Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE IMPROPERLY PAID ACUTE-CARE HOSPITALS FOR INPATIENT CLAIMS SUBJECT TO THE POST-ACUTE-CARE TRANSFER POLICY OVER A 4-YEAR PERIOD, BUT CMS'S SYSTEM EDITS WERE EFFECTIVE IN REDUCING IMPROPER PAYMENTS BY THE END OF THE PERIOD

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Office of Inspector General

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

Report in Brief
Date: September 2023
Report No. A-09-23-03016

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

Medicare Improperly Paid Acute-Care Hospitals for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy Over a 4-Year Period, but CMS's System Edits Were Effective in Reducing Improper Payments by the End of the Period

Why OIG Did This Audit

Prior OIG audits identified over $563 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 audit to evaluate whether Medicare properly paid acute-care hospitals' claims subject to that policy for those claims with dates of service from January 1, 2019, through December 31, 2022 (audit period).

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

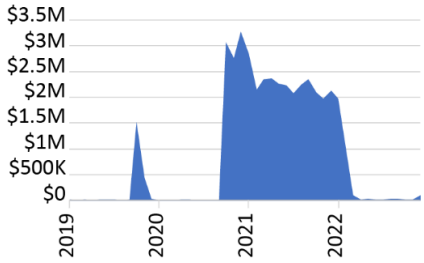
How OIG Did This Audit

Our audit covered $198 million in Medicare Part A payments for 12,133 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 health care institutions. We used the Medicare enrollee information and service dates from those claims to identify services furnished in post-acute-care settings 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).

What OIG Found

For our audit period, Medicare improperly paid $41.4 million to acute-care hospitals for inpatient claims subject to the transfer policy. These hospitals improperly billed these claims by using the incorrect discharge status codes. Specifically, they coded these claims as discharges to home (6,338 claims) or to certain types of health care institutions (5,795 claims), such as facilities that provide custodial care, rather than as transfers to post-acute care. 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 health care institutions, but pays an acute-care hospital that transfers an enrollee to post-acute care a per diem rate for each day of the enrollee's stay in the hospital. The total overpayment of $41.4 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.

These improper payments were made because CMS's system edits were not effective in detecting inpatient claims subject to the transfer policy in October and November 2019 and from October 2020 through March 2022. However, after CMS fixed the edits in April 2022, improper payments significantly decreased through the end of the audit period (i.e., through December 2022).



What OIG Recommends and CMS Comments

We recommend that CMS: (1) direct the Medicare contractors to recover from acute-care hospitals the portion of the $41.4 million in identified overpayments for our audit period that are within the 4-year reopening period and (2) instruct the Medicare contractors to notify appropriate providers so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule.

CMS concurred with both of our recommendations and provided information on actions that it planned to take to address our recommendations, including directing its Medicare contractors to recover the identified overpayments.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/92303016.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

Prior Office of Inspector General (OIG) audits identified over $563 million in overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (also referred to as the "transfer policy" in this report) for claims with dates of service from October 1998 through December 2018. 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.

A prior OIG audit of inpatient claims with transfers to post-acute-care settings (i.e., home health agencies (HHAs), SNFs, long-term-care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and cancer hospitals) and with dates of service from January 2016 through December 2018 found that Medicare improperly paid acute-care hospitals $54.4 million for claims subject to the transfer policy.[1] Although the claims processing system edits appropriately detected inpatient claims subject to the transfer policy, the Medicare administrative contractors (MACs) did not receive automatic notifications of improperly billed claims or did not take action on those claims to adjust them. We recommended that the Centers for Medicare & Medicaid Services (CMS) recover the identified overpayments and ensure that the MACs were receiving the automatic notifications of improperly billed claims and were taking action to adjust them. CMS concurred with our recommendations and created an automatic process for adjusting claims to minimize manual intervention by the MACs.

Because compliance with the transfer policy has been an issue over a long period and our analysis showed a significant increase in overpayments after the period covered by our prior audit, we conducted this followup audit to evaluate whether Medicare properly paid acute-care hospitals' claims subject to the transfer policy for claims with dates of service from January 1, 2019, through December 31, 2022 (audit period). Prior OIG audits did not cover inpatient claims for Medicare enrollees who were transferred to hospice care because discharges to hospices were not subject to the transfer policy until October 1, 2018. This audit included inpatient claims for Medicare enrollees who were transferred to hospices.

