

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE IMPROPERLY PAID  
ACUTE-CARE HOSPITALS \$54.4 MILLION  
FOR INPATIENT CLAIMS SUBJECT TO THE  
POST-ACUTE-CARE TRANSFER POLICY**

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# *Office of Inspector General*

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## Report in Brief

Date: November 2019

Report No. A-09-19-03007

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



### Why OIG Did This Review

Prior OIG reviews identified almost \$242 million in overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (transfer policy). These hospitals transferred patients to certain post-acute-care settings, such as skilled nursing facilities (SNFs), but claimed the higher reimbursements associated with discharges to home. Because compliance with the transfer policy has been an issue over a long period, we conducted this followup review to evaluate whether Medicare properly paid acute-care hospitals' claims subject to that policy for those claims with dates of service from January 1, 2016, through December 31, 2018 (audit period).

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

### How OIG Did This Review

Our review covered \$212 million in Medicare Part A payments for 18,647 inpatient claims subject to the transfer policy. We first identified specific inpatient claims for our audit period that had a patient discharge status code indicating a discharge to home or certain types of healthcare institutions. We used the beneficiary information and service dates from those claims to identify services from post-acute-care providers that began (1) on the same date as the inpatient discharge (e.g., SNF claims) or (2) within 3 days of the inpatient discharge (i.e., home health claims).

## Medicare Improperly Paid Acute-Care Hospitals \$54.4 Million for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy

### What OIG Found

Medicare improperly paid acute-care hospitals \$54.4 million for 18,647 claims subject to the transfer policy. These hospitals improperly billed the claims by using the incorrect patient discharge status codes. Specifically, they coded these claims as discharges to home (16,599 claims) or to certain types of healthcare institutions (2,048 claims), such as facilities that provide custodial care, rather than as transfers to post-acute care. Of these claims, 83 percent were followed by claims for home health services, and 17 percent were followed by claims for services in other post-acute-care settings.

Medicare makes the full Medicare Severity Diagnosis-Related Group (MS-DRG) payment to an acute-care hospital that discharges an inpatient to home or certain types of healthcare institutions. 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 overpayment of \$54.4 million represented the difference between the amount of the full MS-DRG payments and the amount that would have been paid if the per diem rates had been applied.

The Centers for Medicare & Medicaid Services (CMS) officials stated that the edits appropriately detected inpatient claims subject to the transfer policy. However, some Medicare contractors reported that they did not receive the automatic notifications of improperly billed claims or did not take action on those claims to adjust them. If all of the contractors had received the notifications and properly taken action since calendar year 2013, Medicare could have saved \$70 million.

### What OIG Recommends and CMS Comments

We recommend that CMS direct the Medicare contractors to (1) recover the \$54.4 million in identified overpayments, (2) identify any claims for transfers to post-acute care in which incorrect patient discharge status codes were used and direct the Medicare contractors to recover any overpayments after our audit period, and (3) ensure that the Medicare contractors are receiving the postpayment edit's automatic notifications of improperly billed claims and are taking action by adjusting the original inpatient claims to initiate recovery of the overpayments.

CMS concurred with all of our recommendations and provided information on actions that it planned to take to address our recommendations.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

Prior Office of Inspector General (OIG) reviews identified almost \$242 million in overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy. (Appendix B lists related OIG reports.) These hospitals transferred patients to certain post-acute-care settings, such as skilled nursing facilities (SNFs), but claimed the higher reimbursements associated with discharges to home.

In our most recent review, covering January 2009 through September 2012, we recommended that the Centers for Medicare & Medicaid Services (CMS) correct the claim processing system edits, ensure that the edits were working properly, and recover the identified overpayments to acute-care hospitals. CMS generally concurred with our recommendations and implemented them. Because compliance with the post-acute-care transfer policy has been an issue over a long period, we conducted this followup review to evaluate whether Medicare properly paid acute-care hospitals' claims subject to that policy for those claims with dates of service from January 1, 2016, through December 31, 2018 (audit period).

### OBJECTIVE

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

### BACKGROUND

#### The Medicare Program

The Medicare program provides health insurance for people age 65 or older, 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 claims submitted for hospital services. For our audit period, seven Medicare contractors processed and paid Part A claims.

