



May 19, 2010

**TO:** Marilyn Tavenner  
Acting Administrator and Chief Operating Officer  
Centers for Medicare & Medicaid Services

**FROM:** /Joseph E. Vengrin/  
Deputy Inspector General for Audit Services

**SUBJECT:** Nationwide Review of Medicare Part A Emergency Department Adjustments for  
Inpatient Psychiatric Facilities During Calendar Years 2006 and 2007  
(A-01-09-00504)

The attached final report provides the results of our nationwide review of Medicare Part A emergency department adjustments for inpatient psychiatric facilities during calendar years 2006 and 2007.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at [George.Reeb@oig.hhs.gov](mailto:George.Reeb@oig.hhs.gov). Please refer to report number A-01-09-00504 in all correspondence.

Attachment

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NATIONWIDE REVIEW OF  
MEDICARE PART A  
EMERGENCY DEPARTMENT  
ADJUSTMENTS FOR  
INPATIENT PSYCHIATRIC  
FACILITIES DURING  
CALENDAR YEARS  
2006 AND 2007**



Daniel R. Levinson  
Inspector General

May 2010  
A-01-09-00504

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## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Under the Medicare prospective payment system for inpatient psychiatric facilities (IPF), the Centers for Medicare & Medicaid Services (CMS) makes an additional payment to an IPF for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute-care section of a hospital to its hospital-based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the hospital receives for the beneficiary's immediately preceding inpatient stay.

CMS designated source-of-admission code D for a hospital-based IPF to enter on its Medicare claim form to indicate that the beneficiary was admitted from the acute-care section of the same hospital. This code is designed to ensure that the hospital-based IPF does not receive an additional payment for the costs of emergency department services that Medicare covers in its payment to the acute-care hospital.

CMS's Medicare contractors process and pay claims submitted by hospital-based IPFs.

### **OBJECTIVE**

Our objective was to determine whether hospital-based IPFs nationwide correctly coded the source of admission on claims for beneficiaries who had been admitted to the IPFs upon discharge from the acute-care section of the same hospital.

### **SUMMARY OF FINDINGS**

Hospital-based IPFs correctly coded the source of admission on 25 of the 100 sampled claims for beneficiaries who had been admitted to the IPFs upon discharge from the acute-care section of the same hospital. IPFs incorrectly coded the source of admission on the 75 remaining sampled claims, and thus Medicare contractors made \$3,111 in overpayments to the IPFs for emergency department services. Based on these sample results, we estimated that for calendar years 2006 and 2007, Medicare contractors made \$1.7 million in overpayments to hospital-based IPFs on behalf of beneficiaries who had been admitted to the IPFs upon discharge from the acute-care section of the same hospital. These overpayments occurred because the IPFs had inadequate controls to ensure that claims were coded correctly to prevent overpayments for emergency department services. In addition, Medicare payment controls in CMS's Common Working File were not adequate to prevent or detect these overpayments.

### **RECOMMENDATIONS**

We recommend that CMS:

- instruct its Medicare contractors to recover the \$3,111 in overpayments for the sampled claims;

- instruct its Medicare contractors to immediately reopen the 54,702 nonsampled claims, review our information on these claims (which have overpayments estimated at \$1.7 million), and recover any overpayments;
- instruct its Medicare contractors to emphasize to hospital-based IPFs the importance of using source-of-admission code D to identify beneficiaries who were discharged from the acute-care section of the same hospital;
- establish edits in the Common Working File to prevent and detect overpayments to IPFs that use incorrect source-of-admission codes on claims; and
- consider conducting periodic postpayment reviews of claims submitted after our review to identify any claims that were billed and paid with incorrect source-of-admission codes.

### **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In comments on our draft report, CMS concurred with our recommendations and described the corrective actions that it was taking or planned to take. CMS's comments are included in their entirety as Appendix C.

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## INTRODUCTION

### BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

#### **Prospective Payment System for Inpatient Psychiatric Facilities**

As mandated by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, P.L. No. 106-113, together with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 (MMA), CMS implemented a prospective payment system for inpatient psychiatric facilities (IPF).<sup>1</sup> The prospective payment system was effective for cost-reporting periods beginning on or after January 1, 2005. A prospective payment represents reimbursement in full for the inpatient operating and capital-related costs of furnishing Medicare-covered services in an IPF.

