

Department of Health and 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**

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Office of Inspector General

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Report in Brief

Date: August 2020

Report No. A-04-18-04067

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



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.

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

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 disproportionately 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.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Audit	1
Objective	1
Background	2
The Medicare Program	2
Medicare Part A Payments to Acute-Care Hospitals	2
Post-Acute-Care Transfer Policy	2
Payments to Acute-Care Hospitals for Transfers to Post-Acute Care and the Use of Patient Discharge Status Codes	3
Claim Processing and Payment Exceptions With the Use of Condition Codes For Post-Acute-Care Transfers to Home With Home Health Services	6
Medicare Home Health Services	6
How We Conducted This Audit	6
FINDINGS	8
Improper Patient Discharge Status Code When Resuming Home Health Services	9
Improper Condition Code 43 When Home Health Services Were Provided Within 3 Days of Discharge	10
Improper Condition Code 42 When Home Health Services Were Related to the Inpatient Diagnosis	11
RECOMMENDATIONS	13
CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	15
APPENDICES	
A: Audit Scope and Methodology	17
B: Related Office of Inspector General Reports	19
C: Statistical Sampling Methodology	20
D: Sample Results and Estimates	24
E: CMS Comments	26

INTRODUCTION

WHY WE DID THIS AUDIT

In certain situations, Medicare makes lower payments to an acute-care hospital that transfers a beneficiary to a post-acute-care facility, such as a skilled nursing facility or to home with home health services, than if the hospital discharges an inpatient to certain types of health care institutions such as facilities that provide custodial care or to home without home health services. Whether Medicare pays for a transfer or a discharge depends on which patient discharge status code the hospital assigns and whether the hospital applies certain condition codes that allow payment exceptions. Previous Office of Inspector General (OIG) audits identified more than \$296 million in Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy. (Appendix B lists related OIG reports.) These hospitals transferred inpatients to certain post-acute-care settings, such as home with home health services, but claimed a higher reimbursement that is 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, create new and correct its existing claim processing system edits, and recover the identified overpayments to acute-care hospitals. CMS generally concurred with our recommendations and implemented them. However, subsequent analysis that we conducted indicated that CMS's system edits were still not properly designed. Also, based on our additional claims analysis, we determined that hospitals may be inappropriately using condition codes to bypass CMS's system edits to receive higher reimbursements for inpatients transferred to home with home health services.

OBJECTIVE

Our objective was to determine whether Medicare properly paid acute-care hospital inpatient claims (inpatient claims) subject to the post-acute-care 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,¹ (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 condition or diagnosis for which the beneficiary received inpatient hospital services.

¹ Resumption of home health services occurs when a beneficiary begins those services before being admitted to an acute-care hospital and, after being discharged from the hospital, resumes home health care within 3 days of the date that the hospital discharged the beneficiary.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for beneficiaries after they are discharged from the hospital.

CMS administers Medicare and contracts with Medicare administrative contractors (Medicare contractors) in each Medicare jurisdiction to, among other things, process and pay Medicare Part A inpatient claims submitted for hospital services.

Medicare Part A Payments to Acute-Care Hospitals

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

Medicare'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 acute-care hospital for all inpatient costs associated with the beneficiary's stay.

Post-Acute-Care Transfer Policy

An acute-care hospital transfers a beneficiary to a post-acute-care setting when it stabilizes the beneficiary's acute condition and the beneficiary requires further treatment. Section 4407 of the Balanced Budget Act of 1997, P.L. No. 105-33, added subparagraph 1886(d)(5)(J) to the Act to establish the Medicare post-acute-care transfer policy, and CMS promulgated implementing regulations at 42 CFR sections 412.4(c), (d), and (f). The intent of this transfer policy is to avoid providing an incentive for a hospital to transfer a beneficiary to a post-acute-care setting early (before the beneficiary's acute condition is stabilized) to minimize its costs while still receiving the full MS-DRG payment. Using a graduated per diem rate, Medicare adjusts the payment to the hospital to approximate the reduced cost for a beneficiary who has been transferred to a post-acute-care setting.

The post-acute-care transfer policy defines a transfer as having occurred when a beneficiary whose hospital stay was classified within specified MS-DRGs is discharged from an IPPS acute-care 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.²
- The beneficiary receives home health services from a home health agency,³ 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 date that the hospital discharged the beneficiary.⁴
- The beneficiary is admitted on the same day to a hospice.⁵

Payments to Acute-Care Hospitals for Transfers to Post-Acute Care and the Use of Patient Discharge Status Codes

Medicare makes the full MS-DRG payment to an acute-care hospital that discharges an inpatient to home or certain types of health care institutions, such as facilities that provide custodial care. In contrast, Medicare pays an acute-care hospital that transfers a beneficiary to post-acute care a per diem rate for each day of the beneficiary's stay in the hospital. The total per diem payment is intended to be payment in full to cover the inpatient costs of the beneficiary stay. The total per diem payment cannot exceed the full MS-DRG payment that would have been made if the beneficiary had been discharged to home. Therefore, the full MS-DRG payment is either higher than or equal to the total per diem payment depending on the patient's length of stay in the hospital (42 CFR § 412.4(f)).

Whether Medicare pays for a discharge or a transfer depends on the patient discharge status code assigned by the hospital. CMS requires acute-care hospitals to include patient discharge

² A skilled nursing facility provides skilled nursing care, rehabilitation services, and other services to beneficiaries who meet certain conditions.

³ A home health agency provides services to qualifying homebound individuals and covers skilled nursing care, home-based assistance, and therapeutic services to treat illness or injury in the convenience of a beneficiary's home.

⁴ For example, if a hospital discharged a beneficiary on January 1, home health services provided on or before January 4 would be within 3 days of discharge.

