

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COULD SAVE MILLIONS BY
STRENGTHENING BILLING
REQUIREMENTS FOR CANCELED
ELECTIVE SURGERIES**

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**August 2013
A-01-12-00509**

Office of Inspector General

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EXECUTIVE SUMMARY

Over a 2-year period, Medicare Part A made an estimated \$38.2 million in prospective payments that were not reasonable and necessary for short-stay inpatient hospital claims involving canceled elective surgeries.

WHY WE DID THIS REVIEW

Medicare Part A provides, among other things, inpatient hospital insurance benefits and coverage of extended care services for beneficiaries after they are discharged from hospitals. In calendar years (CYs) 2009 and 2010, Medicare made Part A prospective payments to hospitals of \$597 million for inpatient claims that involved a canceled elective surgery. Almost \$55 million involved short-stay (2 days or fewer) claims. When an inpatient hospital admission is based on the expectation that a patient will have elective surgery but that surgery does not occur, that cancellation would generally make the admission not reasonable and necessary. Our reviews at several hospitals indicated that short-stay inpatient claims involving canceled elective surgeries often did not meet Medicare requirements for Part A prospective payments because the admissions were not reasonable and necessary. We, therefore, extended our review of Medicare payments for inpatient short-stay claims involving canceled elective surgeries to hospitals nationwide.

Our objective was to determine whether inpatient admissions related to short-stay hospital claims involving canceled elective surgeries were reasonable and necessary.

BACKGROUND

Medicare requires that certain elective surgeries be performed in an inpatient hospital setting. An elective surgery may be canceled because a patient did not comply with preoperative instructions, decided to postpone the surgery to consider other forms of treatment, or demonstrated medical characteristics that made the surgery inappropriate. In addition, a hospital may be unprepared to perform surgery because of a lack of an available operating room, staff scheduling conflicts, or malfunctioning equipment. A hospital may use a set of codes on an inpatient claim when it cancels surgery to explain the cancellation.

Every hospital that receives Medicare reimbursement must have a hospital utilization review committee; one of its purposes is to determine whether an inpatient admission meets the hospital's criteria for admissions. If it does not, the hospital may change the beneficiary's status (using condition code 44 on its Medicare claim) from inpatient to outpatient and submit an outpatient claim for the medically necessary Medicare Part B services that the hospital provided, but it may do so only if certain conditions are met. These conditions include (1) the change in beneficiary status from inpatient to outpatient was made before discharge or release, and (2) both the physician responsible for the care of the beneficiary and the utilization review committee concur with the decision.

WHAT WE FOUND

Most inpatient admissions related to short-stay hospital claims involving canceled elective surgeries were not reasonable and necessary. For 80 of the 100 claims in our sample, Medicare made payments totaling \$345,717 for hospital inpatient claims involving canceled elective surgeries when a clinical condition did not exist on admission or a new condition did not emerge after admission that required inpatient care. Therefore, these inpatient claims did not satisfy Medicare's requirements that the admissions be reasonable and necessary. For the remaining 20 claims in our sample, payments met Federal requirements because a clinical condition existed or a new condition emerged that required inpatient medical care.

On the basis of our sample results, we estimated that Medicare made \$38.2 million in Part A inpatient hospital payments in CYs 2009 and 2010 for short-stay, canceled elective surgery admissions that were not reasonable and necessary. Hospitals may bill Medicare Part B for services related to the incorrectly billed Medicare Part A admissions. We were unable to determine the effect that billing Medicare Part B had on the total overpayment amount because these services had not been billed or adjudicated before the end of our fieldwork. Any rebilling would reduce our \$38.2 million estimate.

These payments occurred because (1) the hospitals were unclear about the Medicare requirements for billing canceled inpatient surgeries; (2) the Centers for Medicare & Medicaid Services (CMS) billing requirements are too restrictive, particularly with regard to changing a beneficiary's status from inpatient to outpatient after discharge; and (3) hospitals did not always have adequate utilization review controls to confirm whether admissions were reasonable and necessary after elective surgeries had been canceled.

WHAT WE RECOMMEND

We recommend that CMS:

- adjust the 80 sampled claims representing overpayments of \$345,717 to the extent allowed under the law;
- strengthen guidance to better explain the Medicare rule that a clinical condition requiring inpatient care must exist for hospitals to bill for Part A prospective payments for elective surgeries that were canceled, which could result in savings totaling \$38.2 million over a 2-year period (but hospital Part B rebilling would reduce this estimate);
- work with the Office of the Inspector General to resolve the remaining 10,915 nonsampled claims and recover overpayments to the extent feasible and allowed under the law; and
- instruct Medicare administrative contractors to emphasize to hospitals the need for stronger utilization review controls for claims that include admissions for elective surgeries that did not occur.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS generally agreed with our recommendations.