#### 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, CMS pays acute-care 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 acute-care hospital for all inpatient costs associated with the beneficiary's stay.

### **Post-Acute-Care Transfer Policy and Types of Providers**

An acute-care hospital transfers a beneficiary to a post-acute-care setting, such as a SNF, when the beneficiary's acute condition is stabilized 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 §§ 412.4(c), (d), and (f). The intent of this policy is to avoid providing an incentive for a hospital to transfer a beneficiary to a post-acute-care setting early (before treatment of the beneficiary's acute condition is stabilized) to minimize its costs while still receiving the full MS-DRG payment. CMS adjusts the payment to the hospital to approximate the reduced cost for a beneficiary who was transferred to a post-acute-care setting. (See the box to the right for descriptions of the post-acute-care providers covered by our review.)

Under the post-acute-care transfer policy, a transfer occurs when a beneficiary whose hospital stay was classified within specified MS-DRGs is discharged from an acute-care hospital in one of the situations described on the following page:

## **Post-Acute-Care Providers**

### **Home Health Agency**

A home health agency (HHA) is an agency or organization primarily engaged in providing skilled nursing services and other therapeutic services. To qualify for Medicare coverage of home health services, a beneficiary must be confined to the home.

### **Skilled Nursing Facility**

A SNF is an institution primarily engaged in providing skilled nursing care and related services and rehabilitation services to residents.

### **Long-Term-Care Hospital**

A long-term-care hospital (LTCH) is primarily engaged in providing inpatient services to beneficiaries with medically complex conditions and has an average inpatient length of stay that is longer than 25 days.

### **Inpatient Rehabilitation Facility**

An inpatient rehabilitation facility (IRF) provides intensive rehabilitation services to patients who can tolerate 3 hours of such services per day.

### **Inpatient Psychiatric Facility**

An inpatient psychiatric facility (IPF) is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons.

### **Cancer Hospital**

A cancer hospital is, as a general rule, organized primarily for treatment of and research on cancer.

- The beneficiary receives home health services from an HHA, 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 beneficiary was discharged from the hospital.
- The beneficiary is admitted on the same day to a SNF.
- The beneficiary is admitted on the same day to a hospital or distinct-part hospital unit that is not reimbursed under the IPPS. These non-IPPS providers include LTCHs, IRFs, IPFs, cancer hospitals, and children’s hospitals.<sup>1</sup>
- The beneficiary is admitted on the same day to a hospice.<sup>2</sup>

### **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 healthcare 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 per diem payment depending on the beneficiary’s length of stay in the hospital. Whether Medicare pays for a discharge or a transfer depends on the patient discharge status code assigned by the hospital (42 CFR § 412.4(f)).

CMS requires acute-care hospitals to include a patient discharge status code 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 discharge status code used depends on the type of post-acute-care setting. For example, when a beneficiary is transferred to a SNF, discharge status code 03 should be used.

If an acute-care hospital submits a bill based on its belief that it is discharging a beneficiary to home or another setting that is 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.

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<sup>1</sup> Our review included no inpatient claims in which beneficiaries were discharged to children’s hospitals.

<sup>2</sup> The post-acute-care transfer policy applies to hospices only for inpatient discharges on or after October 1, 2018. We did not review inpatient claims in which beneficiaries were admitted to hospices (the Act § 1886(d)(5)(J); 42 CFR § 412.4(c); and *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 3, § 40.2.4(C)).



## Medicare Claim Processing Systems and Prepayment and Postpayment Edits

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) for verification, validation, and payment authorization.

The CWF contains both prepayment and postpayment system edits that should prevent or detect overpayments for an inpatient claim subject to the post-acute-care transfer policy when there is a subsequent post-acute-care claim. The edits should work as follows:

- **Prepayment Edit.** If the post-acute-care claim is processed and paid before the inpatient claim is processed, once the inpatient claim is processed, the prepayment edit rejects the incoming inpatient claim and returns it to the acute-care hospital.
- **Postpayment Edit.** If the inpatient claim is processed and paid before the post-acute-care claim is processed, once the post-acute-care claim is processed, the postpayment edit is designed to adjust automatically the inpatient claim by canceling the original inpatient claim and recovering the entire payment. However, if the automatic adjustment fails, the edit is designed to provide an automatic notification to the Medicare contractor to adjust the original inpatient claim.