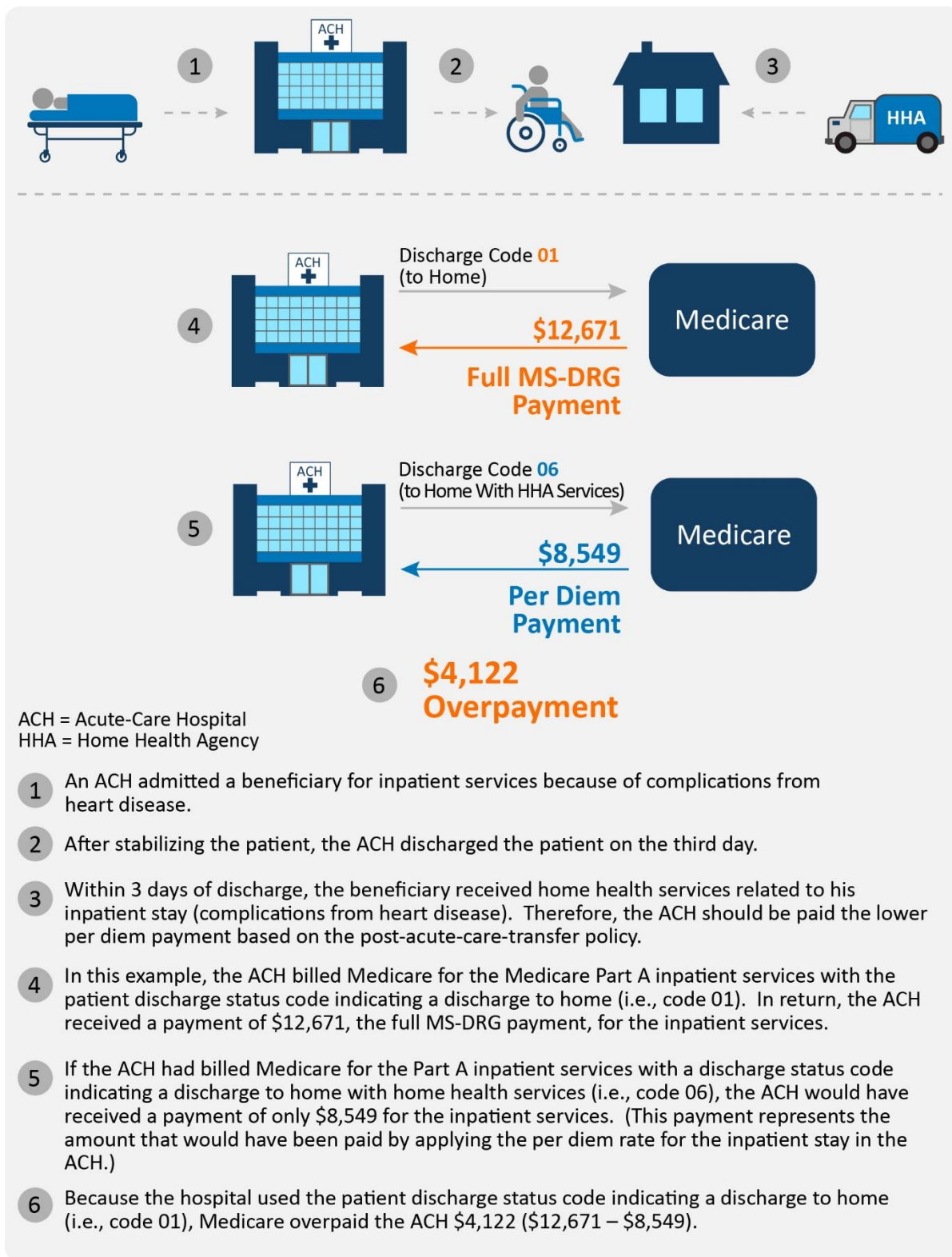
⁵ A hospice is for terminally ill beneficiaries and provides comprehensive services needed to manage pain and other symptoms related to terminal illnesses and related conditions. The post-acute-care transfer policy applies to hospices only for inpatient discharges on or after October 1, 2018.

status codes on all inpatient claims to identify a beneficiary's status after being discharged from the hospital. When a beneficiary is transferred to a setting subject to the post-acute-care transfer policy, the patient discharge status code used depends on the type of post-acute-care setting. For example, patient discharge status code 06 should be used when a beneficiary is transferred to home with home health services.

If an acute-care hospital submits a bill based on its belief that it is discharging a patient to home or another setting not included in the post-acute-care transfer policy but subsequently learns that post-acute care was provided, the hospital should submit an adjusted bill.

Figure 1 on the next page shows an example of an overpayment made to an acute-care hospital for a beneficiary who was discharged to home and obtained post-acute-care services from a home health agency.

Figure 1: Example of an Overpayment to an Acute-Care Hospital for an Inpatient Claim Subject to the Post-Acute-Care Transfer Policy



Claim Processing and Payment Exceptions With the Use of Condition Codes for Post-Acute-Care Transfers to Home With Home Health Services

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 but before payment, all inpatient claims are sent to CMS's Common Working File (CWF) system for verification, validation, and payment authorization.

The CWF contains both prepayment and postpayment system edits that are intended to prevent or detect overpayments for an inpatient claim subject to the post-acute-care transfer policy when there is a home health claim. If the inpatient claim is rejected or canceled, the acute-care hospital can submit an adjusted inpatient claim with the appropriate patient discharge status code to receive a per diem payment.

If a patient is discharged to home with home health services but the continuing care is not related to the condition or diagnosis for which the individual received inpatient hospital services, the hospital can apply condition code 42 and receive the full MS-DRG payment. The CWF edits work with the presumption that the services are related unless the hospital applies condition code 42 on the claim. If the continuing care is related but the home health agency does not provide the home health services within 3 days of discharge, the hospital can apply condition code 43 to the inpatient claim and receive the full MS-DRG payment.⁶

Medicare Home Health Services

Medicare (Parts A and B) covers eligible home health services under a prospective payment system. Under the home health prospective payment system, Medicare pays home health agencies a standardized payment for each 60-day episode of care that a beneficiary receives. Medicare adjusts the 60-day episode payments using a case-mix methodology based on data elements from the Outcome and Assessment Information Set (OASIS). The OASIS classifies home health agency beneficiaries into 153 case-mix groups that are used as the basis for the Health Insurance Prospective Payment System payment codes and represent specific sets of patient characteristics.

Because of this payment methodology, home health claims can span up to 60 days. However, the dates that services were provided are included on each home health claim.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$948 million in Medicare Part A payments for 89,213 inpatient claims in which beneficiaries were transferred to post-acute-care with dates of service from October 1,

⁶ 65 Fed. Reg. 47054, 47081 (Aug. 1, 2000); see also Medicare Learning Network (MLN) Matters Number: SE1411 Reissued.