With regard to our estimated savings of \$38.2 million over a 2-year period, CMS suggested revisions that would forestall misunderstandings. With regard to our last recommendation, CMS stated that it does not concur with the recommendation precisely but has taken action to address our concern.

OFFICE OF INSPECTOR GENERAL RESPONSE

CMS's proposed actions are consistent with our recommendations. We have revised our second recommendation to make it clear that the estimated savings would be reduced if hospitals are allowed to rebill under Part B.

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INTRODUCTION

WHY WE DID THIS REVIEW

In calendar years (CYs) 2009 and 2010, Medicare made Part A prospective payments to hospitals of \$597 million for inpatient claims that involved a canceled elective surgery. Almost \$55 million involved short-stay (2 days or fewer) claims. When an inpatient hospital admission is based on the expectation that a patient will have elective surgery but that surgery does not occur, the hospital may bill for the admission only if it remains reasonable and necessary despite the surgery's cancellation. Our reviews at several hospitals¹ indicated that short-stay inpatient claims involving canceled elective surgeries often did not meet Medicare requirements for Part A prospective payments because the admissions were not reasonable and necessary. We, therefore, extended our review of Medicare payments for inpatient short-stay claims involving canceled elective surgeries to hospitals nationwide.

OBJECTIVE

Our objective was to determine whether inpatient admissions related to short-stay hospital claims involving canceled elective surgeries were reasonable and necessary.

BACKGROUND

The Medicare Program

Medicare Part A provides, among other things, inpatient hospital insurance benefits and coverage of extended care services for beneficiaries after they are discharged from hospitals. Medicare Part B helps pay for physician services, outpatient care, and other medical services that Part A does not cover, such as certain services offered by physical and occupational therapists. The Centers for Medicare & Medicaid Services (CMS) administers Medicare.

Medicare will not pay for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (the Social Security Act (the Act) § 1862(a)(1)(A)).

CMS contracts with Medicare administrative contractors (MACs) so they, among other things, process and pay claims submitted by hospitals.

¹ We identified this issue at selected hospitals during our Medicare compliance reviews. The objectives of these reviews were to determine whether hospitals complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays for acute-care hospital (hospital) admissions at predetermined rates. The rates vary according to the diagnosis-related group (DRG) assigned by CMS to the inpatient claim. The prospective payment generally provides full payment to hospitals for all inpatient services associated with a particular diagnosis and any procedures performed.

CMS's claims processing system assigns a DRG to a hospital's claim primarily on the basis of the diagnosis and procedure codes that the hospital puts on the claim. DRGs were developed to reimburse hospitals appropriately for the resources they use. CMS has selected the coding set in the *International Classification of Disease, 9th Edition, Clinical Modification* (ICD-9-CM) as its approved coding set for reporting diagnoses and inpatient procedures.

Canceled Inpatient Elective Surgeries

Medicare requires certain procedures, including certain elective surgeries, to be performed in the inpatient hospital setting (*Medicare Claims Processing Manual*, chapter 4, section 180.7). Elective surgeries may be canceled because a patient did not comply with preoperative instructions, decided to postpone the surgery to consider other forms of treatment, or demonstrated medical characteristics that made the surgery inappropriate. In addition, a hospital may be unprepared to perform surgery because of a lack of an available operating room, staff scheduling conflicts, or malfunctioning equipment. The ICD-9-CM defines a set of "V-codes" that a hospital may use on an inpatient claim when it cancels a procedure that explains the reason for the cancellation. The three V-codes are: (1) V64.1, a surgical or other procedure not carried out because of a contraindication; (2) V64.2, a surgical or other procedure not carried out because of a patient's decision; and (3) V64.3, a procedure not carried out for other reasons. Including a V-code on a claim does not affect payment because the prospective payment is determined by the claim's surgical procedure code.

Utilization Review

Federal regulations require hospitals to have a utilization review plan that provides for review of services that each hospital furnishes to Medicare beneficiaries (42 CFR § 482.30). Hospitals may conduct reviews of admissions on a sample basis and may perform the reviews before, during, or after the admission. Using utilization review, hospitals may change a beneficiary's admission status from inpatient to outpatient if the hospital meets certain conditions.