OBJECTIVE

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

[1] *Medicare Improperly Paid Acute-Care Hospitals $54.4 Million for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy* (A-09-19-03007), Nov. 1, 2019.

BACKGROUND

Medicare Program

The Medicare program provides health insurance for people aged 65 and 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 people enrolled in Medicare after they are discharged from the hospital.

CMS administers Medicare and contracts with MACs in each Medicare jurisdiction to, among other things, process and pay Medicare Part A claims submitted for hospital services. For our audit period, seven MACs 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 enrollees (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 an enrollee'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 enrollee's stay.

Post-Acute-Care Transfer Policy and Types of Post-Acute-Care Settings

An acute-care hospital transfers an enrollee to a post-acute-care setting, such as an SNF, when the enrollee's acute condition is stabilized and the enrollee requires further treatment. Section 4407 of the Balanced Budget Act of 1997, P.L. No. 105-33, added subparagraph 1886(d)(5)(J) to the Act to establish the Medicare post-acute-care transfer policy, and CMS promulgated implementing regulations at 42 CFR sections 412.4(c), (d), and (f). The intent of this policy is to avoid providing an incentive for a hospital to transfer an enrollee to a post-acute-care setting early (before treatment of the enrollee's acute condition is stabilized) to minimize the hospital's costs while still receiving the full MS-DRG payment. CMS adjusts the payment to the hospital to approximate the reduced cost for an enrollee who was transferred to a post-acute-care setting. (See the box on the next page for descriptions of the post-acute-care settings covered by our audit.)

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

- The enrollee is admitted on the same day to an SNF.
- For discharges occurring on or after October 1, 2018, the enrollee is admitted on the same day to a hospice.
- The enrollee is admitted on the same day to a hospital or distinct-part hospital unit that is not reimbursed under the IPPS. These non-IPPS settings consist of IRFs, LTCHs, IPFs, cancer hospitals, and children's hospitals.[2]
- The enrollee receives home health services from an HHA, the services are related to the condition or diagnosis for which the enrollee received inpatient hospital services, and the services are provided within 3 days of the date that the enrollee was discharged from the hospital.

Post-Acute-Care Settings

Skilled Nursing Facility
An SNF is an institution primarily engaged in providing skilled nursing care and related services and rehabilitation services to residents.

Hospice
A hospice provides palliative care for pain relief and symptom management to terminally ill individuals with a medical prognosis of 6 months or less to live if the illness runs its normal course.

Inpatient Rehabilitation Facility
An IRF provides intensive rehabilitation services to patients who can tolerate 3 hours of such services per day.

Long-Term-Care Hospital
An LTCH is primarily engaged in providing inpatient services to patients with medically complex conditions and who have an average inpatient length of stay that is longer than 25 days.

Home Health Agency
An 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, an enrollee must be confined to the home.

Inpatient Psychiatric Facility
An IPF is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons.

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

Medicare makes the full MS-DRG payment to an acute-care hospital that discharges an inpatient to home or certain types of health care institutions, such as facilities that provide custodial care. In contrast, Medicare pays an acute-care hospital that transfers an enrollee to

[2] Federal regulations specifically exclude the following types of hospitals from the IPPS: psychiatric, rehabilitation, children's, long-term care, and cancer hospitals; hospitals outside of the 50 States, the District of Columbia, and Puerto Rico; and hospitals reimbursed under special arrangements (42 CFR § 412.23). Medicare pays: (1) LTCHs under a prospective payment system (PPS) specific to LTCHs, (2) IRFs under a PPS specific to IRFs, and (3) IPFs under a per diem PPS specific to IPFs (42 CFR §§ 412.404, 412.505, and 412.604). Cancer and children's hospitals are reimbursed on a reasonable cost basis (42 CFR § 136.30). Our audit included no inpatient claims for enrollees who were discharged to cancer and children's hospitals.

post-acute care a per diem rate for each day of the enrollee's stay in the hospital. The total per diem payment is intended to be payment in full to cover the inpatient costs of the enrollee's stay. The total per diem payment cannot exceed the full MS-DRG payment that would have been made if the enrollee 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 enrollee's length of stay in the hospital. Whether Medicare pays for a discharge or a transfer depends on the patient discharge status code that the hospital assigns (42 CFR § 412.4(f)).