In those cases in which 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.

### Prior Office of Inspector General Reviews

Prior OIG reviews identified almost \$242 million in overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy. For example, for claims with dates of service from October 1999 through September 2000, we estimated that Medicare overpaid hospitals approximately \$61 million. For claims with dates of service from October 2002 through September 2005, we estimated that Medicare overpaid hospitals \$24.8 million. For claims with dates of service from January 2009 through September 2012, Medicare overpaid hospitals \$19.5 million.<sup>3</sup>

As a result of these reviews, CMS established edits to prevent or detect the overpayments. In our most recent review, covering January 2009 through September 2012, we determined that

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<sup>3</sup> These reports were titled *Compliance With Medicare's Postacute Care Transfer Policy for Fiscal Year 2000* (A-04-02-07005), issued in April 2003; *Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2003 Through 2005* (A-04-07-03035), issued in February 2009; and *Medicare Inappropriately Paid Hospitals' Inpatient Claims Subject to the Postacute Care Transfer Policy* (A-09-13-02036), issued in May 2014. For the last report, the review was based on an analysis of all claim data rather than on a statistical sample of claims. For a complete list of related OIG reports, see Appendix B.

the edits were not working properly. Specifically, the Medicare contractors did not always receive the automatic notifications of improperly billed claims, the edits incorrectly calculated the number of days between the dates of service on an inpatient claim and a home health claim, and the edits could not properly match inpatient claims with all home health claims because the range of provider numbers that identified home health agencies was not complete. We recommended that CMS correct the edits and ensure that they were working properly. CMS generally concurred with our recommendations and implemented them.

## **HOW WE CONDUCTED THIS REVIEW**

Our review covered \$212 million in Medicare Part A payments for 18,647 inpatient claims with specified MS-DRGs in which beneficiaries were transferred to post-acute care and that had dates of service during our audit period. To identify these claims, we first identified inpatient claims with specified MS-DRGs subject to the post-acute-care transfer policy during our audit period that had a patient discharge status code indicating a discharge to home (code 01) or discharges to certain types of healthcare institutions that are not subject to the post-acute-care transfer policy, such as facilities that provide custodial care (code 04). Then we used the beneficiary information and service dates from those claims to identify services from post-acute-care providers that began (1) on the same date as the inpatient discharge (e.g., SNF claims and non-IPPS claims, such as those from LTCHs and IRFs) or (2) within 3 days of the inpatient discharge (i.e., HHA claims).

We excluded inpatient claims (1) with discharge status codes indicating discharges to home with home health services and discharges to SNFs and non-IPPS facilities because these claims are paid at the per diem rates, (2) in which beneficiaries were discharged to home to resume home health services,<sup>4</sup> (3) billed by acute-care hospitals in Maryland and by cancer hospitals because these hospitals are not paid under the IPPS, (4) in which beneficiaries began hospice care after being discharged from the acute-care hospitals, and (5) in which beneficiaries left the hospital against medical advice but began receiving post-acute-care services after leaving.

In addition, we identified inpatient claims for the 3 years before our audit period (calendar years (CYs) 2013 through 2015) to determine whether the prepayment and postpayment edits were working properly to detect and prevent overpayments during that period. We focused on the improper Medicare Part A payments. We did not use medical review to determine whether (1) the inpatient services billed on Part A claims were medically necessary or (2) the home health services were related to the inpatient condition or diagnosis.

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

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<sup>4</sup> 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 services within 3 days.

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.

## FINDING

For our audit period, Medicare improperly paid \$54.4 million<sup>5</sup> to acute-care hospitals for inpatient claims subject to the post-acute-care transfer policy. Specifically, none of the 18,647 claims should have been reimbursed the full MS-DRG payment; rather, these claims should have been reimbursed the per diem payment. Of these claims, 83 percent were followed by claims for home health services, and 17 percent were followed by claims for services in other post-acute-care settings, such as SNFs.

