Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS COULD STRENGTHEN PROGRAM SAFEGUARDS TO PREVENT AND DETECT IMPROPER MEDICARE PAYMENTS FOR SHORT INPATIENT STAYS

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June 2024
A-09-21-03022

Office of Inspector General

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Report in Brief
Date: June 2024
Report No. A-09-21-03022

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

CMS Could Strengthen Program Safeguards To Prevent and Detect Improper Medicare Payments for Short Inpatient Stays

Why OIG Did This Audit

Under CMS's two-midnight rule, implemented in FY 2014, CMS generally considered it inappropriate for hospital stays not expected to span at least two midnights to be billed as inpatient. OIG issued a report about the effect of this rule on short inpatient stays (i.e., stays that lasted less than two midnights) for FY 2014. According to the report, hospitals were still billing for many short inpatient stays that were potentially inappropriate under the two-midnight rule, and Medicare paid almost $2.9 billion for these stays. Given the high payment amount at risk for noncompliance identified in that report, we focused this audit on program safeguards for claims for short inpatient stays for calendar years 2016 through 2020 (audit period).

Our objective was to assess program safeguards for ensuring that Medicare claims for short inpatient stays complied with Medicare requirements.

How OIG Did This Audit

Our audit covered $19.7 billion in Medicare Part A claims with dates of service during our audit period for 2.5 million short inpatient stays at 3,340 acute-care hospitals. We interviewed CMS officials and one Beneficiary and Family Centered Care–Quality Improvement Organization (BFCC-QIO) to obtain an understanding of program safeguards for short inpatient stays and policies and procedures for reviewing claims for short inpatient stays.

What OIG Found

For our audit period, we identified three weaknesses in the established program safeguards for preventing and detecting improper payments for short inpatient stays and recovering overpayments. Specifically, CMS did not have: (1) adequate information to identify short inpatient stays at risk for noncompliance with the two-midnight rule, (2) prepayment edits for claims at risk for noncompliance with the two-midnight rule, and (3) adequate policies and procedures to review claims at risk for noncompliance with the two-midnight rule and to recover overpayments.

These weaknesses occurred because, among other reasons, CMS relied primarily on postpayment reviews conducted by BFCC-QIOs to ensure compliance with the two-midnight rule. Although BFCC-QIOs reviewed thousands of claims for short inpatient stays and denied $49.2 million in improper payments during our audit period, these reviews denied only 0.6 percent of the $7.8 billion in improper payments estimated by CMS's Comprehensive Error Rate Testing reviews. Without strengthening program safeguards, CMS and its contractors may not be able to prevent or detect improper payments for short inpatient stays and recover overpayments for claims that did not comply with Medicare requirements.

What OIG Recommends and CMS Comments

We recommend that CMS work with its contractors to: (1) add information to inpatient claims indicating any stay that did not span two or more midnights because of an unforeseen circumstance, (2) develop a list of inpatient procedure codes associated with the outpatient procedure codes on the inpatient-only procedures list, (3) implement prepayment edits for claims for short inpatient stays at risk for noncompliance with the two-midnight rule, and (4) update policies and procedures for postpayment reviews to focus on claims for short inpatient stays identified as at risk for noncompliance with the two-midnight rule and to focus on overpayment recoveries. The full text of the recommendations is in the report.

In written comments on our draft report, CMS did not state whether it concurred with our recommendations but said that it will take our findings and recommendations into consideration as it determines appropriate next steps. CMS also provided information on actions that it had taken related to our recommendations. After reviewing CMS's comments, we maintain that CMS should implement our recommendations to address the findings in our report.

The full report can be found on the OIG website.

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INTRODUCTION

WHY WE DID THIS AUDIT

Prior Office of Inspector General (OIG) audits identified millions of dollars in Medicare overpayments for inpatient claims with short lengths of stay.[1] Instead of being billed as inpatient, the claims should have been billed as outpatient, which usually results in a lower Medicare payment. To improve clarity regarding admission decisions, the Centers for Medicare & Medicaid Services (CMS) implemented the two-midnight rule in fiscal year (FY) 2014. Under this rule, CMS generally considered it inappropriate for hospital stays not expected to span at least two midnights to be billed as inpatient. However, claims for procedures designated as "inpatient only" or procedures that CMS identified as rare and unusual exceptions (e.g., mechanical ventilation) were generally considered to be appropriate for inpatient billing even if the stay was less than two midnights. In calendar year (CY) 2016, the two-midnight rule was revised to allow stays expected to last less than two midnights to be billed as inpatient on a case-by-case basis, subject to medical review by a Medicare contractor.

After the two-midnight rule was implemented, OIG issued a report about the effect of this rule on short inpatient stays (i.e., stays that lasted less than two midnights) for FY 2014.[2] The report concluded that although short inpatient stays decreased overall, vulnerabilities to improper payments remained. According to the report, hospitals were still billing for many short inpatient stays that were potentially inappropriate under the two-midnight rule, and Medicare paid almost $2.9 billion for these stays.[3] CMS concurred with the report's recommendations that CMS improve oversight of hospital billing under the two-midnight rule. Given the high payment amount at risk for noncompliance identified in that report, we focused this audit on program safeguards for claims for short inpatient stays for CYs 2016 through 2020 (audit period).

OBJECTIVE

Our objective was to assess program safeguards for ensuring that Medicare claims for short inpatient stays complied with Medicare requirements.

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[1] *Medicare Could Save Millions by Strengthening Billing Requirements for Canceled Elective Surgeries* (A-01-12-00509), Aug. 5, 2013. *Medicare Did Not Pay Selected Inpatient Claims for Bone Marrow and Stem Cell Transplant Procedures in Accordance With Medicare Requirements* (A-09-14-02037), Feb. 1, 2016.

[2] *Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy* (OEI-02-15-00020), Dec. 19, 2016.

[3] The hospitals may have been able to bill the potentially inappropriate short inpatient stays as outpatient services, which on average results in a lower Medicare payment. Therefore, the actual overpayment may have been less than the $2.9 billion identified in the report.

BACKGROUND

Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

To be paid by Medicare, a service or an item must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (Social Security Act (the Act) § 1862(a)(1)(A)). In addition, payment must not be made to any provider of services without information necessary to determine the amount due the provider (the Act § 1815(a)). The provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

CMS administers the Medicare program. CMS uses contractors to, among other things, process and pay claims submitted by hospitals.

The Role of Medicare Contractors

To administer Medicare, CMS contracted with the following entities during our audit period:

- *Beneficiary and Family Centered Care–Quality Improvement Organizations (BFCC-QIOs)*: CMS contracted with BFCC-QIOs to help Medicare enrollees with their concerns about the quality of care they receive from Medicare providers. Specifically, BFCC-QIOs review complaints and quality of care and help to improve the effectiveness, efficiency, economy, and quality of services provided to Medicare enrollees. During our audit period, CMS contracted with two BFCC-QIOs across five regions.

- *Medicare Administrative Contractors (MACs)*: CMS contracted with MACs to, among other things, process and pay Medicare Part A claims submitted by hospitals and conduct reviews and audits for defined geographic areas, or jurisdictions. A hospital must submit claims to the MAC that serves the State or territory in which the hospital is physically located.