CMS requires acute-care hospitals to include a patient discharge status code on all inpatient claims to identify an enrollee's status after being discharged from the hospital. When an enrollee is transferred to a setting subject to the transfer policy, the discharge status code used depends on the type of post-acute-care setting. For example, when an enrollee is transferred to an SNF, discharge status code 03 should be used.

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

Medicare Claims Processing Systems and Prepayment and Postpayment Edits

MACs 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 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 MAC to adjust the original inpatient claim.

In those cases in which the inpatient claim is rejected or canceled, the acute-care hospital may submit an adjusted inpatient claim with the appropriate patient discharge status code to receive a per diem payment.

Prior Office of Inspector General Audits

Prior OIG audits identified over $563 million in overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy for claims with dates of service from October 1998 through December 2018. 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. For claims with dates of service from January 2016 through December 2018, Medicare overpaid hospitals $54.4 million.[3]

As a result of these audits, CMS established edits to prevent or detect overpayments. In our prior audit of inpatient claims with transfers to post-acute-care settings (A-09-19-03007), covering January 2016 through December 2018, we found that although the edits appropriately detected inpatient claims subject to the transfer policy, MACs did not receive the postpayment edit's automatic notifications of improperly billed claims or did not take action on those claims to adjust them. We recommended that CMS ensure that the MACs were receiving the postpayment edit's automatic notifications of improperly billed claims and were taking action by adjusting the original inpatient claims to initiate recovery of the overpayments. CMS concurred with our recommendations and created an automatic process for adjusting claims to minimize manual intervention by the MACs.

Medicare Requirements for Providers To Identify and Return Overpayments

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of: (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[4]

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments

[3] These OIG reports were *Compliance With Medicare's Postacute Care Transfer Policy for Fiscal Year 2000* (A-04-02-07005), Apr. 21, 2003; *Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2003 Through 2005* (A-04-07-03035), Feb. 27, 2009*; Medicare Inappropriately Paid Hospitals' Inpatient Claims Subject to the Postacute Care Transfer Policy* (A-09-13-02036), May 28, 2014*;* and *Medicare Improperly Paid Acute-Care Hospitals $54.4 Million for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy* (A-09-19-03007), Nov. 1, 2019. For the last two reports, the audits were based on analysis of all claim data rather than on a statistical sample of claims. For a complete list of related OIG reports, see Appendix B.

[4] The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.[5]

HOW WE CONDUCTED THIS AUDIT

Our audit covered approximately $198 million in Medicare Part A payments for 12,133 inpatient claims with specified MS-DRGs in which enrollees were transferred to post-acute care settings 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 health care institutions that are not subject to the transfer policy, such as facilities that provide custodial care (code 04). Then we used enrollee information and service dates from those inpatient claims to identify services furnished in post-acute-care settings that began: (1) on the same date as the inpatient discharge (e.g., SNF claims, hospice 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 from our audit all inpatient claims: (1) with discharge status codes indicating discharges to home with home health services and discharges to SNFs, hospices, and non-IPPS facilities because these claims are paid at the per diem rates; (2) in which an enrollee was discharged to home to resume home health services;[6] (3) billed by acute-care hospitals in Maryland and by cancer hospitals because these hospitals are not paid under the IPPS; and (4) in which an enrollee left a hospital against medical advice but began receiving post-acute-care services after leaving the hospital.

We focused on the improper Medicare Part A payments. We did not use medical review to determine whether: (1) inpatient services billed on Part A claims were medically necessary or (2) home health services were related to the inpatient condition or diagnosis. We used CMS's Inpatient PPS 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.

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.

[5] 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

[6] Resumption of home health services occurs when an enrollee begins receiving those services before being admitted to an acute-care hospital and, after being discharged from the hospital, resumes home health care within 3 days.

Appendix A describes our audit scope and methodology.