CMS officials stated that the edits appropriately detected inpatient claims subject to the transfer policy. One Medicare contractor received automatic notifications of improperly billed inpatient claims and took action on most of those claims by adjusting them. However, four Medicare contractors reported that they did not receive the postpayment edit's automatic notifications to take action on improperly billed claims, and two Medicare contractors received the automatic notifications but did not take any action or did not begin to take action until April 2017. If the Medicare contractors had received the automatic notifications since CY 2013 and had taken action, Medicare could have saved \$70 million.<sup>6</sup>

## FEDERAL REQUIREMENTS

For a beneficiary whose hospital stay is classified within one of the specified MS-DRGs, a discharge from an IPPS hospital to a qualifying post-acute-care setting is considered a transfer (42 CFR § 412.4(c)). The qualifying settings are (1) hospitals or distinct-part hospital units that are not reimbursed under the IPPS,<sup>7</sup> (2) SNFs, (3) home for the provision of home health services from an HHA if those services are provided within 3 days of the discharge,<sup>8</sup> and (4) for discharges occurring on or after October 1, 2018, hospice care provided by a hospice program.

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<sup>5</sup> The total improper payment amount was \$54,372,337.

<sup>6</sup> The total savings amount was \$70,011,503.

<sup>7</sup> In this report, hospitals and distinct-part hospital units that "are not reimbursed under the IPPS" are those hospitals and units described in the Act as "not a subsection (d) hospital" (the Act § 1886(d)(5)(J)(ii)(I)). The Act defines the term "subsection (d) hospital" as a hospital located in one of the 50 States or the District of Columbia, but it excludes from that definition psychiatric hospitals and distinct-part units, rehabilitation hospitals and distinct-part units, children's hospitals, LTCHs, and cancer hospitals (the Act § 1886(d)(1)(B)).

<sup>8</sup> If the home health services are not related to the hospital care, the hospital can use condition code 42 on the inpatient claim (Medicare Learning Network's MLN Matters Number: SE1411 Revised).

CMS requires acute-care hospitals to include patient discharge status codes on all inpatient claims.<sup>9</sup> When a beneficiary is transferred to a setting subject to the post-acute-care transfer policy, a specific discharge status code should be used, depending on the type of post-acute-care setting. For example, code 03 should be used when the beneficiary is transferred to a SNF, and code 06 should be used when a beneficiary is transferred to home to receive home health services.<sup>10</sup>

The *Federal Register* emphasizes that a hospital is responsible for coding a bill on the basis of its discharge plan for a beneficiary. If the hospital subsequently determines that post-acute care was provided, it is responsible for either coding the original bill as a transfer or submitting an adjusted claim.<sup>11</sup>

### **MEDICARE IMPROPERLY PAID ACUTE-CARE HOSPITALS FOR INPATIENT CLAIMS SUBJECT TO THE POST-ACUTE-CARE TRANSFER POLICY**

Medicare improperly paid acute-care hospitals for 18,647 inpatient claims subject to the post-acute-care transfer policy. These hospitals improperly billed the claims by using the incorrect patient discharge status codes. Specifically, they coded these claims as discharges to home (16,599 claims) or to certain types of healthcare institutions (2,048 claims), such as facilities that provide custodial care, rather than as transfers to post-acute care. As a result, Medicare overpaid the acute-care hospitals by \$54.4 million. The total overpayment amount represented the difference between the amount of the full MS-DRG payments that were made and the amount that would have been paid if the per diem rates had been applied.

Figure 1 on the following page shows an example of an improper payment to an acute-care hospital for a beneficiary who was discharged to home and obtained post-acute-care services from an HHA.