Although a physician provides the order for an inpatient admission, the hospital's utilization review committee must determine whether the admission or continued stay is medically necessary. Utilization review committees also must consult the practitioners responsible for the care of the beneficiaries and give the practitioners the opportunity to present their views (42 CFR § 482.30). Therefore, a physician cannot unilaterally change a beneficiary's admission status once the hospital has admitted the beneficiary. If a hospital's utilization review committee determines that an inpatient admission does not meet its admission criteria, the hospital may

change the beneficiary's status from inpatient to outpatient and submit an outpatient claim to Part B.

HOW WE CONDUCTED THIS REVIEW

In CYs 2009 and 2010, Medicare made Part A payments to hospitals totaling \$597 million for inpatient stay claims with canceled procedure V-codes.² We sampled 100 of 11,015 Part A claims that had diagnosis codes V64.1, V64.2, or V64.3 with hospital stays of 2 days or fewer and without hospital charges assigned to revenue centers that represent emergency rooms, operating rooms, or cardiac catheterization laboratories.³ Because these claims generally showed few services being provided, we considered the admissions associated with these claims to be at high risk for payments that were not reasonable and necessary. The 11,015 claims in our population related to payments totaling \$54,898,955 in CYs 2009 and 2010.

As part of our review, we sent a detailed questionnaire regarding billing practices for canceled elective surgeries to the 86 hospitals that billed the 100 claims in our sample. We used the hospitals' responses, along with medical and billing records, to help us determine whether the inpatient admissions were reasonable and necessary. We also contacted 10 MACs to gain an understanding of the guidance provided to hospitals for billing canceled elective surgeries. At our request, one of these MACs also conducted an independent medical review on a subset of the sampled claims.⁴

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

Appendix A has the details of our audit scope and methodology, and Appendix B has the details of our sample design and methodology.

FINDINGS

Most inpatient admissions related to short-stay hospital claims involving canceled elective surgeries were not reasonable and necessary. For 80 of the 100 claims in our sample, Medicare made payments totaling \$345,717 for hospital inpatient claims involving canceled elective surgeries when the condition of the patient was not severe enough to warrant an inpatient admission (i.e., a clinical condition did not exist on admission or a new condition did not emerge after admission that required inpatient care). Therefore, these inpatient claims did not satisfy Medicare's requirements that the admissions be reasonable and necessary. For the remaining 20

² We did not quantify additional Part A payments to hospitals for stays with canceled surgeries that hospitals billed as inpatient claims without using V-codes.

³ Claims listing these revenue centers are more likely to contain emergency procedures than elective procedures and more likely to meet inpatient criteria.

⁴ We did not tell the MAC of our determinations beforehand.

claims in our sample, payments met Federal requirements because a clinical condition existed or a new condition emerged that required inpatient medical care.

On the basis of our sample results, we estimated that Medicare made \$38.2 million in Part A inpatient hospital payments in CYs 2009 and 2010 for short-stay, canceled elective surgery admissions that were not reasonable and necessary. Hospitals may bill Part B for some services related to the incorrectly billed Part A admissions. We were unable to determine the effect that billing Part B had on the total overpayment amount because these services had not been billed or adjudicated before the end of our fieldwork. Any rebilling would reduce our \$38.2 million estimate.

These payments occurred because (1) the hospitals were unclear about the Medicare requirements for billing canceled inpatient surgeries; (2) the CMS billing requirements are too restrictive, particularly with regard to changing a beneficiary's status from inpatient to outpatient after discharge; and (3) hospitals did not always have adequate utilization review controls to confirm whether admissions were reasonable and necessary after elective surgeries had been canceled.

FEDERAL REQUIREMENTS

Medical Necessity Requirements

Medicare must not make payments under Part A or Part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (the Act § 1862(a)(1)(A)).

According to the *Medicare Benefit Policy Manual*, the decision to admit a patient is a complex medical judgment, "which can be made only after the physician has considered a number of factors" (chapter 1, section 10). These factors include the severity of the patient's signs and symptoms, the medical predictability of something adverse happening to the patient, and the patient's need for diagnostic studies that are appropriately outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted.

The *Medicare Program Integrity Manual* advises reviewers of inpatient claims for medical necessity that

...the beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting [chapter 6, section 6.5.2].