- *Recovery Audit Contractors (RACs)*: CMS contracted with RACs to perform postpayment reviews of claims to identify improper payments. Specifically, RACs detect and collect overpayments and identify underpayments so that CMS and other Medicare contractors can implement actions to prevent future improper payments.

Hospital Inpatient and Outpatient Prospective Payment Systems

CMS pays for hospital inpatient services under the inpatient prospective payment system (IPPS) and pays for hospital outpatient services under the outpatient prospective payment system (OPPS). CMS designates certain services as "inpatient only."

Inpatient Prospective Payment System

Under the IPPS, CMS pays hospital inpatient services at predetermined rates for patient discharges under the Medicare Part A benefit. The rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which an enrollee's stay is assigned and the severity level of the enrollee's diagnosis. Procedures performed during the stay are reported on the claim using International Classification of Diseases, 10th revision (ICD-10) procedure codes. Condition codes are also reported on the claim, which provide additional information related to the enrollee, the services provided, and billing parameters that affect the processing of the claim, including information about the inpatient admission.

An MS-DRG payment is, with certain exceptions, intended to be a payment in full to a hospital for all inpatient costs associated with an enrollee's stay. CMS calculates and publishes annually the geometric mean length of stay (GMLOS) for each MS-DRG.[4]

Outpatient Prospective Payment System

Under the OPPS, Medicare pays for hospital outpatient services under Medicare Part B on a rate-per-service basis. Hospitals use Healthcare Common Procedure Coding System (HCPCS) codes to report the services provided.[5]

Under a policy known as the "3-day window" policy, certain outpatient services provided to an enrollee on the date of an inpatient admission or during the 3 calendar days before the date of admission are "bundled" (i.e., included) with the IPPS payment for the enrollee's inpatient stay if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital. These services include all diagnostic and nondiagnostic services related to an inpatient admission.[6]

[4] GMLOS is the national mean length of stay for each MS-DRG as determined and published by CMS. The geometric mean reduces the effect of very high or very low values (i.e., outliers), which might bias the mean if a straight average (arithmetic mean) were used.

[5] The health care industry uses HCPCS codes to standardize coding for medical procedures, services, products, and supplies.

[6] The Act § 1886(a)(4); 42 CFR § 412.2(c)(5).

Inpatient-Only Procedures List

CMS designates certain services as "inpatient only" and publishes an inpatient-only procedures list (IPO list) annually.[7] These procedures are generally surgical services that require inpatient care because of: (1) the nature of the procedure, (2) the underlying physical condition of the enrollee who requires the service, or (3) the need for at least 24 hours of postoperative recovery time or monitoring before the enrollee can be safely discharged. The 3-day window policy applies to inpatient admissions for procedures on the inpatient-only list.

Short Inpatient Stays and the Two-Midnight Rule

To improve clarity regarding admission decisions, CMS implemented the two-midnight rule in FY 2014. Under this rule, CMS generally considered it inappropriate for hospital stays not expected to span at least two midnights (i.e., short stays) to be billed as inpatient.[8] However, claims for procedures on the IPO list or procedures that CMS identified as rare and unusual exceptions are generally considered to be appropriate for inpatient billing even if the stay was less than two midnights.[9] After receiving extensive feedback from stakeholders, CMS revised the two-midnight rule in CY 2016 to allow a stay expected to last less than two midnights to be billed as inpatient on a case-by-case basis, subject to medical review by a Medicare contractor.[10]

During the implementation period (FYs 2014 and 2015), CMS limited enforcement of the two-midnight rule. RACs were prohibited from reviewing short inpatient stays, and MACs were limited to Targeted Probe and Educate (TPE) reviews.[11] If the results of a TPE review indicated poor compliance with the two-midnight rule, the MAC provided education to the hospital staff and conducted further reviews. Beginning in FY 2016, BFCC-QIOs assumed responsibility for conducting TPE reviews and educating hospitals. If the deficiencies that BFCC-QIOs identify in their reviews continue, they may refer hospitals to RACs for further reviews.[12]

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[7] 42 CFR § 419.22(n). The IPO list is published annually on the CMS website as OPPS Final Rule Addendum E. In the CY 2021 Medicare OPPS and Ambulatory Surgical Center final rule (CMS-1736-FC), CMS finalized a policy to eliminate the IPO list over a 3-year period. However, CMS received many stakeholder comments that opposed elimination of the IPO list primarily because of patient safety concerns, stating that the IPO list serves as an important programmatic safeguard. As a result, CMS halted elimination of the IPO list in CY 2022 (CMS–1753–FC).

[8] Hospitals may be able to bill inpatient stays that do not satisfy the two-midnight rule as outpatient services, which on average results in a lower Medicare payment.

[9] 78 Fed. Reg. 50496, 50944–50949 (Aug. 19, 2013).

[10] 80 Fed. Reg. 70298, 70538–70545 (Nov. 13, 2015).

[11] TPE reviews are postpayment reviews of short inpatient stays focused on educating doctors and hospitals about the Medicare Part A payment policy for inpatient admissions.

[12] 80 Fed. Reg. 70298, 70540, 70545–70549 (Nov. 13, 2015).

CMS Guidance for Medicare Contractors on Medical Reviews of Short Inpatient Stays

In CY 2017, CMS issued clarifying guidance for Medicare contractors' medical reviews of short inpatient stays. The guidance discussed two distinct but related medical review policies: the two-midnight presumption and the two-midnight benchmark.[13]

Two-Midnight Presumption

Under the two-midnight presumption, Medicare contractors will presume that hospital stays spanning more than two midnights after an enrollee is formally admitted as an inpatient are reasonable and necessary for Medicare Part A payment. Generally, Medicare contractors will not focus their medical review efforts on stays spanning two or more midnights after formal inpatient admission absent evidence of systemic gaming, abuse, or delays in the provision of care in an attempt to satisfy the two-midnight presumption.

Two-Midnight Benchmark

Under the two-midnight benchmark, a hospital stay is generally payable under Medicare Part A if the admitting practitioner expects the enrollee to require medically necessary hospital care spanning two or more midnights and such reasonable expectation is supported by the medical record documentation.[14] Such a stay is payable regardless of whether the anticipated length of stay did not occur because of unforeseen circumstances, such as clinical improvement of the enrollee. An inpatient stay of less than two midnights that does not satisfy the two-midnight benchmark is nonetheless payable if:

- there is a procedure on the IPO list,
- there is a procedure that CMS identified as a rare and unusual exception to the two-midnight rule (e.g., mechanical ventilation), and
- the admission otherwise qualifies for a case-by-case exception because the medical record documentation supports the admitting practitioner's judgment that the enrollee required hospital care on an inpatient basis despite the lack of an expectation of a two-midnight stay. Medicare contractors will note CMS's expectation that stays under 24 hours would rarely qualify for an exception.

[13] CMS, *Clarifying Medical Review of Hospital Claims for Part A Payment*, Medicare Learning Network Matters Number: MM10080, effective June 13, 2017 (revised Jan. 9, 2019).

[14] For purposes of determining whether the admitting practitioner had a reasonable expectation of hospital care spanning two or more midnights at the time of admission, the Medicare contractor takes into account the time that the enrollee spent receiving contiguous outpatient services within the hospital before inpatient admission.

See Appendix B for the guideline that CMS published for BFCC-QIO reviews of claims for short inpatient stays.