2015, through September 30, 2017.⁷ We included only inpatient claims in which (1) the total graduated per diem payment would have been lower than the full MS-DRG payment based on the MS-DRG and length of stay of the inpatient claim⁸ and (2) the beneficiary had a home health claim with a date of service within 3 days of discharge. The inpatient claims consisted of the following three sets:

1. 73,759 inpatient claims for which the beneficiaries resumed home health services, but the hospital did not code the inpatient claim as a discharge to home with home health services or any other patient discharge status code that results in a graduated per diem payment (Resuming Home Health claims);
2. 2,456 inpatient claims for which the hospital transferred the beneficiary to home health services and applied condition code 43 on the inpatient claim (Condition Code 43 claims); and
3. 12,998 inpatient claims for which the hospital transferred the beneficiary to home health services and applied condition code 42 on the inpatient claim (Condition Code 42 claims).

We selected a stratified random sample of 150 inpatient claims from the 89,213 inpatient claims (60 from the first set, 30 from the second and 60 from the third). For these sampled inpatient claims, we collected medical records from the hospitals and home health agencies, and an independent medical review contractor reviewed the medical records to assess whether the home health services were related to the hospital admission.

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 A contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

⁷ When we began our audit, fiscal years (FYs) 2016 and 2017 were the two most recent and complete FYs.

⁸ We included only claims with MS-DRGs subject to the post-acute-care transfer policy and with length of stays 1 day less than the geometric length of stay for the applicable MS-DRG.

FINDINGS

Medicare improperly paid most acute-care inpatient claims subject to the post-acute-care 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 or 43. Of the 150 inpatient claims in our sample, Medicare properly paid 3;⁹ however, it improperly paid 147 with \$722,288 in overpayments.¹⁰ Medicare should have paid these inpatient claims using a graduated per diem rate rather than the full MS-DRG payment. Based on our sample results, we estimated that Medicare improperly paid \$267,078,601 during a 2-year period for acute-care hospital services that should have been paid a graduated per diem payment.

Of the \$267,078,601 in estimated overpayments, we estimate that:

- \$218,844,613 of the overpayments were due to Medicare's inadequate CWF edits, which looked only at the first line of the home health claim and ignored the other dates of service on the home health claim;
- \$7,296,184 of the overpayments were due to Medicare's lack of CWF edits involving the use of condition code 43; and
- \$40,937,804 of the overpayments were due to Medicare's inadequate provider education, oversight, and controls related to the use of condition code 42.

As of the publication of this report, these overpayments include claims outside of the 4-year reopening period.¹¹

⁹ For one of the three properly paid inpatient claims, the hospital correctly adjusted the claim and removed condition code 42 before the start of our audit. For the other two inpatient claims, although the hospitals should have coded the inpatient claims as discharges to home with home health services, the independent medical review contractor determined that the home health services were not related to the hospital admission. Therefore, the hospitals were entitled to the full MS-DRG payment.

¹⁰ For the 147 inpatient claims that Medicare improperly paid, physicians made new or additional orders for home health services that related to the reason for the hospital admission or the beneficiary was already receiving home health services for conditions that related to the reason for the hospital admission.

¹¹ 42 CFR § 405.980(b)(2) (permitting a contractor to reopen an initial determination within 4 years for good cause).

IMPROPER PATIENT DISCHARGE STATUS CODE WHEN RESUMING HOME HEALTH SERVICES

A transfer to home with the provision of home health services is paid using a graduated per diem rate when the beneficiary's stay is assigned to a MS-DRG subject to the post-acute-care transfer policy and the discharge is to home under a written plan of care for home health services provided within 3 days of discharge and the services are related to the hospital admission (the Act § 1886(d)(5)(J) and 42 CFR § 412.4(c)).

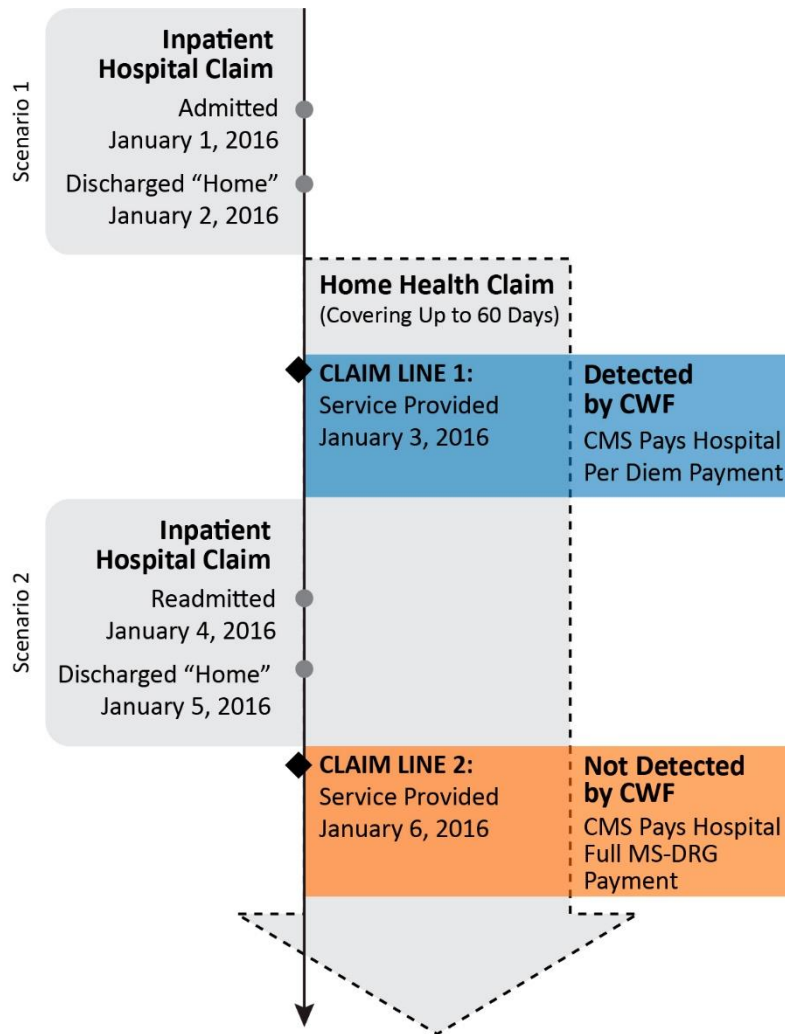
For 58 of the 60 sampled inpatient claims, in which the beneficiary resumed home health services within 3 days of discharge and the hospital did not code the inpatient claim as a discharge to home with home health services or any other patient discharge status code that results in a graduated per diem payment, Medicare improperly paid the full MS-DRG payment instead of the graduated per diem payment. For the remaining two inpatient claims, the independent medical review contractor determined that the home health services were not related to the reason for the hospital admission; therefore, the hospitals were still entitled to the full MS-DRG payment.¹²

