and the CWF maintenance contractor to ensure claims process correctly and overpayments are recovered, if appropriate.

We appreciate the opportunity to comment on this report and the findings. If you have any questions on this response and Noridian's actions, please contact me at 701-282-1356 or through email at Emy.Stenerson@noridian.com.

Sincerely,

A handwritten signature in black ink, appearing to read "Emy St", followed by a long horizontal line extending to the right.

Emy Stenerson,
Senior Vice President and JF Project Manager

cc: Pamela Bragg, JF COR, CMS
Tom McGraw, CEO and President of Noridian Healthcare Solutions, LLC