Medicare Program Safeguards for Compliance With the Two-Midnight Rule

Addressing improper payments in the Medicare fee-for-service (FFS) program, including those for short inpatient stays under the two-midnight rule, and promoting compliance with Medicare coverage and coding rules are top priorities for CMS. In addition, preventing Medicare improper payments requires the active involvement of every component of CMS and effective coordination with CMS partners, including contractors and providers.[15]

CMS and its contractors use a variety of program safeguards to prevent and detect improper payments and to promote provider compliance. These safeguards include measuring improper payment rates through the Comprehensive Error Rate Testing (CERT) program, implementing claims processing edits, and conducting postpayment reviews of claims.

Comprehensive Error Rate Testing Program

To measure payment compliance in the Medicare FFS program (including Part A), CMS reviews a stratified random sample of approximately 50,000 claims each fiscal year under the CERT program.[16] This sample size allows CMS to calculate a national improper payment rate and contractor- and service-specific improper payment rates.[17] The results of each CERT review are published annually on the CMS website and provide data on improper payments for short inpatient stays.

[15] CMS, *Medicare Program Integrity Manual,* Pub. No. 100-08, chapter 1, § 1.3.

[16] Although the Federal fiscal year runs from October 1 through September 30, the Medicare FFS improper payment rate calculation includes claims submitted during the 12-month period from July 1 through June 30 before the start of the corresponding Federal fiscal year. For example, the FY 2020 Medicare FFS improper payment rate included claims submitted during the 12-month period from July 1, 2018, through June 30, 2019. The Medicare FFS sampling period does not correspond with the Federal fiscal year because of practical constraints with claims review and rate calculation methodologies.

[17] The improper payment rate is not a "fraud rate" but a measurement of payments that did not meet Medicare requirements. Improper payments are payments that should not have been made or payments with incorrect amounts, and that consist of both overpayments and underpayments.

Claims Processing Edits

Medicare contractors implement CMS- or contractor-developed claims processing system edits to prevent and detect improper payments.[18] Prepayment edits select claims for electronic review before the claims are paid; evaluate or compare information on the selected claims or other accessible sources; and, depending on the evaluation, take action on each claim. Such action could involve paying all or part of the claim, denying all or part of the claim, or suspending all or part of the claim for manual review. Postpayment edits select claims for electronic or manual review after the claims have been paid, and this review results in either no change to the initial payment determination or a revised determination indicating that an overpayment or underpayment occurred.

Postpayment Reviews of Claims

Beginning in CY 2016, BFCC-QIOs began conducting TPE reviews for short inpatient stays under the revised two-midnight rule. These postpayment reviews are focused on educating doctors and hospitals about the Medicare Part A payment policy for inpatient admissions. BFCC-QIOs may refer providers to RACs for additional postpayment reviews based on patterns of practice, such as high rates of claims denial after medical review or failure to improve after BFCC-QIO assistance has been provided.

CMS Estimated Improper Payments for Short Inpatient Stays

Through its annual CERT review, CMS estimated that Medicare Part A improperly paid $23.9 billion for all inpatient stays paid under the IPPS for FYs 2017 through 2021.[19] The CERT reports provide a breakdown of the estimated improper payments by length of stay. Of the $23.9 billion in estimated improper payments, $7.8 billion was for short inpatient stays.[20]

[18] CMS's *Medicare Program Integrity Manual,* Pub. No. 100-08, chapter 3, section 3.3.1.3.B, states that Medicare contractors shall ensure that automated prepayment and postpayment denials are based on a clear policy that serves as the basis for denial. When a clear policy exists, Medicare contractors have the discretion to automatically deny services without stopping a claim for manual review. The term "clear policy" means a statute, regulation, National Coverage Determination, coverage provision in an interpretive manual, coding guideline, Local Coverage Determination, or Local Coverage Article that specifies the circumstances under which a service will always be considered noncovered, incorrectly coded, or improperly billed.

[19] CMS publishes annually on its website the results of each CERT review in a report called *Medicare Fee-for-Service Supplemental Improper Payment Data*. Table B7 of the report provides the projected improper payments by length of stay for Medicare Part A (Hospital IPPS) payments. Although improper payments may consist of overpayments and underpayments, 89.1 percent of the Medicare Part A (Hospital IPPS) improper payments for FYs 2017 through 2021 were overpayments.

[20] CMS calculates the length of stay as the difference between the date of admission and the date of discharge on a claim. Short inpatient stays are listed under the line item for claims that had a length of stay of 0 or 1 day.

Table 1 shows the estimated improper payment amount by year for short inpatient stays and all inpatient stays.

Table 1: Estimated Improper Payment Amount by Year for Short Inpatient Stays and All Inpatient Stays

	Estimated Improper Payment Amount (in Billions)					
Length of Stay	**2017**	**2018**	**2019**	**2020**	**2021**	**Total**
Short Inpatient Stays	$1.4	$1.3	$1.7	$1.9	$1.5	$7.8
All Inpatient Stays	$5.0	$5.5	$5.3	$4.8	$3.3	$23.9

Compared with all inpatient stays, the estimated improper payment rate for short inpatient stays was higher. Table 2 shows the estimated improper payment rate by year for short inpatient stays and all inpatient stays.

Table 2: Estimated Improper Payment Rates by Year for Short Inpatient Stays and All Inpatient Stays

	Estimated Improper Payment Rate					
Length of Stay	**2017**	**2018**	**2019**	**2020**	**2021**	**Average**
Short Inpatient Stays	18.2%	17.0%	18.4%	19.9%	16.8%	18.1%
All Inpatient Stays	4.4%	4.8%	4.2%	4.0%	3.0%	4.1%

Prior Office Inspector General Report on the Two-Midnight Rule

OIG issued a report about the effect of the two-midnight rule on inpatient and outpatient stays by comparing data for FY 2013 (before implementation of the rule) and for FY 2014 (after the rule took effect).[21] The report found that the number of short inpatient stays (i.e., stays that lasted less than two midnights) decreased but that vulnerabilities remained, including the following:

- Hospitals were still billing for many short inpatient stays that were potentially inappropriate under the two-midnight rule, and Medicare paid almost $2.9 billion for these stays in FY 2014.[22]

[21] *Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy* (OEI-02-15-00020), Dec. 19, 2016.

[22] See footnote 3.

- Medicare paid more for some short inpatient stays than for short outpatient stays, although the stays were for similar reasons.

- Hospitals continued to vary in how they billed inpatient and outpatient stays.

To address these vulnerabilities, the report recommended that CMS: (1) conduct a routine analysis of hospital billing and target for review the hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the two-midnight rule and (2) identify and target for review the short inpatient stays that are potentially inappropriate under the two-midnight rule. CMS concurred with these recommendations and stated that it would instruct BFCC-QIOs to conduct the recommended analysis and review short inpatient stays to determine the appropriateness of Medicare Part A payment.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $19.7 billion in Medicare Part A claims with dates of service from January 1, 2016, through December 31, 2020, for 2.5 million short inpatient stays at 3,340 acute-care hospitals.[23] These claims were paid under the IPPS on behalf of 2.2 million enrollees, each of whom a hospital indicated on each claim went home after an inpatient stay without additional care, such as home health or hospice care. We defined a short inpatient stay as one in which the claim showed that the enrollee was an inpatient for 1 or 2 days (i.e., a stay that lasted less than two midnights) based on the date of admission and date of discharge on the claim. For example:

- A claim with a date of admission on January 1 and a date of discharge on January 1 was considered a 1-day stay (i.e., zero midnights).