By applying an incorrect patient discharge status code, the hospitals received the full MS-DRG payment. CMS did not design the CWF edits to detect these incorrectly billed inpatient claims. Although a home health claim can span up to 60 days, CMS's CWF edits looked only at the first line of a home health claim to assess whether the beneficiary received home health services within 3 days of discharge and ignored the remaining home health claim lines.¹³ Figure 2 shows how this design was inadequate. This figure shows two scenarios in which a hospital incorrectly codes the patient discharge status code as "home." In the first scenario, a beneficiary is discharged from a hospital on January 2, 2016, and receives home health services related to the hospital admission on January 3, 2016, which is within 3 days of discharge. The CWF edits would ensure that the hospital receives only the lower per diem payment because the first line of the home health claim is within 3 days of discharge. In the second scenario, the beneficiary is then readmitted and discharged on January 5, 2016, and receives home health services related to the hospital admission on January 6, 2016, which is within 3 days of the second discharge. The hospital would incorrectly receive the full MS-DRG payment because the CWF edits would look only at the first line of the home health claim (January 3, 2016) to verify whether the beneficiary received home health services within 3 days of discharge and not the second line of the home health claim (January 6, 2016).

¹² In one case, a patient was admitted for pneumonia. After discharge, he resumed home health services for issues related to mobility. The home health services did not address any pulmonary concerns. In the other case, a patient was admitted for coughing up blood with blood clots in his trachea. After discharge, he resumed home health services for rehabilitation for a femur fracture. The home health services did not address any pulmonary concerns.

¹³ CMS previously designed the edits to look at only the home health episode start date but revised the edits to look at the first home health line item date of service.

Figure 2: Inadequacy of CMS CWF Edits



For 5 of the 58 inpatient claims that Medicare improperly paid, the hospitals originally billed the claims correctly. However, the hospitals later rebilled the claims with a revised patient discharge status code to receive the full MS-DRG payment.

Improper payments for sample items in which the beneficiaries resumed home health services totaled \$305,694. Based on our sample results, we estimated that Medicare improperly paid \$218,844,613 during a 2-year period for hospital services that should have been paid using a graduated per diem rate.

IMPROPER CONDITION CODE 43 WHEN HOME HEALTH SERVICES WERE PROVIDED WITHIN 3 DAYS OF DISCHARGE

If the continuing care is related to the hospital admission but the home health agency does not provide the services within 3 days of discharge, the hospital can apply condition code 43 to the

inpatient claim and receive the full MS-DRG payment (65 Fed. Reg. 47054, 47081 (Aug. 1, 2000); see also MLN Matters SE1411 Reissued).

We sampled 30 inpatient claims that hospitals coded as discharges to home with home health services and applied a condition code 43 indicating that the home health agency did not provide the services within 3 days of discharge. For all 30 inpatient claims, the beneficiary received home health services within 3 days of discharge, and the independent medical review contractor determined that the home health services related to the hospital admission. Therefore, Medicare improperly paid the full MS-DRG payment instead of the graduated per diem payment.

By improperly applying condition code 43, the hospitals received the full MS-DRG payment. CMS had no edits to assess whether the beneficiaries received home health services within 3 days when a hospital applied condition code 43.

For 18 of the 30 inpatient claims that Medicare improperly paid, the hospitals originally billed the claims correctly. However, the hospitals later rebilled the claims with condition code 43 to receive the full MS-DRG payment.

Improper payments for these sample items in which the hospitals applied condition code 43 totaled \$89,123. Based on our sample results, we estimated that Medicare improperly paid \$7,296,184 during a 2-year period for hospital services that should have been paid using a graduated per diem rate.

IMPROPER CONDITION CODE 42 WHEN HOME HEALTH SERVICES WERE RELATED TO THE INPATIENT DIAGNOSIS

If a beneficiary is discharged to home with home health services but the continuing care is not related to the condition or diagnosis for which the individual received inpatient hospital services, the hospital can apply condition code 42 and receive the full MS-DRG payment (65 Fed. Reg. 47054, 47081 (Aug. 1, 2000); see also MLN Matters SE1411 Reissued).

We sampled 60 inpatient claims that a hospital coded as discharges to home with home health services and applied a condition code 42 indicating that the home health services did not relate to the inpatient admission. For 59 of the 60 inpatient claims, the independent medical review contractor determined that the services did relate to the hospital admission and the hospital should have been paid the graduated per diem payment. For one inpatient claim, the hospital had correctly adjusted the inpatient claim and removed condition code 42 before the start of our audit.

By improperly applying condition code 42, the hospitals received the full MS-DRG payment. CMS did not have adequate provider education, oversight, or controls to ensure that these inpatient claims were paid correctly. For example, CMS officials defined relatedness as only a “clinical judgment” and did not cite any additional guidance or educational materials defining

“related.” Additionally, CMS has not performed an analysis of hospital use of condition code 42 to identify abnormal billing practices. For example, there were 1,099 hospitals in our sample frame that used condition code 42. The 12th most frequent user of condition code 42 had a staff member that applied condition code 42 as the default for all the claims she billed.¹⁴ If CMS had used data analytics to identify hospitals disproportionately using condition code 42, it might have been able to target this provider with appropriate training to prevent this practice from continuing.

Although there are no documentation requirements for the use of condition code 42, the preamble of the final rule implementing the post-acute-care transfer policy states that hospitals should make “a conscious selection that the home care the beneficiary is to receive is not related to the hospitalization, and would be expected to have documentation in the beneficiary’s records to that effect” (63 Fed. Reg. 40954, 40979 (July 31, 1998)).