CMS's Medicare contractors process and pay Part A claims submitted by institutional providers, including IPFs.<sup>2</sup> Medicare contractors use the Fiscal Intermediary Shared System and the Common Working File for claim processing.

#### **Emergency Department Adjustment Policy**

Under the IPF prospective payment system, CMS makes an additional payment to an IPF for the first day of an inpatient psychiatric stay to account for emergency department costs. CMS makes this payment to every IPF that has a qualifying emergency department, regardless of whether the beneficiary was admitted through the emergency department. However, CMS does not make this payment if the beneficiary was discharged from an acute care hospital and admitted to the same hospital's psychiatric unit. In that case, the costs of emergency department services are covered by the Medicare payment that the hospital receives for the beneficiary's immediately preceding inpatient stay.

CMS designated source-of-admission code D for a hospital-based IPF to enter on its Medicare claim form to indicate that the beneficiary was admitted from the acute-care section of the same hospital.<sup>3</sup> This code is designed to ensure that the hospital-based IPF does not receive an

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<sup>1</sup> The prospective payment system applies to inpatient services of psychiatric hospitals and psychiatric units of acute-care hospitals and critical access hospitals. See the *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 3, § 190.2.

<sup>2</sup> The MMA amended certain sections of the Act to require that Medicare administrative contractors (MAC) replace fiscal intermediaries between October 2005 and October 2011. In this report, the term "Medicare contractors" refers to MACs or fiscal intermediaries, whichever is applicable.

<sup>3</sup> This code replaced source-of-admission code 4, which indicated "transfer from inpatient hospital" but did not indicate whether the beneficiary was admitted to the IPF from the same hospital or from a different hospital.

additional payment for the costs of emergency department services that Medicare covers in its payment to the acute-care hospital.

### **Prior Office of Inspector General Review**

In a prior review,<sup>4</sup> we found that a Medicare contractor had made overpayments to hospital-based IPFs as a result of incorrect coding on claims for beneficiaries who had been admitted to the IPF upon discharge from the acute-care section of the same hospital during calendar years (CY) 2005 and 2006. We recommended that the Medicare contractor recover the overpayments and educate hospital-based IPFs about the importance of reporting the correct source-of-admission code to identify beneficiaries who were discharged from the acute-care section of the same hospital. The Medicare contractor concurred with our recommendations.

### **OBJECTIVE, SCOPE, AND METHODOLOGY**

#### **Objective**

Our objective was to determine whether hospital-based IPFs nationwide correctly coded the source of admission on claims for beneficiaries who had been admitted to the IPFs upon discharge from the acute-care section of the same hospital.

#### **Scope**

Our review covered 54,802 Medicare Part A claims submitted by all 1,208 hospital-based IPFs for beneficiaries with discharge dates in CYs 2006 and 2007 who were admitted to the IPFs from the acute-care section of the same hospital. These claims were paid by all 12 Medicare contractors nationwide.

The objective of our audit did not require an understanding or assessment of the complete internal control structure of hospital-based IPFs or Medicare contractors. Therefore, we limited our review to obtaining an understanding of (1) hospital-based IPFs' procedures for submitting claims for beneficiaries who were admitted upon discharge from the acute-care section of the same hospital and (2) Medicare contractors' policies and procedures for paying such claims.

Our fieldwork consisted of contacting the 92 IPFs that submitted the 100 claims in our sample and 4 Medicare contractors from April through September 2009.

#### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance regarding hospital-based IPF billing and Medicare contractor payments for beneficiaries who had an immediately preceding stay in the acute-care section of the same hospital;

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<sup>4</sup> *Review of Mutual of Omaha's Medicare Part A Emergency Department Adjustments for Inpatient Psychiatric Facilities* (A-01-07-00519, issued July 2008).