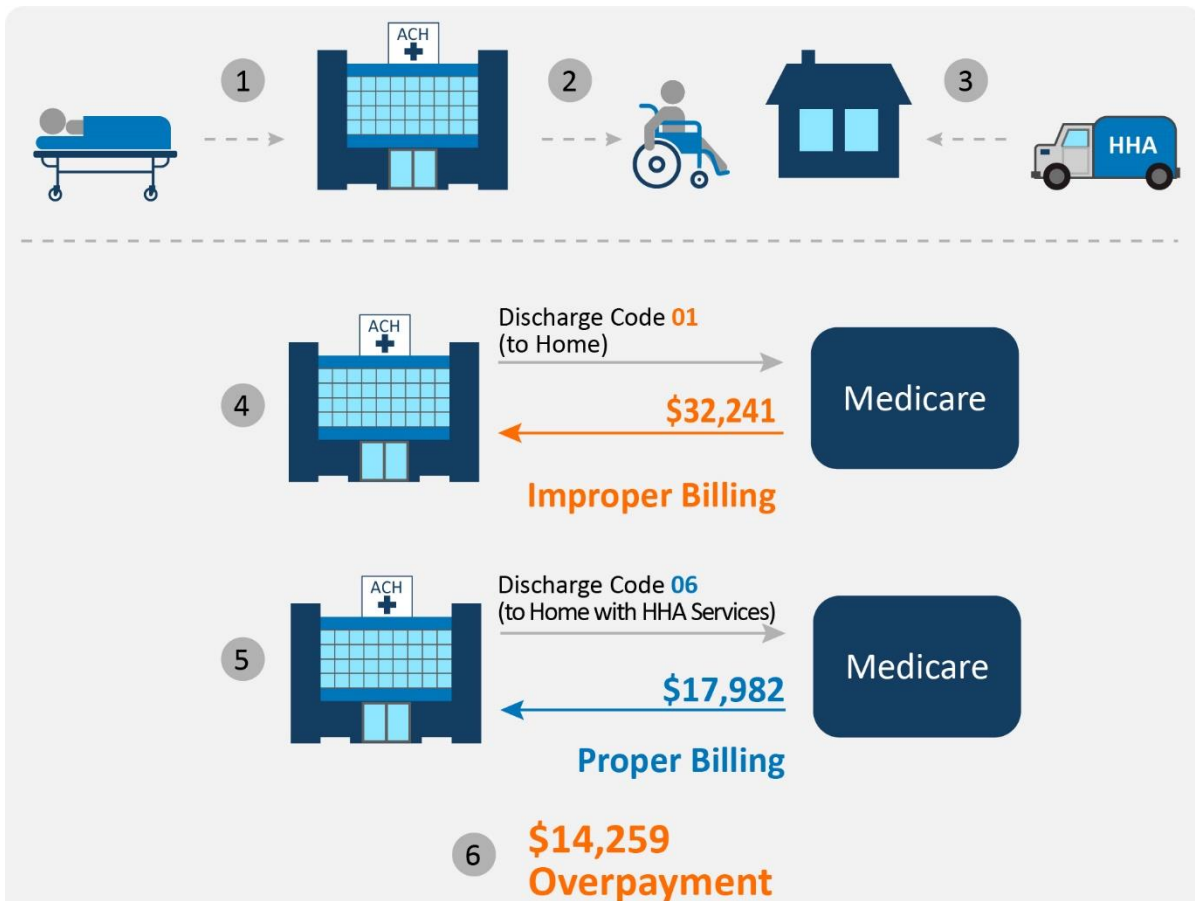
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<sup>9</sup> *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 25, § 75.2.

<sup>10</sup> *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 3, § 40.2.4.

<sup>11</sup> 63 Fed. Reg. 40954, 40980 (July 31, 1998) and 65 Fed. Reg. 47054, 47081 (Aug. 1, 2000). See also MLN Matters Number: SE0408.

**Figure 1: Example of an Improper Payment to an Acute-Care Hospital for a Claim Subject to the Post-Acute-Care Transfer Policy**