FINDING

For our audit period, Medicare improperly paid acute-care hospitals' inpatient claims subject to the post-acute-care transfer policy. Specifically, none of the 12,133 inpatient claims should have been reimbursed the full MS-DRG payment. Rather, these claims should have been reimbursed the per diem payment. As a result, Medicare made $41.4 million in improper payments.[7] For these claims, 67 percent of the enrollees were transferred to SNFs, 20 percent were transferred to hospices, and 13 percent were transferred to other post-acute-care settings, such as IRFs and HHAs.

These improper payments were made because CMS's CWF postpayment edit was not effective in detecting inpatient claims subject to the transfer policy. However, by the end of the 4-year audit period, both the prepayment and postpayment edits were effective in significantly reducing improper payments. The following describes the changes in the effectiveness of the edits during our audit period:

- At the beginning of our audit period (from January through September 2019), CMS's CWF edits were generally working properly. Specifically, both the prepayment and postpayment edits detected inpatient claims subject to the transfer policy and prevented or recovered overpayments made to acute-care hospitals.

- In October and November 2019, the postpayment edit stopped working properly, and improper payments increased.

- From December 2019 through September 2020, improper payments decreased for inpatient claims subject to the transfer policy. CMS stated that it had made claims processing system updates that may have fixed the postpayment edit.

- In October 2020, CMS updated its claims processing system, and the postpayment edit stopped working properly again, resulting in an increase in improper payments through March 2022.

- In April 2022, CMS updated its claims processing system and fixed the postpayment edit, resulting in a significant decrease in improper payments through the end of our audit period (i.e., through December 2022).

[7] The total improper payment amount was $41,401,244.

FEDERAL REQUIREMENTS

For a Medicare enrollee 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,[8] (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,[9] and (4) for discharges occurring on or after October 1, 2018, hospice care provided by a hospice program.

CMS requires acute-care hospitals to include patient discharge status codes on all inpatient claims.[10] When an enrollee is transferred to a setting subject to the 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 an enrollee is transferred to an SNF, and code 06 should be used when an enrollee is transferred to home to receive home health services.[11]

The *Federal Register* emphasizes that a hospital is responsible for coding a bill on the basis of its discharge plan for an enrollee. 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.[12]

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

Medicare improperly paid acute-care hospitals for 12,133 inpatient claims subject to the transfer policy. These hospitals improperly billed these claims by using the incorrect patient discharge status codes. Specifically, they coded these claims as discharges to home (6,338 claims) or to certain types of health care institutions (5,795 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 $41.4 million. The total overpayment amount represented the difference between the amount of the full MS-DRG payments that were made and the

[8] 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)).

[9] 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).