- used nationwide hospital inpatient data from CMS’s National Claims History file to match discharges from a hospital’s acute-care section to admissions to the same hospital’s IPF<sup>5</sup> and identified all claims for beneficiaries who were admitted to IPFs upon discharge from the acute-care section of the same hospital;<sup>6</sup>
- excluded from our sampling frame all hospital-based IPF claims for CY 2006 that were included in our prior review;
- selected a random sample of 100 claims from the sampling frame of 54,802 claims (Appendix A);
- reviewed CMS’s Common Working File records for the 100 sampled claims to validate the results of our computer match, identify source-of-admission codes, and verify that the claims had not been canceled;
- used CMS’s PRICER program and Medicare contractors’ provider-specific information to reprice all sampled claims and to determine the payment error amounts for those that had been incorrectly coded;
- contacted representatives from the IPFs that submitted erroneous claims to confirm the overpayments and to determine the causes of miscoding;
- contacted four Medicare contractors to obtain an understanding of edits in the Common Working File to prevent and detect Medicare Part A overpayments to IPFs;
- estimated the total overpayments (Appendix B); and
- discussed the results of our review with CMS officials.

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

## **FINDINGS AND RECOMMENDATIONS**

Hospital-based IPFs correctly coded the source of admission on 25 of the 100 sampled claims for beneficiaries who had been admitted to the IPFs upon discharge from the acute-care section of the same hospital. IPFs incorrectly coded the source of admission on the 75 remaining sampled claims, and thus Medicare contractors made \$3,111 in overpayments to the IPFs for emergency department services. Based on these sample results, we estimated that for CYs 2006 and 2007,

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<sup>5</sup> The six-digit provider numbers for hospital-based IPFs and their corresponding acute-care hospitals are the same except for the third digit, e.g., 18S005 for the IPF and 180005 for the hospital.

<sup>6</sup> National Claims History files do not include source-of-admission codes.

Medicare contractors made \$1.7 million in overpayments to hospital-based IPFs on behalf of beneficiaries who had been admitted to the IPFs upon discharge from the acute-care section of the same hospital. These overpayments occurred because the IPFs had inadequate controls to ensure that claims were coded correctly to prevent overpayments for emergency department services. In addition, Medicare payment controls in CMS's Common Working File were not adequate to prevent or detect these overpayments.

## **PROGRAM REQUIREMENTS**

Pursuant to 42 CFR § 412.424(d)(1)(v), CMS adjusts the Federal per diem base rate upward for the first day of a Medicare beneficiary's IPF stay to account for the costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary used emergency department services. However, the IPF should not receive the additional payment if the beneficiary was discharged from the acute-care section of the same hospital. In that case, the costs of emergency department services are covered by the Medicare payment to the hospital for the immediately preceding acute-care stay.

CMS requires that an IPF enter a source-of-admission code on each claim. Before April 1, 2006, CMS relied on source-of-admission code 4, "transfer from inpatient hospital," to identify an IPF claim that should not receive an additional emergency department payment. Because this code did not indicate whether the beneficiary was admitted to the IPF from the same hospital or from a different hospital, Medicare made both underpayments and overpayments for claims using this code. In Change Request 3881, dated October 21, 2005, and effective April 1, 2006, CMS established the more specific source-of-admission code D to identify an IPF claim for a beneficiary who was admitted from the acute-care section of the same hospital. An IPF's proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

## **PAYMENTS BASED ON INCORRECT SOURCE-OF-ADMISSION CODES**

For 75 of the 100 sampled claims, Medicare contractors made improper payments to 69 hospital-based IPFs for claims that the IPFs had billed with incorrect source-of-admission codes. Because the IPFs did not use source-of-admission code D (or code 4, when applicable) on these claims, the Medicare contractors were not aware that the beneficiaries had been discharged directly from the same acute-care hospital and that the IPFs were therefore not entitled to emergency department adjustments. As a result, the IPFs incorrectly received additional payments for the costs of emergency department services covered by Medicare payments to the acute-care hospitals for the beneficiaries' immediately preceding stays. The resulting overpayments totaled \$3,111.

We estimated, based on our sample results, that Medicare contractors made \$1.7 million in overpayments for CYs 2006 and 2007 to hospital-based IPFs for emergency department adjustments on behalf of beneficiaries who had been admitted to the IPFs upon discharge from the acute-care section of the same hospital.