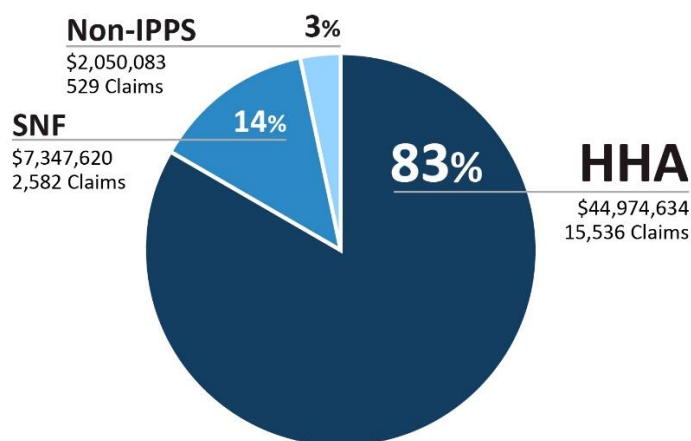


ACH = Acute-Care Hospital

- 1 A beneficiary was admitted to an ACH for inpatient services because of complications from heart disease. While at the ACH, the beneficiary underwent a coronary bypass procedure.
- 2 After recovering in the ACH for about 4 days, the beneficiary was discharged home.
- 3 Within 2 days after the discharge, the HHA began providing home health services to the beneficiary.
- 4 The ACH improperly billed Medicare for the Medicare Part A inpatient services with the patient discharge status code indicating a discharge to home (i.e., code 01). In return, the ACH received a payment of \$32,241, the full MS-DRG payment, for the inpatient services.
- 5 If the ACH had properly billed Medicare for the Part A inpatient services with a discharge status code indicating a discharge to home with home health services (i.e., code 06), the ACH would have received a payment of only \$17,982 for the inpatient services. (This payment represents the amount that would have been paid by applying the per diem rate for the inpatient stay in the ACH.)
- 6 As a result, Medicare overpaid the ACH \$14,259 (\$32,241 – \$17,982).

Figure 2 shows the percentage of total inpatient claims and related overpayments we reviewed that were subject to the post-acute-care transfer policy, by the type of post-acute-care setting to which a beneficiary was transferred. For 83 percent of the inpatient claims, the beneficiaries began home health services provided by an HHA within 3 days of the date of discharge from the acute-care hospital, resulting in \$45 million in overpayments. For 14 percent of the inpatient claims, the beneficiaries began services at SNFs, resulting in \$7.3 million in overpayments. For the remaining 3 percent of inpatient claims, the beneficiaries began services in other post-acute-care settings, such as IRFs, resulting in \$2.1 million in overpayments.

**Figure 2: For 83 Percent of the Inpatient Claims, Beneficiaries Began Home Health Services Within 3 Days of Being Discharged From the Acute-Care Hospitals**



**ALTHOUGH CMS STATED THAT EDITS APPROPRIATELY DETECTED CLAIMS SUBJECT TO THE POST-ACUTE-CARE TRANSFER POLICY, NOT ALL CONTRACTORS RECEIVED AUTOMATIC NOTIFICATIONS OF IMPROPERLY BILLED CLAIMS OR TOOK ACTION ON THOSE CLAIMS**

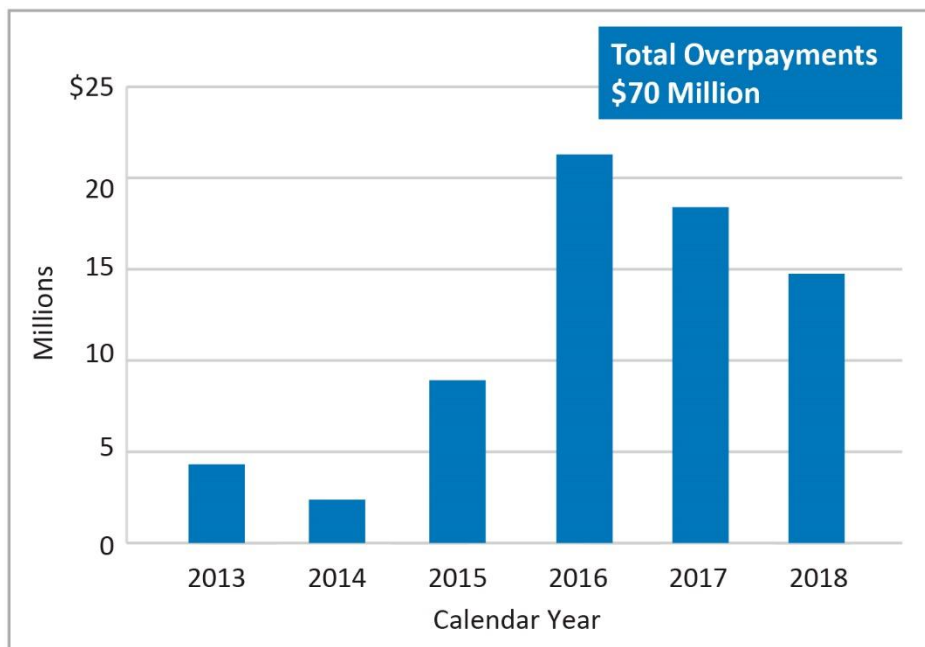
CMS officials stated that the prepayment and postpayment edits for all seven Medicare contractors appropriately detected inpatient claims subject to the transfer policy. One Medicare contractor received automatic notifications of improperly billed inpatient claims and took action on most of those claims by adjusting them. However, four Medicare contractors reported that they did not receive the postpayment edit’s automatic notifications to take action on improperly billed claims.<sup>12</sup> The remaining two Medicare contractors received the automatic notifications, but one contractor did not take action on the improperly billed claims, and one contractor did not begin to take action until April 2017.