Only 2 of the 60 inpatient claims with a condition code 42 had medical records that included any discussion regarding the relatedness of the home health services. We did not assume services were unrelated based on the lack of a documented rationale. Instead, we relied on the clinical judgment of the independent medical review contractor for each sample item. For the two inpatient claims that had a discussion of relatedness in the medical records, the discussion was inadequate to support that the home health services were not related to the hospital admission. Medical records for one inpatient claim compared only the admitting diagnoses of the inpatient claim and home health claim, and medical records for the other inpatient claim noted merely that the patient was resuming home health services with no changes to the plan of care.

For 18 of the 59 inpatient claims that Medicare improperly paid, the hospitals originally billed the claims correctly. However, the hospitals later rebilled the claims with condition code 42 to receive the full MS-DRG payment.

Improper payments for these sample items in which the hospitals improperly applied condition code 42 totaled \$327,471. Based on our sample results, we estimated that Medicare improperly paid \$40,937,804 during a 2-year period for hospital services that should have been paid a graduated per diem payment.

¹⁴ An inpatient claim from this hospital was one of our sample items. The hospital stated that the staff member applied condition code 42 based on training the staff member received at a previous employer. The hospital stated that it would reprocess 274 inpatient claims billed inappropriately with condition code 42.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct its Medicare contractors to recover the portion of the \$722,288 in overpayments identified for the sample items in this audit that are within the 4-year reopening period;
- direct its Medicare contractors to reprocess the remaining inpatient claims identified in our sample frame with an incorrect patient discharge status code when beneficiaries resumed home health services within 3 days of discharge and recover the portion of the estimated \$218,538,919¹⁵ in overpayments that are within the 4-year reopening period along with similarly coded inpatient claims after our audit period;^{16, 17}
- direct its Medicare contractors to reprocess the remaining inpatient claims identified in our sample frame with a condition code 43 and recover the portion of the estimated \$7,207,061¹⁸ in overpayments that are within the 4-year reopening period along with similarly coded inpatient claims after our audit period;^{19, 20}

¹⁵ The estimated overpayments on claims where the hospital applied an incorrect patient discharge status code when beneficiaries resumed home health services within 3 days of discharge less the overpayments that we identified in our sample: (\$218,844,613 - \$305,694) = \$218,538,919. See Appendix D.

¹⁶ For example, using the same methodology that we used for FYs 2016 and 2017, we identified 34,921 inpatient claims for which Medicare paid the full MS-DRG payment in FY 2018 when hospitals did not code the inpatient claim as a discharge to home with home health services when the beneficiary resumed home health services within 3 days of discharge. Although we did not obtain and review medical records to determine relatedness for these inpatient claims, assuming the same error rate and same average overpayments as our results for FYs 2016 and 2017 for each risk category, we calculated overpayments of \$103,611,393 for FY 2018.

¹⁷ After reprocessing, hospitals can rebill the inpatient claims with a condition code 42 if they consider the home health services unrelated to the hospital admission, which is the same process hospitals should follow when the claims are properly denied or adjusted by the CWF edits.

¹⁸ The estimated overpayments on claims with a condition code 43 minus the overpayments in this area that we identified in our sample: (\$7,296,184 - \$89,123) = \$7,207,061. See Appendix D.

¹⁹ For example, using the same methodology that we used for FYs 2016 and 2017, we identified 1,369 inpatient claims for which Medicare paid the full MS-DRG payment in FY 2018 when hospitals applied condition code 43 when the beneficiaries received home health services within 3 days of discharge. Although we did not obtain and review medical records to determine relatedness for these inpatient claims, assuming the same error rate and same average overpayments as our results for FYs 2016 and 2017 for each risk category, we calculated overpayments \$4,066,969 for FY 2018.

²⁰ After reprocessing, hospitals can rebill the inpatient claims with a condition code 42 if they consider the home health services unrelated to the hospital admission, which is the same process hospitals should follow when the claims are properly denied or adjusted by the CWF edits.

- direct its Medicare contractors to analyze the remaining inpatient claims in our sample frame with a condition code 42, determine which claims were overpaid, and recover the portion of the estimated \$40,610,333²¹ in potential overpayments that are within the 4-year reopening period along with similarly coded inpatient claims paid after our audit period;²²
- correct its CWF edits to ensure that the edits use the home health services on each line within a home health claim rather than only the first line, which will allow the edits to capture home health claims that overlap a hospital stay;
- create CWF edits to prevent the use of condition code 43 from allowing the hospital to receive the full MS-DRG payment when the beneficiary receives home health services within 3 days of discharge;
- educate providers regarding the proper use of patient discharge status codes, condition code 43, and condition code 42, particularly when beneficiaries resume home health services;
- use data analytics to identify hospitals that disproportionately use condition code 42 when the diagnosis codes on the inpatient claim and the respective home health claim appear related; and
- 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”²³ (which would have saved an estimated \$46.6 million during our 2-year audit period).

²¹ The estimated overpayments on claims with a condition code 42 minus the overpayments in this area that we identified in our sample: (\$40,937,804 - \$327,471) = \$40,610,333. See Appendix D.

²² For example, using the same methodology that we used for FYs 2016 and 2017, we identified 8,571 inpatient claims for which Medicare paid the full MS-DRG payment in FY 2018 when hospitals applied condition code 42, indicating that the home health services did not relate to the inpatient admission, when the beneficiaries received home health services within 3 days of discharge. Although we did not obtain and review medical records to determine relatedness for these inpatient claims, assuming the same error rate and same average overpayments as our results for FYs 2016 and 2017 for this risk category, we calculated potential overpayments of \$26,994,762 for FY 2018.

²³ This recommendation is supported by the medical reviewer’s determinations that 148 of our 150 sample items had home health services within 3 days of discharge that related to the hospital admission.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with all but one of our recommendations and described actions that it had taken or planned to take to address those recommendations. CMS's comments are included in their entirety as Appendix E.