## **CAUSES OF OVERPAYMENTS**

### **Inadequate Controls at Inpatient Psychiatric Facilities**

The 69 hospital-based IPFs that received overpayments had not established the necessary controls to ensure that they used the correct source-of-admission code to prevent overpayments for emergency department services. Officials of these IPFs stated that their billing personnel had coded the source of admission incorrectly for one or more of the following reasons:

- At 31 IPFs, billing personnel were unaware that using an incorrect source-of-admission code could change the Medicare payment.
- At 23 IPFs, administrative personnel were not aware of CMS's Change Request 3881 containing instructions on the use of source-of-admission code D.
- At 10 IPFs, billing personnel made data entry errors because of staff turnover and the need for more training.
- At seven IPFs, some administrative personnel were aware of CMS's Change Request 3881 but had not communicated the information to billing personnel.
- At four IPFs, billing personnel mistakenly believed that source-of-admission code D should be used to bill outpatient claims rather than inpatient claims.

### **Inadequate Medicare Payment Controls**

Medicare payment controls were not adequate to prevent or detect overpayments to hospital-based IPFs that used incorrect source-of-admission codes on their claims. Specifically, the Common Working File had neither prepayment edits to prevent overpayments when the acute-care section of the same hospital submitted its claim first nor postpayment edits to detect overpayments when the hospital-based IPF submitted its claim first. Additionally, none of the four Medicare contractors that we contacted conducted periodic postpayment reviews to identify and recover any overpayments to hospital-based IPFs.

## **RECOMMENDATIONS**

We recommend that CMS:

- instruct its Medicare contractors to recover the \$3,111 in overpayments for the sampled claims;
- instruct its Medicare contractors to immediately reopen the 54,702 nonsampled claims, review our information on these claims (which have overpayments estimated at \$1.7 million), and recover any overpayments;

- instruct its Medicare contractors to emphasize to hospital-based IPFs the importance of using source-of-admission code D to identify beneficiaries who were discharged from the acute-care section of the same hospital;
- establish edits in the Common Working File to prevent and detect overpayments to IPFs that use incorrect source-of-admission codes on claims; and
- consider conducting periodic postpayment reviews of claims submitted after our review to identify any claims that were billed and paid with incorrect source-of-admission codes.

### **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In comments on our draft report, CMS concurred with our recommendations and described the corrective actions that it was taking or planned to take. CMS stated that it would recover the overpayments consistent with its policies and procedures and requested that we furnish the data necessary for it to review claims and recover the overpayments. CMS's comments are included in their entirety as Appendix C.

As requested, we provided the data necessary for CMS to initiate its review and recovery efforts.

# **APPENDIXES**

## **APPENDIX A: SAMPLE DESIGN AND METHODOLOGY**

### **POPULATION**

The population consisted of Medicare Part A claims submitted by hospital-based inpatient psychiatric facilities (IPF) for dates of discharge in calendar years (CY) 2006 and 2007 and paid by Medicare contractors for beneficiaries who were admitted to the IPFs upon discharge from the acute-care section of the same hospital.

### **SAMPLING FRAME**

The sampling frame was a database containing 54,802 paid claims that 1,208 hospital-based IPFs submitted for beneficiaries with discharge dates in CYs 2006 and 2007 who were admitted to the IPFs from the acute-care section of the same hospital.

### **SAMPLE UNIT**

The sample unit was an IPF paid claim.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

The sample size was 100 claims.

### **SOURCE OF RANDOM NUMBERS**

We used the Office of Inspector General, Office of Audit Services, statistical software to generate the random numbers.

### **METHOD OF SELECTING SAMPLED UNITS**

We consecutively numbered the sample units in the frame from 1 to 54,802. After generating 100 random numbers, we selected the corresponding sample units.

### **ESTIMATION METHODOLOGY**

We used the Office of Inspector General, Office of Audit Services, statistical software to estimate the overpayments.