<sup>12</sup> These Medicare contractors stated that the edit did not detect the inpatient claims, and subsequently they were not notified to take action. CMS disagreed with the contractors. Although CMS was unable to confirm that these contractors received the notifications for the improperly billed claims (because of the age of the claims), CMS confirmed with each contractor that each one was currently receiving notifications and had a process to address the notifications.

## MEDICARE COULD HAVE SAVED \$70 MILLION OVER 6 YEARS

In addition to identifying inpatient claims for our audit period (CYs 2016 through 2018) subject to the post-acute-care transfer policy, we identified inpatient claims subject to that policy for the previous 3 years, dating back to CY 2013, to determine whether the edits were adequate to prevent overpayments during that period. We identified overpayments in each of the 3 years (CYs 2013, 2014, and 2015). Although there was a decrease in CY 2014, overpayments increased significantly in CYs 2015 and 2016, before decreasing again in CYs 2017 and 2018 (Figure 3).

**Figure 3: Overpayments From CYs 2013 Through 2018 Totaled \$70 Million**



If all of the Medicare contractors had received the postpayment edit's automatic notifications of improperly billed claims and had properly taken action since CY 2013, Medicare could have saved \$70 million over 6 years.

## RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services take the following steps:

- Direct the Medicare contractors to recover the \$54,372,337 in identified overpayments in accordance with CMS's policies and procedures.
- Identify any claims for transfers to post-acute care in which incorrect patient discharge status codes were used, and direct the Medicare contractors to recover any overpayments after our audit period.

- Ensure that the Medicare contractors are receiving the postpayment edit's automatic notifications of improperly billed claims and are taking action by adjusting the original inpatient claims to initiate recovery of the overpayments. If all of the Medicare contractors had received the postpayment edit's automatic notifications of improperly billed claims and had properly taken action since CY 2013, Medicare could have saved \$70,011,503.

### **CMS COMMENTS**

In written comments on our draft report, CMS concurred with all of our recommendations and provided information on actions that it planned to take to address our recommendations. CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix C.



## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our review covered \$211,941,697 in Medicare Part A payments for 18,647 inpatient claims with specified MS-DRGs in which beneficiaries were transferred to post-acute care and that had dates of service from January 1, 2016, through December 31, 2018.

To identify these claims, we first identified inpatient claims with specified MS-DRGs subject to the post-acute-care transfer policy during our audit period that had a patient discharge status code indicating a discharge to home (code 01) or discharges to certain types of healthcare institutions that are not subject to the post-acute-care transfer policy, such as facilities that provide custodial care (code 04). Then we used the beneficiary information and service dates from those claims to identify services from post-acute-care providers that began (1) on the same date as the inpatient discharge (e.g., SNF claims and non-IPPS claims, such as those from LTCHs and IRFs) or (2) within 3 days of the inpatient discharge (i.e., HHA claims).

We excluded inpatient claims (1) with discharge status codes indicating discharges to home with home health services and discharges to SNFs and non-IPPS facilities because these claims are paid at the per diem rates, (2) in which beneficiaries were discharged to home to resume home health services, (3) billed by acute-care hospitals in Maryland and by cancer hospitals because these hospitals are not paid under the IPPS, (4) in which beneficiaries began hospice care after being discharged from the acute-care hospitals, and (5) in which beneficiaries left the hospital against medical advice but began receiving post-acute-care services after leaving.

In addition, we identified inpatient claims for the 3 years before our audit period (CYs 2013 through 2015) to determine whether the prepayment and postpayment edits were working properly to detect and prevent overpayments during that period. We focused on the improper Medicare Part A payments. We did not use medical review to determine whether (1) the inpatient services billed on Part A claims were medically necessary or (2) the home health services were related to the inpatient condition or diagnosis.