Hospital Billing Options When an Inpatient Admission Is Not Medically Necessary

The *Medicare Claims Processing Manual* states that in cases in which a hospital's utilization review committee determines that an inpatient admission does not meet the hospital's criteria defining an appropriate inpatient admission, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (using condition code 44) for medically necessary Part B services that were furnished to the beneficiary if certain conditions are met (chapter 1, section 50.3). These conditions include (1) the change in beneficiary status from inpatient to outpatient was made before discharge or release, and (2) both the physician responsible for the care of the beneficiary and the utilization review committee concur with the decision.

If these conditions are not met or if the MAC has denied the claim for an inpatient admission, hospitals may bill and be paid under Part B only for some services related to the incorrectly billed Part A admission.

PAYMENTS FOR CLAIMS WITH CANCELED SURGERIES OFTEN DID NOT MEET REQUIREMENTS

For 80 of the 100 claims in our sample, Medicare made Part A payments totaling \$345,717 for hospital inpatient claims involving canceled elective surgeries in which a clinical condition did not exist on admission or a new condition did not emerge after admission that required inpatient care. Therefore, these inpatient claims did not satisfy Medicare's requirements that the services must be reasonable and necessary.⁵

Surgeries Canceled Because Patients Were Not Ready

For 71 claims in our sample, hospitals canceled surgeries because admitted beneficiaries were not ready for their surgeries on the basis of preoperative examinations that disclosed, for example, abnormal test results, a medical condition that made the surgery inappropriate, or anxiety. Because the inpatient admissions would not have been medically necessary if the preoperative examinations had occurred before the admissions, they were not medically necessary after the admissions occurred.

⁵ The MAC's independent medical review of a subset of the sampled claims supported our determinations.

Example 1: Surgery Canceled Because of the Results of Preoperative Examination

The beneficiary was scheduled for an elective hip replacement surgery. The preoperative examination showed that the beneficiary had developed a urinary tract infection. The physician canceled the hip replacement and discharged the beneficiary later that morning. The hospital billed Part A for an inpatient admission, and Medicare paid \$2,600. Part A also paid the hospital \$9,400 for the beneficiary's subsequent stay that included the rescheduled hip replacement. Hospital officials admitted to us that the initial admission was in error.

Surgeries Canceled Because Hospitals Were Not Ready

For nine claims in our sample, hospitals canceled surgeries because they were unprepared, including cancellations because of equipment failure, operating room unavailability, or staff scheduling conflicts. For these claims, the hospitals' lack of preparedness did not justify billing inpatient claims and the resultant Part A payments.

Example 2: Surgery Canceled Because a Hospital Was Unprepared

The beneficiary was scheduled for an elective knee replacement surgery. The hospital canceled the surgery because of an equipment failure and discharged the beneficiary on the same day. The hospital billed Part A for an inpatient admission, and Medicare paid \$2,900. Part A also paid the hospital \$19,900 for the beneficiary's subsequent stay that included the rescheduled knee replacement.

Surgeries That Met Federal Requirements

For the remaining 20 claims in our sample, payments met Federal requirements because a clinical condition existed on admission or a new condition emerged after admission that required inpatient medical care. In one case, a beneficiary came to the hospital for an elective removal of a basal cell carcinoma that the hospital expected to perform as an outpatient surgery. After the beneficiary was anesthetized, the beneficiary developed a new cardiac condition, the symptoms and treatment of which warranted an inpatient admission.

CAUSES OF INCORRECT PAYMENTS

Hospitals Unclear About Medicare Requirements

Most hospitals responding to our questionnaire were unclear about Medicare requirements for billing Part A prospective payments for canceled elective surgeries. Some hospitals stated that if they had valid physician admission orders and had used ICD-9-CM V-codes to indicate that the elective surgery had been canceled, they could appropriately bill Part A payments.

Although regulations clearly state that Medicare will not pay for items or services that are not reasonable and necessary, Medicare manuals did not specifically address the billing for claims in which the reason for the inpatient admission was an elective surgery that did not occur. In the absence of specific national directives, MACs have been applying their own interpretations for billing claims in which the reason for the inpatient admission was an elective surgery that did not occur. As a result, hospitals nationwide have billed the same types of claims differently.