To address our recommendations, CMS stated that it:

- will instruct its Medicare contractors to recover the identified overpayments in our sample consistent with relevant law and the agency's policies and procedures;
- will instruct its Medicare contractors to reprocess the remaining inpatient claims in our sample frame with an incorrect patient discharge status code or condition code 43, along with similarly coded inpatient claims after the audit period, and recover any identified overpayments consistent with relevant law and the agency's policies and procedures;
- will instruct its Medicare contractors to review a sample of the remaining inpatient claims in the sample frame with a condition code 42 to determine whether they were billed correctly and based on the findings of the sample review, determine the appropriate course of action, including recovering, as appropriate, any identified overpayments with the reviews consistent with agency policy and procedures;
- modified its CWF edits, effective April 2020, to use the home health services on each line with a home health claim rather than only the first line to allow the edits to capture home health claims that overlap a hospital stay;
- created a CWF edit, effective April 2020, to prevent the use of condition code 43 from allowing the hospital to receive the full MS-DRG payment when a beneficiary received home health services within 3 days of discharge;
- will continue to educate providers on the proper use of patient discharge status and condition codes; and
- will explore opportunities to use data analytics to identify hospitals that disproportionately use condition code 42.

Regarding our recommendation to reduce the need for clinical judgment and deem any home health service within 3 days of discharge to be "related," CMS stated that Section 1886(d)(5)(J)(ii)(III) of the Act requires complex clinical judgment to determine whether home health care services "relate" to the condition or diagnosis for which an individual received inpatient hospital services, and the word "relate" is used throughout the Act for such instances in which a determination cannot be presumed.

We appreciate the actions that CMS said it has taken and plans to take in response to our recommendations. However, 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 reasons for this limited exception to the post-acute-care transfer payment reductions may be outweighed by the opportunity for hospitals to use condition code 42 inappropriately and the administrative burden to monitor and manage its use. Additionally, disagreements in clinical judgement may burden an already backlogged appeals system.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$948,257,796 in Medicare Part A payments for 89,213 inpatient claims submitted by 2,511 short-term acute-care hospitals in which beneficiaries were transferred to post-acute-care with dates of service from October 1, 2015, through September 30, 2017. We included only inpatient claims in which (1) the graduated per diem payment would be lower than the full MS-DRG payment based on the MS-DRG and length of stay of the inpatient claim and (2) the beneficiary had a home health claim with a date of service within 3 days of discharge. The inpatient claims consisted of the following three sets:

1. 73,759 inpatient claims in which the beneficiaries resumed home health services, but the hospital did not code the inpatient claim as a discharge to home with home health services or any other patient discharge status code that results in a graduated per diem payment;
2. 2,456 inpatient claims in which the hospital transferred the beneficiary to home health services and applied condition code 43 on the inpatient claim; and
3. 12,998 inpatient claims in which the hospital transferred the beneficiary to home health services and applied condition code 42 on the inpatient claim.

We sampled 150 inpatient claims from the 89,213 inpatient claims (60 from the first set, 30 from the second and 60 from the third). For these sampled inpatient claims, we collected medical records from the hospitals and home health agencies, and an independent medical review contractor assessed whether the home health services were related to the hospital admission. Additionally, we discussed coding and billing practices with some of the hospitals in our sample. We also discussed the results of the audit with CMS along with its relevant provider education, oversight, and CWF edits.

We did not review the overall internal control structure of CMS because our objective did not require us to do so. Rather, we limited our review of CMS's internal controls to those applicable to the post-acute-care transfer policy.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance;

- used CMS’s National Claims History file and data analysis techniques to identify 89,213 potentially overpaid inpatient claims during our audit period for beneficiaries who received home health services within 3 days of discharge;²⁴
- requested medical records from hospitals and the home health agencies for the applicable time periods;
- discussed coding and billing practices with some of the hospitals in our sample;
- used an independent medical review contractor to determine whether a statistical sample of 150 home health services were related to the hospital admission;
- used CMS’s PC Pricer to reprice each improperly paid inpatient claim to determine the transfer payment amount, compared the repriced payment with the actual payment, and determined the value of the overpayment;
- interviewed CMS officials and reviewed documentation provided by them to understand how the CWF edits work and to determine why Medicare made payments for the miscoded inpatient claims; and
- discussed the results of our audit with CMS 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.

²⁴ See Appendix C for a more detailed description of how we identified these 89,213 claims.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Medicare Improperly Paid Acute-Care Hospitals \$54.4 Million for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy</i>	A-09-19-03007	11/01/2019
<i>Medicare Inappropriately Paid Hospitals' Inpatient Claims Subject to the Postacute Care Transfer Policy</i>	A-09-13-02036	5/28/2014
<i>Noridian Healthcare Solutions, LLC, Inappropriately Paid Hospitals' Medicare Claims Subject to the Postacute Care Transfer Policy in Jurisdiction 2</i>	A-09-13-02035	11/26/2013
<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 Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care</i>	A-01-12-00507	5/28/2013
<i>Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2003 Through 2005</i>	A-04-07-03035	2/27/2009
<i>Review of Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2001 and 2002</i>	A-04-04-03000	4/11/2005
<i>Compliance With Medicare's Postacute Care Transfer Policy for Fiscal Year 2000</i>	A-04-02-07005	4/21/2003
<i>Implementation of Medicare's Postacute Care Transfer Policy</i>	A-04-00-01220	10/10/2001

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

From CMS's National Claims History file, we identified inpatient claims with dates of service in FYs 2016 and 2017 in which the beneficiaries received home health services within 3 days of discharge and a lower payment would result if the hospital (1) coded the inpatient claim as a discharge to home with home health services or (2) did not apply condition code 42 or 43.

More specifically, we identified three types of at-risk claims:

1. Inpatient claims in which:
 - a. the beneficiary received home health services within 3 days of discharge as indicated by any of the beneficiary's home health claim line items other than the first line item on a claim;²⁵
 - b. the hospital did not code the inpatient claim with a patient discharge status code that would trigger a payment reduction under the post-acute-care transfer rules;²⁶
 - c. the MS-DRG is subject to the post-acute-care transfer rules; and
 - d. the length of stay is more than 1 day less than the geometric mean length of stay for the applicable MS-DRG.

We refer to these types of inpatient claims as Resuming Home Health claims.

2. Inpatient claims in which:
 - a. the beneficiary received home health services within 3 days of discharge as indicated by the beneficiary's home health claim line items,
 - b. the hospital coded the inpatient claim with a patient discharge status code to home with home health services and applied condition code 43,

²⁵ The first line item of these home health claims has a date of service before the inpatient stay and at least one additional line item with a date of service within 3 days of the discharge. In other words, the beneficiaries are resuming home health and the dates of the home health claims overlap the inpatient stay. We did not include inpatient claims in which the beneficiary had a corresponding home health claim in the first line item with a date of service within 3 days of discharge. These inpatient claims should have been detected by the existing CWF edits. We addressed this issue recently in *Medicare Improperly Paid Acute-Care Hospitals \$54.4 Million for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy (A-09-19-03007)*.