## APPENDIX B: SAMPLE RESULTS AND ESTIMATES

### Sample Results

<b>Frame Size</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Miscoded Claims</b>	<b>Value of Overpayments</b>
54,802	100	\$781,345	75	\$3,111

### Estimated Value of Overpayments (Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$1,704,868
Lower limit	1,489,130
Upper limit	1,920,606



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Centers for Medicare &amp; Medicaid Services

*Administrator*  
Washington, DC 20201

APR 23 2010

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** *Marilyn Tavenner*  
Marilyn Tavenner  
Acting Administrator and Chief Operating Officer

**SUBJECT:** Office of Inspector General (OIG) Restricted Draft Report: Nationwide Review of Medicare Part A Emergency Department Adjustments for Inpatient Psychiatric Facilities During CY 2006 and 2007 (A-01-09-00504)

Thank you for the opportunity to review and comment on the OIG draft report, "Nationwide Review of Medicare Part A Emergency Department Adjustments for Inpatient Psychiatric Facilities During CY 2006 and 2007." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG has invested to determine the extent to which fiscal intermediaries, Medicare Administrative Contractors, and our claims processing systems properly adjudicated claims with source-of-admission code D.

The OIG found that hospital-based inpatient psychiatric facilities (IPFs) incorrectly coded the source of admission on 75 out of 100 sampled claims for beneficiaries who had been admitted to the IPFs upon discharge from the acute-care section of the same hospital. CMS recognizes more work needs to be done to ensure we consistently issue proper payments on emergency department adjustments. CMS also understands IPFs require more education regarding the proper use of source-of-admission code D. CMS will work towards educating inpatient psychiatric facilities and implementing new Common Working File edits in a future quarterly systems release.

#### **OIG Recommendation**

CMS instruct its Medicare contractors to recover the \$3,111 in overpayments for the sampled claims.

#### **CMS Response**

The CMS concurs that the \$3,111 in overpayments should be recovered. CMS plans to recover the overpayments identified consistent with the agency's policies and procedures.

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The CMS will request that the OIG furnish for each overpayment or potential overpayment the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor specific data should be written to separate cd-roms or separate hardcopy worksheets in order to better facilitate the transfer of information to the appropriate contractors.

#### **OIG Recommendation**

CMS instruct its Medicare contractors to immediately reopen the 54,702 nonsampled claims, review OIG's information on these claims (which have overpayments estimated at \$1.7 million), and recover any overpayments.

#### **CMS Response**

The CMS concurs. CMS will analyze a subset of the 54,702 nonsampled claims to determine the cost effectiveness of conducting review of all claims. CMS will also collect applicable overpayments identified during the claims review. CMS will share the results of the cost effectiveness study across fee-for-service claims processing contractors.

#### **OIG Recommendation**

CMS instruct its Medicare contractors to emphasize to hospital-based IPFs the importance of using source-of-admission code D to identify beneficiaries who were discharged from the acute-care section of the same hospital.

#### **CMS Response**

The CMS concurs. In the short term, we will develop a Special Edition MLN Matters article directed towards hospital-based IPFs emphasizing the use of source-of-admission code D according to billing guidelines and stressing the importance of how this code directly impacts payments to hospital-based IPFs. In addition, as part of Recommendation 4 below, we plan to issue instructions to our Medicare contractors as part of the CMS Quarterly System Release process to ensure IPFs properly use source-of-admission code D. We expect instructions to be implemented for the April 2011 quarterly system release.

#### **OIG Recommendation**

CMS establish edits in the Common Working File to prevent and detect overpayments to IPFs that use incorrect source of admission codes on claims.

#### **CMS Response**

The CMS concurs. CMS will establish edits in the Common Working File to prevent and detect overpayments to IPFs that use incorrect Source of Admission Codes on claims as part of our

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CMS Quarterly System Release. We expect instructions to be implemented for the April 2011 quarterly system release.

**OIG Recommendation**

CMS consider conducting periodic post payment reviews for claims submitted after OIG's review to identify any claims that were billed and paid with incorrect source-of-admission codes.

**CMS Response**

The CMS concurs. The Recovery Audit Contractors (RACs) review Medicare claims on a post payment basis and are tasked with identifying underpayments and overpayments. While CMS does not mandate areas for RAC review, we will share this information with them and encourage them to consider these findings as they decide what claims to review.