Medicare Requirements May Be Too Restrictive

Current Medicare inpatient hospital billing requirements may be too restrictive. Specifically, physicians responsible for the care of a beneficiary cannot unilaterally change an admission decision after an admission for an elective surgery that has been canceled—even if the physician determined that the stay was no longer medically necessary. To change a physician’s admission order, the hospital’s utilization review committee must determine that the inpatient admission was not reasonable and necessary before the beneficiary’s discharge. Further, the utilization review committee must also consult the beneficiary’s physician and give him or her the opportunity to present his or her views. For short-stay admissions, hospitals were often unable to complete a timely utilization review and change the beneficiary’s status from inpatient to outpatient before discharge in accordance with condition code 44 requirements. Further, if the utilization review committee determined that the inpatient admission was not reasonable and necessary after the beneficiary had been discharged, the hospital could bill an inpatient claim only for certain Part B ancillary services.⁶ As a result, some hospitals billed an inpatient claim solely on the basis of the physician’s admission order and received an unwarranted Part A payment.

Inadequate Hospital Utilization Review Controls

Many hospitals had not established utilization review controls to confirm whether inpatient admissions remained reasonable and necessary after an elective surgery was canceled. According to hospital officials, these hospitals did not perform concurrent utilization reviews because of the short stays (in some cases, only a few hours), and the hospitals did not perform utilization review after discharges because the opportunity to change the beneficiary’s status from inpatient to outpatient was not available.

ESTIMATE OF INCORRECT PAYMENTS FOR CANCELED ELECTIVE SURGERIES

On the basis of our sample results, we estimated that Medicare made \$38.2 million in Part A payments in CYs 2009 and 2010 for short-stay hospital inpatient claims involving canceled

⁶ After our fieldwork, CMS published a Ruling and a Proposed Rule allowing hospitals to bill under Part B, if the Part A admission had been denied as being not reasonable or necessary, for all Part B services that would have been payable if the hospital had originally treated the beneficiary as a hospital outpatient. Accordingly, we are not making a recommendation to address this cause.

elective surgeries that were not reasonable and necessary.⁷ Hospitals may bill Part B for services related to the incorrect Part A claims. We were unable to determine the effect that billing Part B would have had on the total overpayment amount because these services had not been billed or adjudicated before the end of our fieldwork. Any rebilling would reduce our \$38.2 million estimate.

CONCLUSIONS

When a hospital admits a patient with the expectation that it will perform an elective surgery that does not occur, the cancellation often negates the need for the admission. Because CMS had not issued specific guidance for billing claims for canceled surgeries, MACs and hospitals have been interpreting and applying general guidance, which has led to conflicting interpretations, inconsistent billing practices, and potential noncompliance with Medicare requirements.

Additionally, Medicare regulations did not allow physicians to change their admission decisions unilaterally after elective surgeries were canceled, even if the physicians determined that the admissions were no longer medically necessary. This, and the Medicare regulations that made it difficult for hospitals to bill services for these canceled elective surgeries as Part B outpatient services, encouraged unwarranted Part A payments.

Finally, hospital utilization review procedures were generally inadequate to determine whether an admission remained necessary after an elective surgery was canceled. The short timeframe before a beneficiary was discharged, the Medicare requirements to change a beneficiary's status from inpatient to outpatient, and the impossibility of changing a beneficiary's status after he or she had been discharged all contributed to the inadequacy of hospital utilization review in our sample.

RECOMMENDATIONS

We recommend that the CMS:

- adjust the 80 sampled claims representing overpayments of \$345,717 to the extent allowed under the law;
- strengthen guidance to better explain the Medicare rule that a clinical condition requiring inpatient care must exist for hospitals to bill for Part A prospective payments for elective surgeries that were canceled, which could result in savings totaling \$38.2 million over a 2-year period (but hospital Part B rebilling would reduce this estimate);

⁷ We identified claims for canceled elective surgeries using V-codes, and our estimate represents payments to hospitals for inpatient stays of 2 days or fewer, which was less than 10 percent of the inpatient claims that hospitals billed during our review period. Therefore, our estimate may be understated because it does not include claims that did not include V-codes or claims for stays of longer than 2 days.

- work with the Office of the Inspector General to resolve the remaining 10,915 nonsampled claims and recover overpayments to the extent feasible and allowed under the law; and
- instruct MACs to emphasize to hospitals the need for stronger utilization review controls for claims that include admissions for elective surgeries that did not occur.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS generally agreed with our recommendations.

CMS stated that it partially concurred with our recommendation that it adjust the 80 sampled claims representing overpayments of \$345,717 to the extent allowed under the law. CMS explained that only 53 of these claims, with overpayments valued at approximately \$229,375, remain eligible for reopening and adjustment.