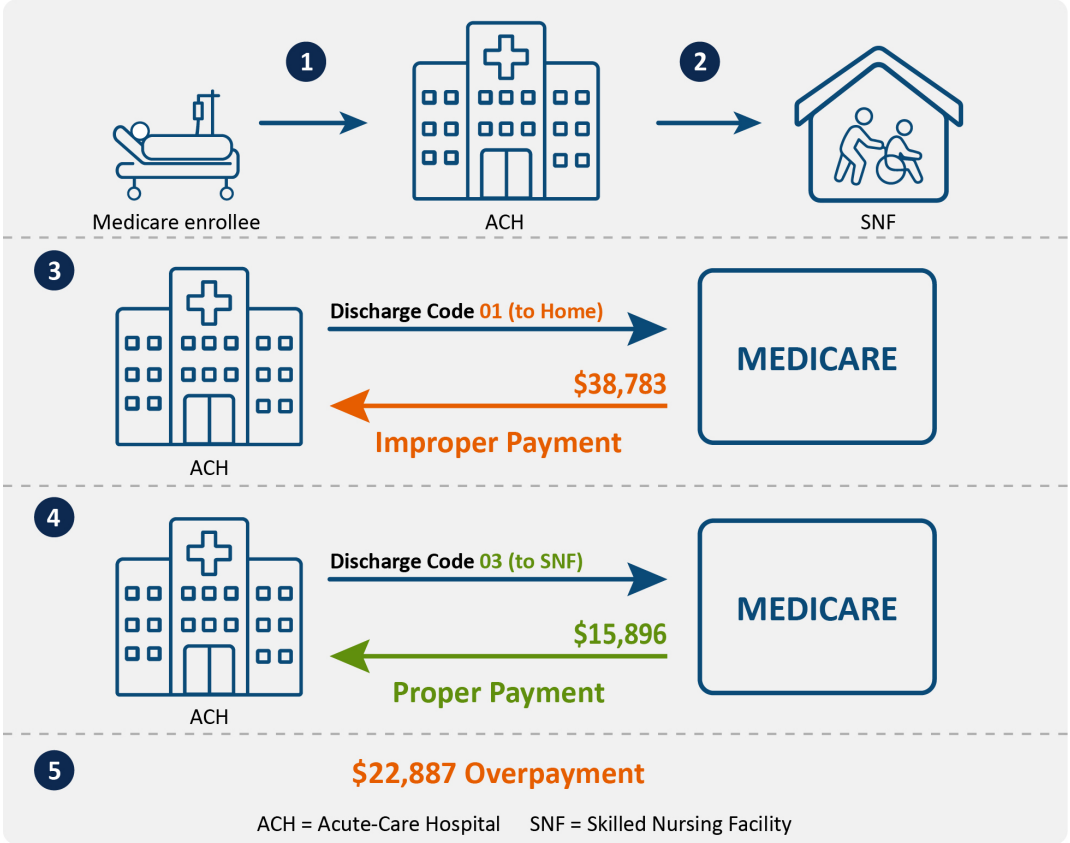
[10] *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 25, § 75.2.

[11] *Medicare Claims Processing Manual,* Pub. No. 100-04, chapter 3, § 40.2.4.

[12] 63 Fed. Reg. 40954, 40980 (July 31, 1998); 65 Fed. Reg. 47054, 47081 (Aug. 1, 2000).

amount that would have been paid if the per diem rates had been applied. Figure 1 shows an example of an overpayment to an acute-care hospital for an enrollee who was discharged from an acute-care hospital and obtained post-acute-care services from an SNF on the same day.

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



1. A Medicare enrollee was admitted to an ACH for inpatient services because of sepsis (a body's extreme response to an infection). While at the ACH, the enrollee received mechanical ventilation.
2. Four days later, the enrollee was discharged from the ACH to an SNF. On the day of discharge, the SNF began providing services to the enrollee.
3. 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 $38,783, the full MS-DRG payment, for the inpatient services.
4. If the ACH had properly billed Medicare for the Part A inpatient services with a discharge status code indicating discharge to an SNF (i.e., code 03), the ACH would have received a payment of only $15,896 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.)
5. As a result, Medicare overpaid the ACH $22,887 ($38,783 – $15,896).

Figure 2 shows the percentage of total inpatient claims that were subject to the transfer policy and the related overpayments, by the type of post-acute-care setting to which an enrollee was transferred. Specifically:

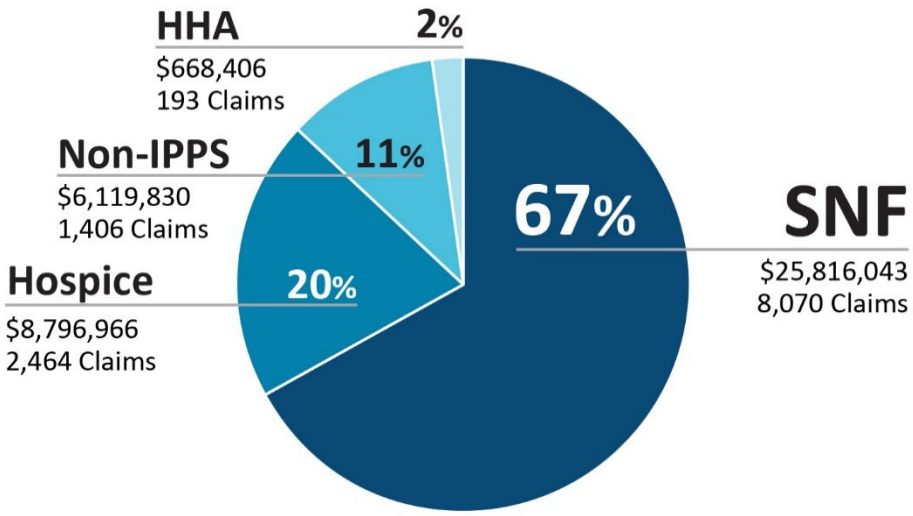
- For 67 percent of the inpatient claims, each enrollee began receiving services at an SNF on the same day that the enrollee was discharged from an acute-care hospital, resulting in overpayments of $25.8 million.