- A claim with a date of admission on January 1 and a date of discharge on January 2 was considered a 2-day stay (i.e., one midnight).

We interviewed CMS officials to obtain an understanding of program safeguards (such as claims processing edits and postpayment reviews) for short hospital stays paid under the IPPS. We also interviewed one BFCC-QIO to obtain an understanding of its policies and procedures for reviewing claims for short inpatient stays.

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.

[23] CMS defines an acute-care hospital as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

Appendix A describes our audit scope and methodology.

FINDINGS

CMS could strengthen program safeguards for ensuring that Medicare claims for short inpatient stays comply with Medicare requirements. For our audit period, we identified three weaknesses in the established program safeguards for preventing and detecting improper payments for short inpatient stays and recovering overpayments. Specifically, CMS did not have:

- adequate information to identify short inpatient stays at risk for noncompliance with the two-midnight rule,
- prepayment edits for claims at risk for noncompliance with the two-midnight rule, and
- adequate policies and procedures to review claims at risk for noncompliance with the two-midnight rule and to recover overpayments.

These weaknesses occurred because CMS relied primarily on postpayment reviews conducted by BFCC-QIOs to ensure compliance with the two-midnight rule. Although BFCC-QIOs reviewed thousands of claims for short inpatient stays and denied $49.2 million in improper payments during our audit period, these reviews denied only 0.6 percent of the $7.8 billion in improper payments estimated by CMS's CERT reviews. In addition, BFCC-QIOs did not refer any providers to RACs for additional reviews and recovery of overpayments after furnishing the providers with assistance, and the BFCC-QIO reviews did not significantly reduce the improper payment rate for short inpatient stays estimated by CMS's CERT reviews. Without strengthening program safeguards, CMS and its contractors may not be able to prevent or detect improper payments for short inpatient stays and recover overpayments for claims that did not comply with Medicare requirements.

CMS DID NOT HAVE ADEQUATE INFORMATION TO IDENTIFY SHORT INPATIENT STAYS AT RISK FOR NONCOMPLIANCE WITH THE TWO-MIDNIGHT RULE

CMS did not have claim information to identify short inpatient stays for which the admitting practitioner expected a longer stay and the longer stay did not occur because of an unforeseen circumstance. In addition, CMS had inadequate claim information to identify short inpatient stays with inpatient only procedures. As a result, Medicare paid $19.7 billion for 2.5 million short inpatient stays that were at risk for noncompliance with the two-midnight rule. Specifically, these claims did not satisfy the two-midnight presumption (i.e., each stay lasted less than two midnights), and CMS and its contractors could not easily identify which short inpatient stays would have satisfied the two-midnight benchmark or an exception to the benchmark.

CMS Did Not Have Claim Information To Identify Short Inpatient Stays for Which the Admitting Practitioner Expected a Longer Stay and the Longer Stay Did Not Occur Because of an Unforeseen Circumstance

Under the two-midnight benchmark, a hospital stay is generally payable under Medicare Part A if the admitting practitioner reasonably expects the enrollee to require hospital care spanning two or more midnights (i.e., a longer stay) and that expectation is supported by the medical record documentation. This is true regardless of whether the anticipated length of stay did not occur because of an unforeseen circumstance. However, there was no information, such as a condition code, on claims for short inpatient stays indicating that an unforeseen circumstance occurred that resulted in a shorter stay. Therefore, without conducting a medical review on a claim-by-claim basis, CMS and its contractors could not identify short inpatient stays in which a longer stay did not occur because of an unforeseen circumstance.

CMS Had Inadequate Claim Information To Identify Short Inpatient Stays With Inpatient-Only Procedures

Inpatient stays of less than two midnights that do not satisfy the two-midnight benchmark are nonetheless payable when there is a procedure on the IPO list. However, the IPO list has HCPCS codes that are used to report procedures on outpatient claims and does not include ICD-10 procedure codes, which are used to report procedures on inpatient claims.[24] Therefore, CMS and its contractors did not have adequate information to identify short inpatient stays with inpatient only procedures unless they manually reviewed the procedure codes listed on each claim. The prior OIG report on the two-midnight rule (OEI-02-15-00020) also identified as a concern the lack of an IPO list using ICD-10 procedure codes.

According to CMS officials, CMS does not have a list of ICD-10 procedure codes that correspond to the HCPCS codes on the IPO list. CMS stated that creating such a list would be technically challenging because of differences between the two classification systems. For example, an HCPCS code may map to zero, one, or more than one ICD-10 procedure code. However, the BFCC-QIO we interviewed stated that it "developed an exclusion list [IPO list] and also utilized a credentialed coder with software crosswalk support to evaluate the actual procedure documented in the medical record as there is not a one-to-one correlation between the HCPCS codes and the ICD procedure codes."

[24] Under the 3-day window policy, an inpatient-only procedure provided before inpatient admission by the admitting hospital, or an entity that is wholly owned or wholly operated by the admitting hospital, is generally included on an inpatient claim as an ICD-10 procedure code.

Medicare Paid Billions of Dollars for Short Inpatient Stays

Medicare paid $19.7 billion for 2.5 million short inpatient stays that did not satisfy the two-midnight presumption (i.e., each stay lasted less than two midnights).[25] Table 3 below shows the number of and payment for short inpatient stays by year for our audit period. Because these claims did not satisfy the two-midnight presumption in the contractor guidance, these claims would have had to satisfy the two-midnight benchmark or an exception to the benchmark in order to qualify for IPPS payment. This includes the admitting practitioner's expectation that the enrollee requires medically necessary hospital care spanning two or more midnights or an assessment of the claim to determine whether an exception exists that would make a payment appropriate, such as the presence of an inpatient only procedure .

Table 3: Number of and Payment for Short Inpatient Stays From CYs 2016 Through 2020

	1-Day Stays (Zero Midnights)		2-Day Stays (One Midnight)		All Short Inpatient Stays (Zero or One Midnight)	
Year	Number of Stays	Payment	Number of Stays	Payment	Number of Stays	Payment
2016	45,356	$310,522,081	411,821	$2,883,438,595	457,177	$3,193,960,676
2017	55,250	395,328,425	513,592	3,710,602,102	568,842	4,105,930,527
2018	54,755	414,764,077	499,056	3,772,294,316	553,811	4,187,058,393
2019	57,659	472,477,739	528,338	4,356,053,778	585,997	4,828,531,517
2020	39,010	353,660,997	337,372	3,042,378,388	376,382	3,396,039,385
Total	**252,030**	**$1,946,753,319**	**2,290,179**	**$17,764,767,179**	**2,542,209**	**$19,711,520,498**

CMS and Its Contractors Could Not Easily Identify Which Short Inpatient Stays Would Have Satisfied the Two-Midnight Benchmark or an Exception to the Benchmark

Without claim information indicating that a longer stay did not occur because of an unforeseen circumstance or an IPO list with ICD-10 procedure codes, CMS and its contractors could not easily identify which short inpatient stays would have satisfied the two-midnight benchmark or an exception to the benchmark. Not being able to make this identification could lead to an inefficient use of resources because CMS and its contractors may not focus postpayment reviews on claims at higher risk of improper payments.