CMS stated that it has taken action on our recommendation to strengthen its guidance by issuing an IPPS proposed rule for FY 2014, which proposes that a physician or other practitioner should order an inpatient hospital admission if he or she expects that the beneficiary's length of stay will exceed 2 Medicare utilization days (defined as encounters that span past midnight) or if the beneficiary requires a procedure specified as inpatient only. While the proposed rule does not specifically mention canceled inpatient procedures, CMS stated that it "can address this circumstance in its responses to comments in the final rule." CMS stated that it has also proposed new medical review criteria for inpatient admissions, under which there would be a presumption that physician-ordered inpatient admissions are reasonable and necessary for beneficiaries who spend more than one Medicare utilization day in the hospital after admission. With regard to our estimated savings of \$38.2 million over a 2-year period, CMS suggested that we present an annual rather than a 2-year figure "to avoid the misunderstanding that this amount of savings could be recovered annually." CMS also suggested that we "specifically acknowledge in the recommendation that paying claims under Part B would reduce this estimate."

CMS stated that it does not concur with our recommendation precisely that it instruct MACs to emphasize to hospitals the need for stronger utilization review controls for claims that include admissions for elective surgeries that did not occur. However, CMS stated that it has taken action to address our concern.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

CMS's proposed action is consistent with our recommendation that it adjust the 80 sampled claims representing overpayments of \$345,717 to the extent allowed under the law.

We are unable to present an annual rather than a 2-year amount of estimated savings because our population and sampling frame consisted of certain types of Medicare-paid inpatient claims for CYs 2009 and 2010 and our sample design did not stratify by CY. However, we have revised

our second recommendation to reflect the fact that the estimated savings would be reduced if hospitals are allowed to rebill under Part B.

With regard to our fourth recommendation, we agree with CMS that its proposed rule, if finalized, would reduce the financial penalties associated with an incorrect inpatient admission decision. Such action would be consistent with our recommendation.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

In CYs 2009 and 2010, Medicare made Part A payments to hospitals totaling \$597 million for claims with a canceled procedure V-code. We limited our review to Part A payments to hospitals for stays of 2 days or fewer that were billed with diagnosis codes V64.1, V64.2, or V64.3 and without hospital charges assigned to revenue centers that represent emergency rooms, operating rooms, or cardiac catheterization laboratories. We considered these claims to be at high risk for payments that were not reasonable and necessary. Accordingly, our review covered 11,015 claims with payments totaling \$54,898,955 in CYs 2009 and 2010.

Our objective did not require an understanding or assessment of the complete internal control structure of hospitals, CMS, or MACs. Therefore, we limited our review at hospitals to the controls related to submitting inpatient claims that involved canceled elective surgeries. We limited our review at CMS and MACs to the guidance provided to hospitals for billing claims in which the reason for the admission was an elective surgery that was canceled.

Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History file, but we did not assess the completeness of the file.

Our fieldwork consisted of contacting hospitals nationwide and visiting five hospitals in Massachusetts, Connecticut, and Vermont. We conducted our fieldwork from May through August 2012.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- extracted 11,015 Medicare-paid hospital claims with an ICD-9-CM code indicating a canceled surgery from CMS's National Claims History file for CYs 2009 and 2010;
- selected a stratified random sample of 100 claims from the 11,015 inpatient claims with canceled surgeries (Appendix B);
- reviewed data from CMS's Common Working File for the 100 sampled claims to validate claim information extracted from the National Claims History file and determine whether any of the selected claims had been canceled;
- sent detailed internal control questionnaires and requests for medical and billing records to, and received responses from, the 86 hospitals that billed the 100 sampled claims;

- reviewed the questionnaire responses and medical and billing records to determine the circumstances that resulted in the canceled surgeries and, if necessary, contacted hospital officials to discuss their responses;
- obtained the services of a MAC to confirm the accuracy of our determinations by conducting an independent medical review on a subset of the sampled claims;
- reviewed the guidance that each of 10 MACs provided to hospitals for billing claims in which the reason for the admission was the elective surgery that was canceled;
- estimated the total value of Part A payments made to hospitals for inpatient stays in which the reason for the admission was the elective surgery that was subsequently canceled and in which the beneficiaries exhibited no severe symptoms or received no intensive services (Appendix C); and
- discussed the results of our review with CMS.