- For 20 percent of the inpatient claims, each enrollee began receiving hospice services on the same day that the enrollee was discharged from an acute-care hospital, resulting in overpayments of $8.8 million.

- For 11 percent of the inpatient claims, each enrollee began receiving services in a non-IPPS facility (such as an IRF) on the same day that the enrollee was discharged from an acute-care hospital, resulting in overpayments of $6.1 million.

- For the remaining 2 percent of inpatient claims, each enrollee began receiving home health services provided by an HHA within 3 days of the date of discharge from an acute-care hospital, resulting in overpayments of $668,406.

Figure 2: For 67 Percent of the Inpatient Claims, Each Enrollee Began Receiving Skilled Nursing Facility Services on the Same Day the Enrollee Was Discharged From an Acute-Care Hospital



CMS's Edits Were Effective in Significantly Reducing Overpayments by the End of Our Audit Period

Our prior audit A-09-19-03007 (which covered dates of service from January 2016 through December 2018) found that the CWF edits appropriately detected inpatient claims subject to the transfer policy, but the MACs did not receive the postpayment edit's automatic

notifications of improperly billed claims or did not take action on those claims by adjusting them. CMS fixed the CWF edits by creating an automatic process for adjusting claims to minimize interventions by the MACs.

During our audit period (from January 2019 through December 2022), improper payments were still being made because the CWF postpayment edit was not effective in detecting inpatient claims subject to the transfer policy. However, by the end of the 4-year audit period, both the prepayment and postpayment edits were effective in significantly reducing improper payments. The following describes the changes in the effectiveness of the edits during our audit period:

- At the beginning of our audit period (from January through September 2019), CMS's CWF edits were generally working properly. Specifically, both the prepayment and postpayment edits detected inpatient claims subject to the transfer policy and prevented or recovered overpayments made to acute-care hospitals.

- In October and November 2019, because of certain issues with the CWF system, the postpayment edit stopped working properly, and improper payments increased.

- From December 2019 through September 2020, improper payments decreased for inpatient claims subject to the transfer policy. CMS stated that it had made CWF system updates that may have fixed the postpayment edit.