[25] Hospitals may have been able to bill inpatient stays that did not satisfy the two-midnight rule as outpatient services, which on average results in a lower Medicare payment. Therefore, the actual overpayment may have been less than the $19.7 billion we identified for short inpatient stays that did not satisfy the two-midnight presumption.

CMS DID NOT HAVE PREPAYMENT EDITS FOR CLAIMS AT RISK FOR NONCOMPLIANCE WITH THE TWO-MIDNIGHT RULE

Although OIG and CMS, as well as the BFCC-QIO we interviewed, identified risk factors for noncompliance with the two-midnight rule, CMS did not have prepayment edits to prevent potentially improper payments for short inpatient stays with these risk factors. Without prepayment edits for claims for short inpatient stays with known risk factors, CMS may have made billions of dollars in potentially improper payments.

There Were No Prepayment Edits for Claims for Short Inpatient Stays With Four Risk Factors

Prior OIG reports, CMS, and the BFCC-QIO we interviewed identified short inpatient stays with the following four risk factors for noncompliance with the two-midnight rule: (1) stays for care generally spanning 1 week or longer, (2) stays with canceled procedures, (3) stays billed with MS-DRGs that CMS identified as at risk for noncompliance, and (4) stays billed with MS-DRGs identified by a BFCC-QIO as at risk for noncompliance. Of the $19.7 billion that Medicare paid for short inpatient stays during our audit period, up to $11 billion was paid for claims with one or more of these risk factors. However, there were no prepayment edits for claims for short inpatient stays with these risk factors. Instead, CMS relied on postpayment edits and claim reviews to ensure compliance with the two-midnight rule.

Medicare Paid Millions of Dollars for Short Stays for Care Generally Spanning 1 Week or Longer

For our audit period, Medicare paid $306.5 million for 10,512 short inpatient stays billed with MS-DRGs that had a GMLOS greater than or equal to 7 days. The average payment for these claims ($29,162) was almost four times higher than the average for all short inpatient stays ($7,754).

A prior OIG report (A-09-14-02037) identified a similar issue in which millions of dollars in overpayments for short inpatient stays were billed with MS-DRGs that had a long average length of stay (i.e., a high GMLOS).[26] Specifically, the report identified $6.3 million in overpayments from January 2010 through September 2013 for inpatient claims for bone marrow and stem-cell transplant procedures. The lengths of stay for these claims were 1 to 2 days, but the GMLOS for each of these claims was 10 to 21 days. Most of these stays were incorrectly billed as inpatient and should have been billed as outpatient.

Based on the findings in the prior OIG report, it is reasonable to maintain that for our audit period the claims for inpatient stays billed with MS-DRGs that had a long average length of stay

[26] *Medicare Did Not Pay Selected Inpatient Claims for Bone Marrow and Stem Cell Transplant Procedures in Accordance With Medicare Requirements* (A-09-14-02037), Feb. 1, 2016.

may have been at risk for noncompliance with the two-midnight rule, and that the lack of prepayment edits may have allowed improper payments for claims with this risk factor.

Medicare Paid Millions of Dollars for Short Inpatient Stays With Canceled Procedures

For our audit period, Medicare paid $156.3 million for 20,855 short inpatient stays with canceled procedures. These claims were billed with ICD-10 diagnosis codes that indicated specific procedures or treatments were not carried out.[27]

Another prior OIG report (A-01-12-00509) identified millions of dollars in overpayments for short inpatient stays with canceled elective surgeries.[28] Specifically, the report identified $38.2 million in estimated overpayments for CYs 2009 and 2010 for short inpatient stays (i.e., stays that lasted less than two midnights) that had a diagnosis code indicating that the surgical procedure on the claim was not carried out.

Based on our findings in the prior OIG report on canceled elective surgeries, it is reasonable to maintain that for our audit period the claims for short inpatient stays with canceled procedures may have been at risk for noncompliance with the two-midnight rule and that the lack of prepayment edits may have allowed improper payments for claims with this risk factor. Table 4 shows payments for short inpatient stays with canceled procedures by year for our audit period.

Table 4: Payments for Short Inpatient Stays With Canceled Procedures by Year From CYs 2016 Through 2020

Year	Number of Claims	Payment
2016	3,531	$23,684,597
2017	4,541	31,872,575
2018	4,467	33,271,084
2019	4,891	38,261,954
2020	3,425	29,229,134
Total	**20,855**	**$156,319,344**

[27] These diagnosis codes are in the Z53 series for "Persons encountering health services for specific procedures and treatments, not carried out." We excluded diagnosis codes in subgroup Z53.3, "Procedure converted to open procedure," because these codes indicate that a different type of procedure was performed than the type of procedure that was planned.

[28] *Medicare Could Save Millions by Strengthening Billing Requirements for Canceled Elective Surgeries* (A-01-12-00509), Aug. 5, 2013.

Medicare Paid Hundreds of Millions of Dollars for Short Inpatient Stays Billed With MS-DRGs That CMS Identified as High Risk

As part of its oversight of inpatient billing, CMS previously identified (i.e., before our audit) short inpatient stays billed with 45 MS-DRGs that were at risk for noncompliance with the two-midnight rule. According to CMS, these MS-DRGs were associated with 1-day inpatient stays (i.e., stays that did not span one midnight) that most likely were outpatient services rather than inpatient stays. Each of these MS-DRGs had a GMLOS ranging from 1.7 to 5.5 days. For our audit period, Medicare paid $505.6 million for 91,804 one-day inpatient stays billed with these MS-DRGs.

Medicare Paid Billions of Dollars for Short Inpatient Stays Billed With MS-DRGs That a BFCC-QIO Identified as High Risk

The BFCC-QIO we interviewed previously (i.e., before our audit) identified short inpatient stays billed with 370 MS-DRGs that were considered at high risk for improper payments. Each of these MS-DRGs had a GMLOS ranging from 1.2 to 10.4 days, and many of them were on the list of MS-DRGs that CMS identified as at risk for noncompliance with the two-midnight rule. For our audit period, Medicare paid $11 billion for 1,452,062 short inpatient stays billed with these MS-DRGs. Table 5 shows payments for 1-day and 2-day inpatient stays billed with MS-DRGs at high risk for improper payments.

Table 5: Payments for 1-Day and 2-Day Inpatient Stays Billed With MS-DRGs at High Risk for Improper Payments

Length of Stay	Number of Claims	Payment
1 Day (Zero Midnights)	152,843	$1,135,518,224
2 Days (One Midnight)	1,299,219	9,852,299,591
Total	**1,452,062**	**$10,987,817,815**

Medicare May Have Made Billions of Dollars in Potentially Improper Payments

Because CMS did not have prepayment edits for claims for short inpatient stays with four risk factors, Medicare may have made up to $11 billion in potentially improper payments. Implementing claims processing edits—instead of conducting potential postpayment claim reviews such as those conducted by BFCC-QIOs—may be able to prevent potentially improper payments before they are made. These edits would reduce the number of claims requiring postpayment reviews and allow BFCC-QIOs to focus reviews on claims that most require them.