²⁶ We included only inpatient claims with patient discharge status codes 01, 04, 07, 21, 43, 50, 51, 61, 64, and 70.

- c. the MS-DRG is subject to the post-acute-care transfer rules, and
- d. the length of stay is more than 1 day less than the geometric mean length of stay for the applicable MS-DRG.

We refer to these types of inpatient claims as Condition Code 43 claims.

3. Inpatient claims in which:

- a. the beneficiary received home health services within 3 days of discharge as indicated by the beneficiary's home health claim line items,
- b. the hospital coded the claim with a patient discharge status code to home with home health services and applied condition code 42,
- c. the MS-DRG is subject to the post-acute-care transfer rules, and
- d. the length of stay is more than 1 day less than the geometric mean length of stay for the applicable MS-DRG.

We refer to these types of inpatient claims as Condition Code 42 claims.

From all claim types, we further removed:

- inpatient claims from providers not subject to the IPPS,
- inpatient claims from Medicare Dependent Hospitals (MDH) and Sole Community Hospitals (SCH),²⁷
- inpatient claims with outlier payments,
- inpatient claims in which Medicare was not the primary payer,
- inpatient claims in which the Medicare payment was less than the base operating MS-DRG payment by at least \$3,000,
- inpatient claims in which the beneficiary was admitted and discharged on the same day and the only home health claim line item within 3 days of discharge was on the day of discharge,

²⁷ MDHs and SCHs are paid based on either the Federal rate or their hospital-specific rate, whichever will result in the greatest payment, so they are not always paid using the graduated per diem Federal rate when a patient is transferred to home with home health services after discharge.

- inpatient claims in which none of the beneficiary’s home health claim line items within 3 days of discharge contained a Healthcare Common Procedure Code, and
- inpatient claims subsequently canceled or correctly adjusted based on claims data in CMS’s Integrated Data Repository.²⁸

This resulted in a sampling frame of 89,213 unique Medicare claims totaling \$948,257,796.

SAMPLE UNIT

The sample unit was a Medicare paid claim.

SAMPLE DESIGN AND SIZE

We used a stratified sample. We grouped the sampling frame into strata based on claim type and the estimated amount of potential overpayments of each claim,²⁹ resulting in five strata:

- Strata 1 and 2 include Resuming Home Health claims separated by the estimated amount of potential overpayments,³⁰
- Stratum 3 includes all Condition Code 43 claims, and
- Strata 4 and 5 include Condition Code 42 claims separated by the estimated amount of potential overpayments.³¹

All inpatient claims were unduplicated, appearing only once in the sampling frame and in only one stratum.³² See Table 1 on the next page.

²⁸ The claims data in CMS’s Integrated Data Repository was more up to date than the data we had from CMS’s National Claims History file.

²⁹ We estimated the potential overpayments of each inpatient claim by taking the difference in the amount paid by Medicare and an estimated payment using the graduated per diem rate. To calculate the estimated graduated per diem payment, we used a formula to calculate the payment had the inpatient claim been applied with the patient discharge status code to home with home health services and without a condition code 42 or 43.

³⁰ Inpatient claims with estimated potential overpayments less than \$4,503.55 are in stratum 1 and inpatient claims with estimated potential overpayments of \$4,503.55 or greater are in stratum 2.

³¹ Inpatient claims with estimated potential overpayments of less than \$4,853.28 are in stratum 4, and inpatient claims with estimated potential overpayments of \$4,853.28 or greater are in stratum 5.

³² We assigned inpatient claims with both a condition code 42 and a condition code 43 into Stratum 4 or Stratum 5, so there are no duplicates within any strata.

Table 1: Sample Size and Frame Description

Stratum	Medicare Type of Claim	Sample Size	Number of Claims in Frame	Amount of Payments in Frame
1	Resuming Home Health—Low Overpayment Estimates	30	61,432	\$512,825,156
2	Resuming Home Health—High Overpayment Estimates	30	12,327	241,182,093
3	Condition Code 43	30	2,456	36,931,615
4	Condition Code 42—Low Overpayment Estimates	30	10,955	104,547,145
5	Condition Code 42—High Overpayment Estimates	30	2,043	52,771,787
	Totals	150	89,213	\$948,257,796

SOURCE OF RANDOM NUMBERS

We generated random numbers by using the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the inpatient claims within each stratum. After generating the random numbers, we selected the corresponding inpatient claims in each of these strata.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the improper Medicare payments in our sampling frame. In addition, we used this same program to estimate Medicare savings if CMS deemed any home health service within 3 days of discharge as “related” and to separately estimate the total improper payments for:

- claims in which the beneficiaries resumed home health services,
- claims in which the hospitals applied condition code 43, and
- claims in which the hospitals applied condition 42.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results by Stratum

Stratum	Area	Frame Size (Claims)	Sample Size	Total Value of Sample	Number of Incorrectly Billed Claims in Sample	Value of Overpayments in Sample
1	Resuming Home Health	61,432	30	\$250,844	29	\$56,960
2	Resuming Home Health	12,327	30	602,727	29	248,734
3	Condition Code 43	2,456	30	445,325	30	89,123
4	Condition Code 42	10,955	30	329,276	30	62,737
5	Condition Code 42	2,043	30	776,074	29	264,734
Total		89,213	150	\$2,404,246	147	\$722,288

ESTIMATES

Table 3: Estimates of Overpayments and Savings for the Audit Period
Limits Calculated at the 90-Percent Confidence Interval