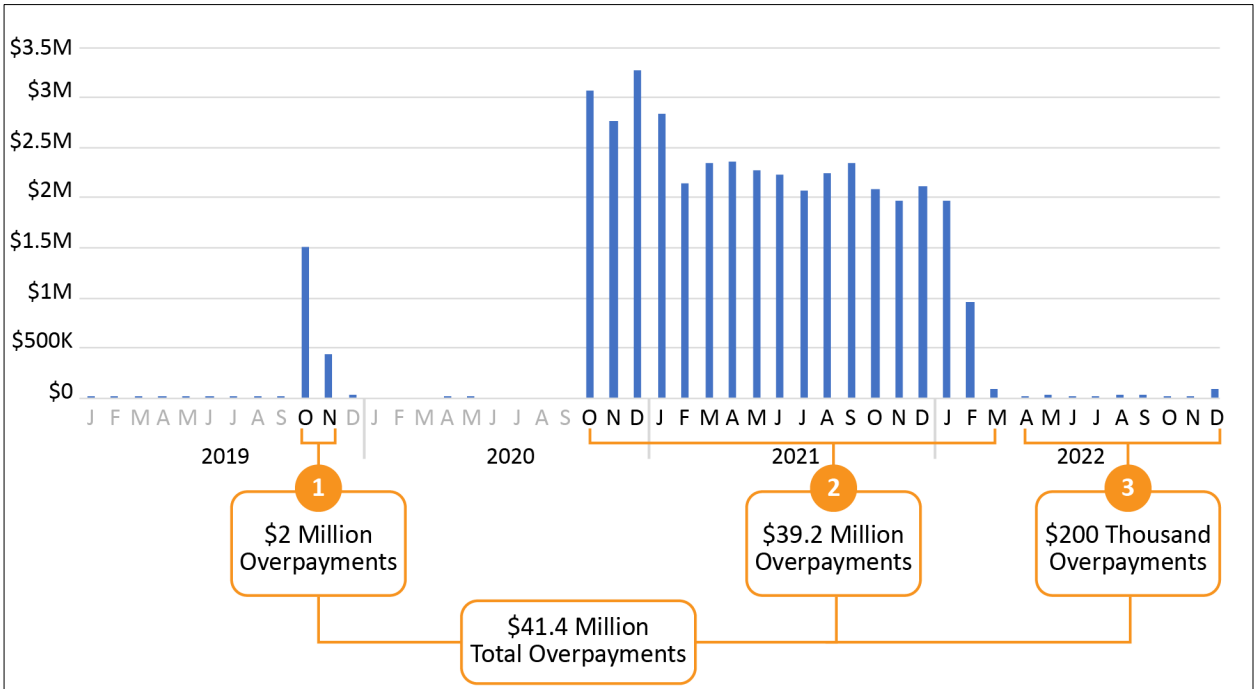
- In October 2020, CMS updated its claims processing system, and the postpayment edit stopped working properly again. Specifically, from October 2020 through March 2022, the postpayment edit stopped reading information on inpatient claims correctly (i.e., stopped reading MS-DRGs correctly), resulting in an increase in improper payments.

- In April 2022, CMS updated its claims processing system and fixed the postpayment edit. From April through December 2022 (the end of our audit period), the postpayment edit was effective in reducing improper payments.

Because CMS implemented system updates and edits, we are not making any procedural recommendations.

Figure 3 on the next page shows the change in overpayments for inpatient claims subject to the transfer policy during our audit period.

Figure 3: Change in Overpayments for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy From January 2019 through December 2022



1. In October and November 2019, the postpayment edit stopped working properly, and improper payments increased. During these 2 months, Medicare improperly paid acute-care hospitals approximately $2 million. From December 2019 through September 2020, improper payments decreased. CMS stated that system updates to the claims processing system may have fixed the edit.

2. In October 2020, CMS updated its claims processing system, and the postpayment edit stopped working properly again. Specifically, the postpayment edit stopped reading information on claims correctly, resulting in an increase in improper payments. From October 2020 through March 2022, Medicare improperly paid acute-care hospitals $39.2 million.

3. In April 2022, CMS updated its claims processing system again, which fixed the postpayment edit. Both the prepayment and postpayment edits were effective in reducing improper payments through the end of our audit period. From April through December 2022, Medicare improperly paid acute-care hospitals approximately $200,000.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct the MACs to recover from acute-care hospitals the portion of the $41,401,244 in identified overpayments for our audit period that are within the 4-year reopening period in accordance with CMS's policies and procedures, and

- instruct the MACs to, based on the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.

CMS COMMENTS

In written comments on our draft report, CMS concurred with both of our recommendations and provided information on actions that it planned to take to address our recommendations. Regarding our first recommendation, CMS stated that it will direct its MACs to recover the identified overpayments consistent with relevant law and the agency's policies and procedures. Regarding our second recommendation, CMS stated that it will: (1) analyze OIG's data to identify appropriate providers to notify of potential overpayments and (2) instruct the MACs to notify the identified providers of those potential overpayments and track any returned overpayments made in accordance with this recommendation.

CMS's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $197,504,348 in Medicare Part A payments for 12,133 inpatient claims with specified MS-DRGs in which enrollees were transferred to post-acute care settings and that had dates of service from January 1, 2019, through December 31, 2022.

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 health care institutions that are not subject to the transfer policy, such as facilities that provide custodial care (code 04). Then we used enrollee information and service dates from those inpatient claims to identify services furnished in post-acute-care settings that began: (1) on the same date as the inpatient discharge (e.g., SNF claims, hospice 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 from our audit all inpatient claims: (1) with discharge status codes indicating discharges to home with home health services and discharges to SNFs, hospice, and non-IPPS facilities because these claims are paid at per diem rates; (2) in which an enrollee was 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; and (4) in which an enrollee left a hospital against medical advice but began receiving post-acute-care services after leaving the hospital.