CMS DID NOT HAVE ADEQUATE POLICIES AND PROCEDURES TO REVIEW CLAIMS AT RISK FOR NONCOMPLIANCE WITH THE TWO-MIDNIGHT RULE AND RECOVER OVERPAYMENTS

CMS did not have adequate policies and procedures to ensure that: (1) BFCC-QIO reviews were adequate to prevent billions of dollars in improper payments for short inpatient stays and (2) BFCC-QIOs referred providers to RACs for additional reviews to recover overpayments. Without adequate policies and procedures to review claims at risk for noncompliance with the two-midnight rule, billions of dollars in estimated overpayments may not be recovered.

Reviews by BFCC-QIOs Were Not Adequate To Prevent Billions of Dollars in Improper Payments for Short Inpatient Stays

Although BFCC-QIOs reviewed thousands of claims for short inpatient stays and denied millions of dollars in improper payments during our audit period, these reviews were not adequate to prevent billions of dollars in estimated improper payments for short inpatient stays.

In accordance with CMS's policies and procedures, BFCC-QIOs began conducting TPE reviews of claims for short inpatient stays in FY 2016. The first statement of work (SOW 11) covered claims with hospital discharge dates from April 1, 2015, through December 31, 2018, and the TPE reviews were conducted in six probe cycles (i.e., rounds) by two BFCC-QIOs. Each probe cycle covered a 6- to 9-month period of claims, and the BFCC-QIOs reviewed 4,313 to 19,184 claims in each cycle. The BFCC-QIOs initially selected claims based on hospital size; however, the methodology was later refined to focus on the top 175 providers with high or increasing numbers of short inpatient stays. In total, the BFCC-QIOs reviewed 65,539 claims for short inpatient stays and denied payment for 8,904 claims totaling $49.2 million for SOW 11. See Table 6 for results of the BFCC-QIO reviews of short inpatient stays by probe cycle for SOW 11.

Table 6: Results of the BFCC-QIO Reviews of Short Inpatient Stays by Probe Cycle

Probe Cycle	Number of Claims Reviewed	Number of Claims Denied	Payment Denied
1	18,053	298	$1,937,081
2	19,184	3,539	22,782,748
3	9,820	1,497	7,770,049
4	5,538	1,068	6,044,108
5	8,631	1,649	1,636,648
6	4,313	853	8,995,452
Total	**65,539**	**8,904**	**$49,166,086**

The second statement of work (SOW 12) covered claims with hospital discharge dates starting on August 1, 2021. As a result, BFCC-QIOs have not reviewed claims for short inpatient stays with discharge dates from January 1, 2019, through July 31, 2021.

Although BFCC-QIOs denied $49.2 million in improper payments for short inpatient stays during our audit period, these reviews were focused on educating doctors and hospital staff about inpatient admission requirements after implementation of the two-midnight rule rather than on recovering overpayments. However, the two-midnight rule is now an established policy, and these reviews were not adequate to significantly reduce improper payments for short inpatient stays, which were estimated by CMS's CERT reviews to total $7.8 billion during our audit period.[29] If CMS does not update its policies and procedures for postpayment reviews to focus on claims for short inpatient stays identified as at risk for noncompliance with the two-midnight rule, billions of dollars in estimated overpayments may not be recovered.

BFCC-QIOs Did Not Refer Any Providers to RACs for Additional Reviews To Recover Overpayments

Although BFCC-QIOs identified and provided education to hundreds of providers for which there were major concerns over compliance with the two-midnight rule, the BFCC-QIOs did not refer these providers to RACs for additional reviews and recovery of overpayments.

According to CMS policies and procedures, RACs were prohibited from reviewing claims for short inpatient stays without a referral from a BFCC-QIO. According to the policy, a BFCC-QIO should have referred a provider to an RAC for additional review based on a pattern of improper billing, such as a high rate of claims denial after a medical review or failure to improve after BFCC-QIO assistance has been provided. For SOW 11, BFCC-QIOs identified 860 providers for which they had "major concerns" over compliance with the two-midnight rule.[30] However, BFCC-QIOs did not refer any providers to RACs for additional review because the providers did not continue to meet the criteria (i.e., patterns of improper billing) for referral after BFCC-QIO assistance (i.e., education) had been provided. Table 7 on the following page shows the number of providers that BFCC-QIOs identified with major compliance concerns by probe cycle.

[29] The dates of service for the BFCC-QIO recoveries and the CERT estimate do not align. The BFCC-QIO recoveries were for claims with dates of service from Apr. 1, 2015, through Dec. 31, 2018. (There were no additional recoveries until SOW 12 began in 2021.) The CERT estimate was for claims with dates of service from July 1, 2015, through June 30, 2020.

[30] A BFCC-QIO identified a "major concern" with a provider's compliance if the provider's denial rate was 20.01 percent or greater of the reviewed claims for the provider-specific sample. A BFCC-QIO may have identified major concerns with the same provider in more than one probe cycle.

Table 7: Providers for Which the BFCC-QIOs Identified Major Concerns Over Compliance With the Two-Midnight Rule by Probe Cycle

Probe Cycle	Number of Providers Reviewed	Number of Providers With Major Compliance Concerns
1	1,661	28
2	1,704	502
3	443	99
4	222	68
5	346	111
6	173	52
Total	**4,549**	**860**

Although BFCC-QIOs assisted providers with compliance concerns as part of their reviews, these reviews did not significantly reduce the improper payment rates for short inpatient stays, which were estimated by CMS's CERT reviews to average 18.1 percent during our audit period. In addition, there were no RAC reviews over our 5-year audit period under the BFCC-QIO referral policy. If CMS does not update its policies and procedures for postpayment reviews to allow for additional reviews (whether by RACs or other contractors), billions of dollars in estimated overpayments may not be recovered.

CMS and Its Contractors Did Not Recover Billions of Dollars in Estimated Improper Payments

Although BFCC-QIOs denied $49.2 million in improper payments for short inpatient stays during our audit period, this amount was only 0.6 percent of the $7.8 billion in improper payments estimated by CMS's CERT reviews. Despite identifying providers with compliance concerns, BFCC-QIOs did not refer any of these providers to RACs for additional reviews and recovery of overpayments after furnishing the providers with assistance. If CMS does not update its policies and procedures for postpayment reviews to focus on claims for short inpatient stays at risk for noncompliance with the two-midnight rule and recovery of overpayments (whether by RACs or other contractors), billions of dollars in estimated improper payments may not be recovered.

CONCLUSION

We identified three weaknesses in the established program safeguards for preventing and detecting improper payments for short inpatient stays and recovering overpayments. Specifically: (1) CMS did not have claim information to identify short inpatient stays for which the admitting practitioner expected a longer stay and the longer stay did not occur because of an unforeseen circumstance, and CMS had inadequate claim information to identify short inpatient stays with inpatient only procedures; (2) CMS did not have prepayment edits for claims at risk for noncompliance with the two-midnight rule; and (3) CMS did not have

adequate policies and procedures to review claims at risk for noncompliance with the two-midnight rule and recover overpayments.