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.

We conducted our audit from January to June 2019 and performed fieldwork at CMS's offices in Baltimore, Maryland.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- used CMS’s National Claims History (NCH) file to identify inpatient claims with specified MS-DRGs during our audit period for beneficiaries who received certain services from post-acute-care providers after inpatient stays;<sup>13</sup>
- used computer matching, data mining, and data analysis techniques to identify for review 18,647 claims coded as discharges to home or certain types of healthcare institutions that are not subject to the post-acute-care transfer policy, such as facilities that provide custodial care;
- reviewed available data from CMS’s CWF to determine whether the claims had been canceled or adjusted;
- interviewed CMS officials and reviewed documentation provided by them to understand how the CWF prepayment and postpayment edits work and to determine why Medicare made payments for improperly billed claims;
- used CMS’s PC Pricer to reprice each paid claim to determine the transfer payment amount, compared the repriced payment with the actual payment, and determined the value of any overpayment;<sup>14</sup>
- provided to CMS the complete list of improperly paid inpatient claims that we identified for our audit period;
- identified additional inpatient claims from CYs 2013 through 2015 that were subject to the post-acute-care transfer policy; and
- discussed the results of our review 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.

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<sup>13</sup> Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS’s NCH file, but we did not assess the completeness of the file.

<sup>14</sup> 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 exactly match the actual claim payments.

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Medicare Inappropriately Paid Hospitals' Inpatient Claims Subject to the Postacute Care Transfer Policy</i>	<a href="#">A-09-13-02036</a>	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 href="#">A-09-13-02035</a>	11/26/2013
<i>Palmetto GBA, LLC, Inappropriately Paid Hospitals' Medicare Claims Subject to the Postacute Care Transfer Policy in Jurisdiction 1</i>	<a href="#">A-09-12-02038</a>	5/29/2013
<i>Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care</i>	<a href="#">A-01-12-00507</a>	5/28/2013
<i>Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2003 Through 2005</i>	<a href="#">A-04-07-03035</a>	2/27/2009
<i>Review of Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2001 and 2002</i>	<a href="#">A-04-04-03000</a>	4/11/2005
<i>Compliance With Medicare's Postacute Care Transfer Policy for Fiscal Year 2000</i>	<a href="#">A-04-02-07005</a>	4/21/2003
<i>Implementation of Medicare's Postacute Care Transfer Policy</i>	<a href="#">A-04-00-01220</a>	10/10/2001

## APPENDIX C: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

**DATE:** October 10, 2019

**TO:** Joanne Chiedi  
Acting Inspector General  
Office of Inspector General

**FROM:** Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Acute-Care Hospitals \$54.4 Million for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy (A-09-19-03007)

A handwritten signature in blue ink that reads "Seema Verma".

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

CMS recognizes the importance of providing Medicare beneficiaries with access to medically necessary 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 improper payments in accordance with relevant law and agency policies and procedures.

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 information booklet in February 2019 regarding the acute care hospital inpatient prospective payment system, which included information on the transfer policy and related payment adjustments.<sup>1</sup>

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

### **OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services direct the Medicare contractors to recover the \$54,372,337 in identified overpayments in accordance with CMS's policies and procedures.

### **CMS Response**

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

<sup>1</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfetsht.pdf>

**OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services identify any claims for transfers to post-acute care in which incorrect patient discharge status codes were used, and direct the Medicare contractors to recover any overpayments after the audit period.

**CMS Response**

CMS concurs with this recommendation. CMS will direct its Medicare Administrative Contactors to use the available resources to identify any claims for transfers to post-acute care in which incorrect patient discharge status codes were used after the audit period and to recover any associated overpayments consistent with relevant law and the agency's policies and procedures.

**OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services ensure that the Medicare contractors are receiving the postpayment edit's automatic notification of improperly billed claims and are taking action by adjusting the original inpatient claims to initiate recovery of the overpayments.

**CMS Response**

CMS concurs with this recommendation. CMS will work with its Medicare contractors to ensure that the postpayment edit's automatic notification of improperly billed claims are being received and that the necessary action is being taken to initiate recovery of the overpayments. Additionally, CMS will evaluate opportunities to further automate this recovery process.