We focused on the improper Medicare Part A payments. We did not use medical review to determine whether: (1) inpatient services billed on Part A claims were medically necessary or (2) home health services were related to the inpatient condition or diagnosis.

We did not perform an overall assessment of the internal control structures 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 transfer policy. Specifically, we interviewed CMS officials and obtained written responses regarding their claims processing system and CWF edits. We also reviewed CMS's Change Requests for information on updates to the claims processing system and CWF edits and reviewed Medicare billing guidance, including related sections of the *Medicare Claims Processing Manual.*

Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file. We assessed the reliability of data obtained from CMS's Integrated Data Repository (IDR) by: (1) considering prior data reliability assessments of data from the IDR and (2) performing electronic testing on the data, such as testing for missing data. We determined that the data were sufficiently reliable for the purposes of this audit.

We conducted our audit from July 2022 to August 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- used CMS's NCH file to identify inpatient claims with specified MS-DRGs during our audit period for enrollees who received certain services in post-acute-care settings after inpatient stays;

- used computer matching, data mining, and data analysis techniques to identify for review 12,133 claims coded as discharges to home or certain types of health care institutions that are not subject to the 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 Inpatient PPS 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;[13]

- provided to CMS the complete list of improperly paid inpatient claims that we identified for our audit period; 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.

[13] CMS's Inpatient PPS Pricer is a tool 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

Report Title	Report Number	Date Issued
Inadequate Edits and Oversight Caused Medicare To Overpay More Than $267 Million for Hospital Inpatient Claims With Post-Acute-Care Transfers to Home Health Services	A-04-18-04067	08/05/2020
Medicare Improperly Paid Acute-Care Hospitals $54.4 Million for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy	A-09-19-03007	11/01/2019
Medicare Inappropriately Paid Hospitals' Inpatient Claims Subject to the Postacute Care Transfer Policy	A-09-13-02036	5/28/2014
Noridian Healthcare Solutions, LLC, Inappropriately Paid Hospitals' Medicare Claims Subject to the Postacute Care Transfer Policy in Jurisdiction 2	A-09-13-02035	11/26/2013
Palmetto GBA, LLC, Inappropriately Paid Hospitals' Medicare Claims Subject to the Postacute Care Transfer Policy in Jurisdiction 1	A-09-12-02038	5/29/2013
Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care	A-01-12-00507	5/28/2013
Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2003 Through 2005	A-04-07-03035	2/27/2009
Review of Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2001 and 2002	A-04-04-03000	4/11/2005
Compliance With Medicare's Postacute Care Transfer Policy for Fiscal Year 2000	A-04-02-07005	4/21/2003
Implementation of Medicare's Postacute Care Transfer Policy	A-04-00-01220	10/10/2001

APPENDIX C: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 29, 2023

TO: Amy J. Frontz
Deputy Inspector General for Audit Services
Office of Inspector General

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

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Acute-Care Hospitals for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy Over a 4-Year Period, but CMS's System Edits Were Effective in Reducing Improper Payments by the End of the Period (A-09-23-03016)

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.

CMS is pleased that OIG found that by the end of the audit period the claim processing system edits were effective in reducing improper payments for inpatient claims subject to the postacute care transfer policy. CMS has processes in place to maintain the complex claims processing systems, including identifying and resolving processing errors that may arise. As noted within the report, there were a series of changes and updates made during the audit period which ultimately resulted in the edits functioning as intended.

CMS appreciates OIG's work on this issue and looks forward to working with OIG on this and other issues in the future.

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

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the MACs to recover from acute-care hospitals the portion of the $41,401,244 in identified overpayments for our audit period that are within the 4-year reopening period 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.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services instruct the MACs to, based on the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.

CMS Response

CMS concurs with this recommendation. CMS will analyze OIG's data to identify appropriate providers to notify of potential overpayments. CMS will then instruct the Medicare Administrative Contractors to notify the identified providers of OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.