Medicare paid $19.7 billion for 2.5 million short inpatient stays that did not satisfy the two-midnight presumption (i.e., each stay lasted less than two midnights). Of the $1.9 billion , up to $11 billion was for claims at higher risk for improper payments. Specifically, we identified $306.5 million for short inpatient stays for care generally spanning 1 week or longer, $156.3 million for short inpatient stays with canceled procedures, $505.6 million for short inpatient stays billed with MS-DRGs that CMS identified as at risk, and $11 billion for short inpatient stays billed with MS-DRGs that one BFCC-QIO identified as at risk.

These weaknesses occurred because CMS relied primarily on postpayment reviews conducted by BFCC-QIOs to ensure compliance with the two-midnight rule. Although BFCC-QIOs reviewed thousands of claims for short inpatient stays and denied $49.2 million in improper payments during our audit period, these reviews denied only 0.6 percent of the $7.8 billion in improper payments estimated by CMS's CERT reviews. In addition, BFCC-QIOs did not refer any providers to RACs for additional reviews and recovery of overpayments after furnishing the providers with assistance, and the BFCC-QIO reviews did not significantly reduce the improper payment rate for short inpatient stays estimated by CMS's CERT reviews. Without strengthening program safeguards, CMS and its contractors may not be able to prevent and detect improper payments for short inpatient stays and recover overpayments for claims that did not comply with Medicare requirements.

RECOMMENDATIONS

To strengthen program safeguards for preventing and detecting improper payments for short inpatient stays and recovering overpayments for claims that do not comply with Medicare requirements, we recommend that the Centers for Medicare & Medicaid Services work with its contractors to:

- add information to inpatient claims indicating any stay that did not span two or more midnights because of an unforeseen circumstance (e.g., a condition code);

- develop a list of ICD-10 procedure codes associated with the HCPCS codes on the inpatient only procedures list;

- implement prepayment edits for claims for short inpatient stays at risk for noncompliance with the two-midnight rule (i.e., short inpatient stays with risk factors such as canceled procedures or certain MS-DRGs); and

- update policies and procedures for postpayment reviews to focus on:

    - claims for short inpatient stays identified as at risk for noncompliance with the two-midnight rule and

- recovery of overpayments (e.g., through additional reviews by RACs or other contractors).

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not state whether it concurred with our recommendations but said that it will take our findings and recommendations into consideration as it determines appropriate next steps. In addition, CMS provided information on actions that it had taken related to our recommendations. CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix C.

CMS had the following comments on our recommendations:

- Regarding our first and second recommendations, CMS stated that it uses a robust program integrity strategy to reduce and prevent Medicare improper payments including automated system edits within the claims processing system and conducting prepayment and postpayment reviews. For our second recommendation, CMS noted that there would be limitations in developing a one-to-one mapping because the ICD-10 and HCPCS code sets are intended to reflect services in different health care settings.

- Regarding our fourth recommendation, CMS stated that the BFCC-QIO has an Improper Payment Reduction Strategy (IPRS) for reviews of claims for short inpatient stays, which is a problem-focused, outcome-based operational plan that identifies risks to the Medicare Trust Fund. CMS stated that the IPRS addresses both provider and DRG-specific vulnerabilities and includes a prioritization of claims selection based on data analysis findings and the availability of resources. CMS also stated that the IPRS annually incorporates available data to continuously improve the accuracy of claims that are at risk for noncompliance with the two-midnight policy.

For all four of our recommendations, CMS stated that it will take our findings and recommendations into consideration as it determines appropriate next steps.

We appreciate CMS's continued efforts to prevent and detect improper payments for short inpatient stays and its willingness to consider our recommendations. However, after reviewing CMS's comments, we maintain that CMS should implement our recommendations to address the findings in our report.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $19,711,520,498 in Medicare Part A claims with dates of service from January 1, 2016, through December 31, 2020, for 2,542,209 short inpatient stays at 3,340 acute-care hospitals. These claims were paid under the IPPS on behalf of 2,223,592 enrollees, each of whom a hospital indicated on each claim went home after an inpatient stay without additional care, such as home health or hospice care. We defined a short inpatient stay as one in which the claim showed that the enrollee was an inpatient for 1 or 2 days (i.e., a stay that lasted less than two midnights) based on the date of admission and date of discharge on the claim. For example:

- A claim with a date of admission on January 1 and a date of discharge on January 1 was considered a 1-day stay (i.e., zero midnights).

- A claim with a date of admission on January 1 and a date of discharge on January 2 was considered a 2-day stay (i.e., one midnight).

We did not perform an overall assessment of the internal control structures of CMS or its contractors. Rather, we limited our review to those internal controls related to Medicare requirements for the two-midnight rule. Specifically, we interviewed CMS officials to obtain an understanding of policies and procedures and claims processing system edits for short inpatient stays. We also interviewed one BFCC-QIO to obtain an understanding of its policies and procedures for reviewing claims for short inpatient stays. Because our audit was designed to provide only reasonable assurance that the internal controls we reviewed were effective, it would not necessarily have detected all internal control deficiencies.

Our audit enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History file (NCH), but we did not assess the completeness of the data. We assessed the reliability of the data obtained from the NCH file by: (1) considering prior data reliability assessments on data from the NCH file; and (2) performing electronic testing of the data, such as verifying that the data met the parameters of our request and recalculating values such as length of stay. We determined that the data were sufficiently reliable for purposes of this audit.

We conducted our audit from November 2021 to January 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- reviewed CMS's CERT data for FYs 2016 through 2020;

- interviewed CMS officials and officials from one BFCC-QIO to obtain an understanding of Medicare program safeguards and oversight activities for short inpatient stays;