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: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of nationwide Medicare-paid inpatient claims for CYs 2009 and 2010 billed with ICD-9-CM diagnosis codes indicating that a procedure was canceled during the inpatient stay (V64.1, V64.2, and V64.3).

SAMPLING FRAME

The sampling frame consisted of 11,015 inpatient hospital claims with a total claim paid amount of \$54,898,955. We excluded claims with a length of stay longer than 2 days or with any covered charges assigned to revenue centers which represent emergency rooms (045X), operating rooms (036X), or cardiac catheterization laboratories (0481).

SAMPLE UNIT

The sample unit was an inpatient acute hospital claim.

SAMPLE DESIGN

Our sample design was a stratified random sample with the following two strata:

- claims for which we were able to identify, for the same beneficiary, a subsequent inpatient stay at the same provider within 30 days of the date of discharge on the claim with the canceled surgery; and
- claims for which we could not identify such a readmission.

SAMPLE SIZE

The sample consisted of 100 claims, with 35 in the stratum with identified readmissions and 65 in the stratum without identified readmissions.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum. After generating 35 random numbers for Stratum 1 and 65 for Stratum 2, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG OAS statistical software to estimate the dollar value of overpayments.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Claims Not Reasonable and Necessary	Value of Claims Not Reasonable and Necessary
1	4,093	\$19,479,111	35	\$147,825	33	\$136,018
2	6,922	35,419,844	65	299,932	47	209,699
Total	11,015	\$54,898,955	100	\$447,757	80	\$345,717

**Estimate of Claims Not Reasonable and Necessary
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$38,237,651
Lower limit	32,905,059
Upper limit	43,570,244



APPENDIX D: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

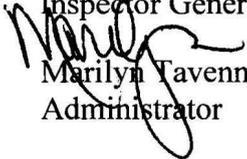
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 12 2013

TO: Daniel R. Levinson
Inspector General

FROM: 
Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Could Save Millions by Strengthening Billing Requirements for Canceled Elective Surgeries (A-01-12-00509)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above subject OIG draft report. The objective of this study is to determine whether inpatient admissions related to short-stay hospital claims involving canceled elective surgeries were reasonable and necessary. OIG found that most of them were not reasonable and necessary. For 80 of the 100 claims in OIG's sample, Medicare made payments totaling \$345,717 for hospital inpatient claims involving canceled elective surgeries when a clinical condition did not exist on admission nor did a new condition emerge after admission that required inpatient care. OIG found that these inpatient claims did not satisfy Medicare's requirements for reasonable and necessary admissions. In the remaining 20 claims in OIG's sample, Medicare payments met federal requirements because a clinical condition existed at the time of admission or a new condition emerged that required inpatient medical care. In addition, the OIG also found that—(1) Hospitals were unclear about the Medicare requirements for billing canceled inpatient surgeries; (2) CMS billing requirements are too restrictive, particularly with regard to changing a beneficiary's status from inpatient to outpatient after discharge; and (3) Hospitals did not always have adequate utilization review controls to confirm whether admissions were reasonable and necessary after elective surgeries had been canceled.

The OIG estimated, on the basis of this sample, that Medicare made \$38.2 million in Part A inpatient hospital payments in calendar years (CY) 2009 and 2010 for short-stay canceled elective surgery admissions that were not reasonable and necessary. As OIG acknowledges, total savings could potentially be less than the \$38.2 million that they estimated due to limited rebilling of Part B inpatient ancillary services subject to timely filing.

The OIG's recommendations and CMS's response to those recommendations are discussed below.

Recommendation 1

The OIG recommends that CMS adjust the 80 sampled claims representing overpayments of \$345,717 to the extent allowed under the law.

CMS Response

The CMS partially concurs with this recommendation. Of the 80 sampled claims with overpayments valued at approximately \$345,717, 27 representing a value of approximately \$116,342 cannot be reopened as a result of the claims being beyond the four year reopening period or are uncollectible for other reasons. CMS will attempt to recover the remaining 53 overpayments valued at approximately \$229,375 consistent with the agency's policies and procedures.

Recommendation 2

The OIG recommends that CMS strengthen guidance to better explain the Medicare rule that a clinical condition requiring inpatient care must exist for hospitals to bill for Part A prospective payments for elective surgeries that were canceled which could result in savings totaling \$38.2 million over a 2-year period.