Description	Value of Overpayments or Savings in Sample	Lower Limit	Point Estimate	Upper Limit
Total overpayments*	\$722,288	\$235,867,705	\$267,078,601	\$298,289,498
Overpayments for claims in which the beneficiaries resumed home health services	305,694	188,088,756	218,844,613	249,600,470
Overpayments for claims in which the hospitals applied condition code 43	89,123	5,925,317	7,296,184	8,667,051
Overpayments for claims in which the hospitals applied condition code 42	327,471	35,807,696	40,937,804	46,067,913
Savings if CMS deemed any home health service within 3 days of discharge as “related”†	\$334,411	\$38,111,860	\$46,564,475	\$55,017,090
<p>* The upper and lower limits of the sub-estimates do not sum to the upper and lower limits of the overall estimate because the overall estimate is more precise than the sub-estimates.</p> <p>† These estimates are based on the differences in payments between the full MS-DRG payment and the per diem payment for the 59 claims paid the full MS-DRG payment in the Condition Code 42 strata (\$327,471) and the 2 claims in the Resuming Home Health strata without overpayments because we determined that condition code 42 could have been applied. The differences in payment were \$1,696 for the claim in stratum 1 and \$5,244 for the claim in stratum 2.</p>				



APPENDIX E: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES


Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: June 9, 2020

TO: Christi Grimm
Principal Deputy Inspector General
Office of Inspector General

FROM: Seema Verma
Administrator
Centers for Medicare & Medicaid Services 

SUBJECT: Office of Inspector General (OIG) Draft Report: 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 (A-04-18-04067)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

As OIG notes, in certain situations, Medicare makes lower payments to an acute-care hospital that transfers a beneficiary to a post-acute-care facility, such as a skilled nursing facility or to a home with home health services, than if the hospital were to discharge an inpatient to certain types of healthcare institutions such as facilities that provide custodial care or to a home without home health services. Whether Medicare pays for a transfer or a discharge depends on which patient discharge status code the hospital assigns and whether the hospital applies certain condition codes that allow payment exceptions.

CMS recognizes the importance of providing Medicare beneficiaries with access to medically necessary and appropriate services and, at the same time, protecting the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and prepayment and postpayment medical reviews. As part of this strategy, CMS recovers identified overpayments in accordance with relevant law and agency policies and procedures. It is important to note, however, that the estimated overpayments described in the OIG's report represent approximately 0.1 percent of the overall payments made for inpatient services during the audit timeframe.

Regardless, to address the issues the OIG identified in their report, in April 2020, CMS modified the claims processing edits to capture home health claims that overlap a hospital stay, and to prevent the use of condition code 43 from allowing the hospital to receive the full Medicare Severity Diagnosis-Related Group payment when the beneficiary received home health services within 3 days of discharge.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing under the Inpatient Prospective Payment System. CMS educates health care providers on appropriate Medicare billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance

newsletters. For example, CMS published an informational booklet in February 2019 regarding the acute care hospital inpatient prospective payment system, which included information on the transfer policy and related payment adjustments.¹

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct its Medicare contractors to recover the portion of the \$722,288 in overpayments identified for the sample items in this audit that are within the 4-year reopening period.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare contractors to recover the identified overpayments consistent with relevant law and the agency's policies and procedures.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct its Medicare contractors to reprocess the remaining inpatient claims identified in our sample frame with an incorrect patient discharge status code when beneficiaries resumed home health services within 3 days of discharge and recover the portion of the estimated \$218,538,919 in overpayments that are within the 4-year reopening period along with similarly coded inpatient claims after our audit period.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare contractors to reprocess the remaining inpatient claims with an incorrect patient discharge status code when beneficiaries resumed home health services within 3 days of discharge, along with similarly coded inpatient claims after the audit period, and recover any identified overpayments consistent with relevant law and the agency's policies and procedures.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct its Medicare contractors to reprocess the remaining inpatient claims identified in our sample frame with a condition code 43 and recover the portion of the estimated \$7,207,061 in overpayments that are within the 4-year reopening period along with similarly coded inpatient claims paid after our audit period.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare contractors to reprocess the remaining inpatient claims with a condition code 43, along with similarly coded inpatient claims after the audit period, and recover any identified overpayments consistent with relevant law and the agency's policies and procedures.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct its Medicare contractors to analyze the remaining inpatient claims in our sample frame with a condition code 42, determine which claims were overpaid, and recover the portion of the estimated \$40,610,333

¹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsh.pdf>
Audit of Post-Acute-Care Transfers to Home Health Services (A-04-18-04067)

in potential overpayments that are within the 4-year reopening period along with similarly coded inpatient claims paid after our audit period.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare contractors to review a sample of the remaining inpatient claims in the sample frame with a condition code 42 to determine whether they were billed correctly. Based on the findings of the sample review, CMS will determine the appropriate course of action. CMS will recover, as appropriate, any identified overpayments associated with the reviews consistent with agency policy and procedures.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services correct its CWF edits to ensure that the edits use the home health services on each line within a home health claim rather than only the first line, which will allow the edits to capture home health claims that overlap a hospital stay.

CMS Response

CMS concurs with this recommendation. Effective, April 2020, CMS modified its common working file edits to use the home health services on each line within a home health claim rather than only the first line to allow the edits to capture home health claims that overlap a hospital stay.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services create CWF edits to prevent the use of condition code 43 from allowing the hospital to receive the full MS-DRG payment when the beneficiary received home health services within 3 days of discharge.

CMS Response

CMS concurs with this recommendation. As stated above, effective April 2020, CMS created a common working file edit to prevent the use of condition code 43 from allowing the hospital to receive the full Medicare Severity Diagnosis-Related Group payment when the beneficiary received home health services within 3 days of discharge.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services educate providers regarding the proper use of patient discharge status codes, condition code 43, and condition code 42, particularly when beneficiaries resume home health services.

CMS Response

CMS concurs with this recommendation. CMS will continue to educate providers on proper billing under the inpatient prospective payment system including the proper use of patient discharge status and condition codes.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services use data analytics to identify hospitals that disproportionately use condition code 42 when the diagnosis codes on the inpatient claim and the respective home health claim appear related.

CMS Response

CMS concurs with this recommendation. CMS will explore opportunities to use data analytics to identify hospitals that disproportionately use condition code 42.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services reduce the need for clinical judgement 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” (which would have saved an estimated \$46.6 million during our two-year audit period).

CMS Response

CMS does not concur with this recommendation. Section 1886(d)(5)(J)(ii)(III) of the Social Security Act requires complex clinical judgment to determine whether home health care services “relate” to the condition or diagnosis for which an individual received inpatient hospital services and the word “relate” is used throughout the Social Security Act for such instances in which a determination cannot be presumed. However, CMS will take action, as described in the above recommendations to address OIG’s findings.