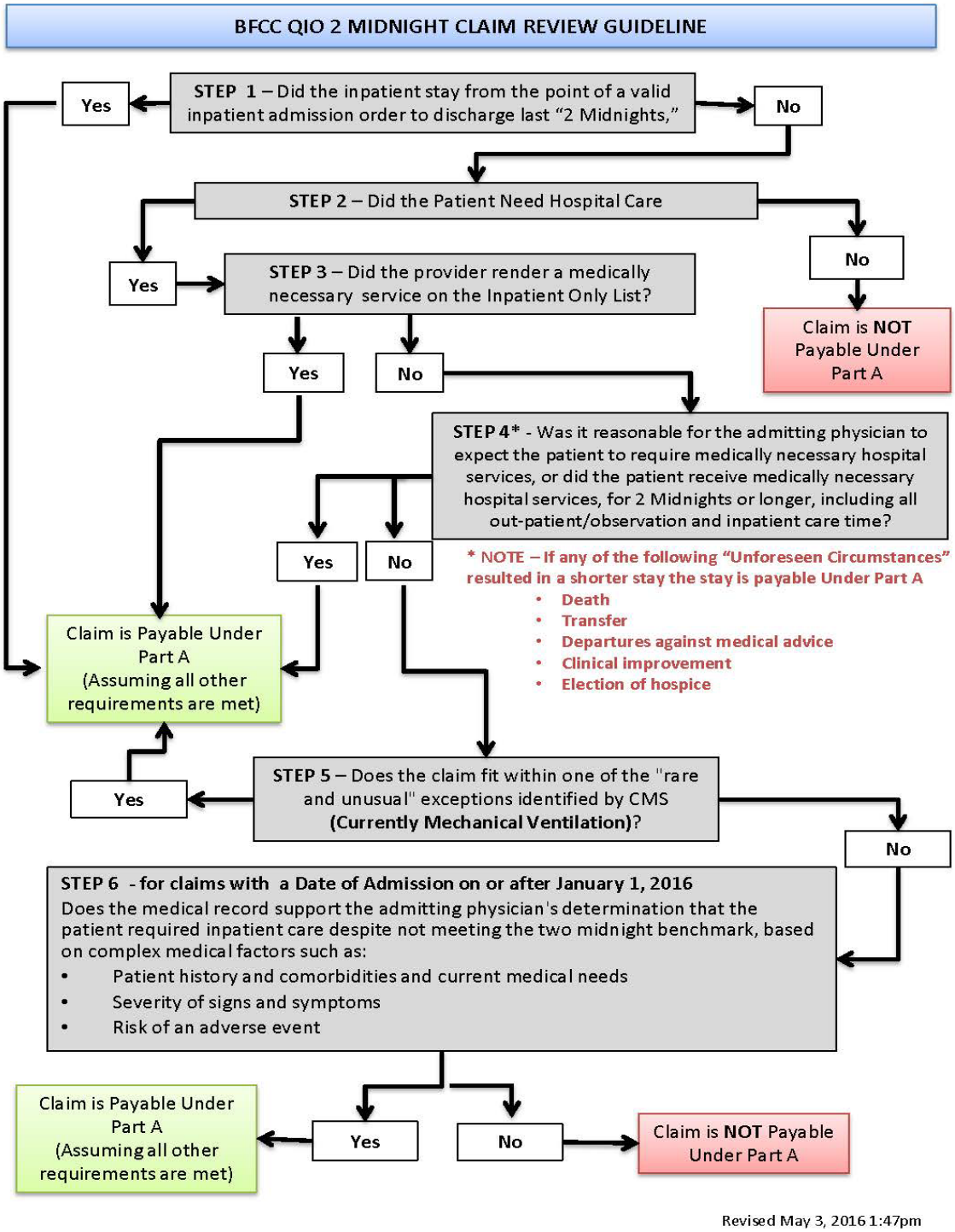
- obtained from the NCH file the Medicare Part A paid claims data for short inpatient stays (i.e., stays that lasted less than two midnights) with dates of service for our audit period;

- analyzed the Part A paid claims data for short inpatient stays to identify claims at risk for noncompliance with the two-midnight rule; 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.

APPENDIX B: THE CMS GUIDELINE FOR BFCC-QIO REVIEWS OF CLAIMS FOR SHORT INPATIENT STAYS[31]



[31] CMS, Center for Clinical Standards and Quality, Quality Improvement and Innovation Group, BFCC-QIO 2 Midnight Claim Review Guideline, Mar. 23, 2022. Available at https://www.cms.gov/files/document/bfcc-qio-2-midnight-claim-review-guideline.pdf. Accessed on Dec. 1, 2022.

APPENDIX C: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: April 2, 2024

TO: Juliet T. Hodgkins
Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS Could Strengthen Program Safeguards To Prevent and Detect Improper Medicare Payments for Short Inpatient Stays (A-09-21-03022)

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 continuing to provide Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect 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 conducting prepayment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

To provide greater clarity to hospital and physician stakeholders regarding appropriate billing and payment, and to address the long outpatient stays receiving observation services for extended periods of time, CMS adopted the 2-Midnight policy for admissions beginning on or after October 1, 2013. This policy, finalized through rulemaking, establishes that an admission is generally appropriate for payment under Part A if the admitting physician reasonably expects the beneficiary to require hospital care that lasts at least 2 midnights and admits the beneficiary based on that expectation; otherwise, the care should generally be billed as outpatient services under Part B. Additional rulemaking, effective for admissions on or after January 1, 2016, established a case-by-case exception to this rule such that when the admitting physician does not expect the beneficiary to require hospital care that lasts at least 2 midnights, payment under Part A may still be appropriate if the admitting physician determines that inpatient hospital admission is reasonable and necessary and that determination is supported by the medical record. When considering this rule, CMS sought to balance principles shared by all stakeholders, including beneficiaries, hospitals, and physicians. These principles include the need for criteria that are clear, and consistent with sound clinical practice, reflect the beneficiaries' medical needs, respect a physician's judgment, and are consistent with the efficient delivery of care to protect the Medicare Trust Funds.

CMS has taken a collaborative approach to the education and enforcement of the 2-Midnight policy. Since October 2015, CMS has used the Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) to conduct the initial medical reviews of Medicare Part A claims with short inpatient stays.[1] The BFCC-QIOs have a significant history of collaborating with hospitals and other stakeholders to provide high quality education regarding CMS' policies and procedures. Under this enforcement strategy, claims for inpatient admissions that are determined not to be appropriate pursuant to the 2-Midnight policy are denied, and the BFCC-QIOs provide one-to-one provider education regarding the policy. As of January 2016, BFCC-QIOs are instructed to refer to the Recovery Audit Contractors (RACs) those providers exhibiting persistent noncompliance with Medicare payment policies, including, but not limited to consistently failing to adhere to the 2-Midnight policy, or failing to improve their performance after BFCC-QIO educational intervention. However, as noted in the OIG's report, BFCC-QIOs have not referred any providers to the RACs because the providers were able to improve their performance after the educational intervention. CMS would like to emphasize that no providers met the criteria for referral to the RACs after educational intervention.

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

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services work with its contractors to add information to inpatient claims indicating any stay that did not span two or more midnights because of an unforeseen circumstance (e.g., a condition code).

CMS Response

CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and post-payment reviews. CMS will take the OIG's findings and recommendations into consideration as we determine appropriate next steps.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services work with its contractors to develop a list of ICD-10 procedure codes associated with the HCPCS codes on the inpatient-only procedure list.

CMS Response

CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and post-payment reviews. CMS will take the OIG's findings and recommendations into consideration as we determine appropriate next steps. We note that because the ICD-10 and HCPCS code sets are intended to reflect and represent services in different healthcare settings that there would be limitations in developing a one-to-one mapping.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services work with its contractors to implement prepayment edits for short inpatient stays at risk for noncompliance with the two-midnight rule (i.e., short inpatient stays with risk factors, such as canceled procedures or certain MS-DRGs).

[1] An overview of the BFCC-QIOs review process is available online at: https://www.cms.gov/files/document/bfcc-qio-2-midnight-claim-review-guideline.pdf.

CMS Response
CMS will take the OIG's findings and recommendations into consideration as we determine appropriate next steps.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services work with its contractors to update policies and procedures for postpayment review to focus on claims for short inpatient stays identified as at risk for noncompliance with the two-midnight rule and recovery of overpayments (e.g., through additional reviews by RACs or other contractors).

CMS Response
Currently, the BFCC-QIO, has an Improper Payment Reduction Strategy (IPRS) for short inpatient stay claim reviews, which is a problem-focused, outcome-based operational plan that identifies risks to the Medicare Trust Fund. The IPRS addresses both provider and DRG specific vulnerabilities and includes a prioritization of the claims selection based on data analysis findings and the availability of resources. On an annual basis, the IPRS incorporates available data to continuously improve the accuracy of claims that are at risk for noncompliance with the 2-Midnight policy.

As stated above, CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments. CMS will take the OIG's findings and recommendations into consideration as we determine appropriate next steps.