CMS Response

The CMS concurs and we have already taken action on this recommendation as explained below. However, as OIG acknowledges on page four of the report, we expect that the savings from implementing this recommendation will be less than the report's estimate of \$38.2 million over a 2 year period because hospitals may be able to bill Medicare for reasonable and necessary services under Part B. CMS recommends that OIG present an annual rather than a two-year figure to avoid the misunderstanding that this amount of savings could be recovered annually. CMS also recommends that OIG specifically acknowledge in the recommendation that paying claims under Part B would reduce this estimate.

The Hospital Inpatient Prospective Payment System (IPPS) proposed rule for fiscal year (FY) 2014 proposes inpatient hospital admission guidance under which a physician or other practitioner should order admission if he or she expects that the beneficiary's length of stay will exceed a two midnight threshold or if the beneficiary requires a procedure specified as inpatient-only under 42 C.F.R. §419.22. While the proposed rule does not specifically mention canceled inpatient procedures, we can address this circumstance in our responses to comments in the final rule. CMS also proposed new medical review criteria for inpatient admissions, under which there would be a presumption that inpatient admission pursuant to a physician order is reasonable and necessary for beneficiaries who spend more than one Medicare utilization day (defined as encounters crossing two "midnights") in the hospital after admission. Based on this presumption, inpatient admissions crossing the two-midnight threshold would not generally be subject to medical review for patient status unless CMS suspects that a provider is using the presumption to effect systematic abuse or gaming. Instead, medical review efforts would focus on those inpatient hospital admissions that do not cross two midnights, reviewing the medical

record to determine whether it was reasonable for the admitting physician to expect the beneficiary to require a stay lasting at least 2 midnights, even though that did not ultimately transpire.

Recommendation 3

The OIG recommends that CMS work with the Office of the Inspector General to resolve the remaining 10,915 non-sampled claims and recover overpayments to the extent feasible and allowed under the law.

CMS Response

The CMS concurs. CMS will work with OIG to develop a strategy to address non-sampled claims. However, if medical review is required, it is unlikely CMS can address all 10,915 unsampled claims due to resource limitations. However, CMS will distribute this report to the Recovery Auditors for possible review. It should be noted that this is already an approved Recovery Auditor review issue.

Recommendation 4

The OIG recommends that CMS instruct Medicare administrative contractors to emphasize to hospitals the need for stronger utilization review controls for claims that include admissions for elective surgeries that did not occur.

CMS Response

The CMS does not concur with OIG's precise recommendation, but has taken action to address this concern prior to receiving this OIG report. As indicated above, we have already provided guidance in the FY 2014 IPPS proposed rule when it is appropriate to admit a patient for inpatient hospital services.

In addition to the proposed guidance, CMS has also proposed policies in a proposed rule CMS published on March 18, 2013 that we believe respond to OIG's concern. The rule proposes that when a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was deemed not to be reasonable and necessary, or when a hospital determines after a beneficiary is discharged that an inpatient admission was not reasonable and necessary under §482.30(d) or §485.641, the hospital may be paid for all Part B services that would have been reasonable and necessary (except for services that specifically require an outpatient status) had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient, if the beneficiary is enrolled in Medicare Part B.

Under current policy, the only way to change a patient's status from inpatient to outpatient is by using "condition code 44" as OIG indicates on page (i) of the Executive Summary of the draft report. As OIG notes, the change in status must occur prior to the inpatient discharge. In addition, both the physician responsible for the care of the beneficiary and the utilization review committee of the hospital must agree to the change in status. Finally, if the change from

inpatient to outpatient status does not occur until after the patient is discharged from the hospital, the hospital must bill for Part A inpatient services and receive a denial in order to bill for a limited list of Part B inpatient services.

The OIG expresses concern that the requirements for using “condition code 44” may be too restrictive. Although the proposed rule does not specifically address use of “condition code 44”, the proposed change in policy would eliminate this concern. Under the proposed rule, CMS is expanding—with some exceptions—the list of Part B inpatient services to all services that would otherwise be paid had the hospital originally billed Medicare Part B for outpatient services. Under the proposed policy, the hospital may “self-audit”, that is, submit an inpatient Part B bill and submit a “no-pay” Part A bill indicating the hospital (and not the beneficiary) is liable for the Part A charges, which serves the same function as a denied Part A claim.

If finalized, this change in policy would reduce the financial penalties associated with an incorrect inpatient admission decision by allowing hospitals to fully bill for Part B inpatient services (with the exceptions noted above) without delay after the patient is discharged.

The CMS thanks OIG and looks forward to working with you on this and other issues in the future.