

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE SAME-DAY,  
SAME-PROVIDER ACUTE CARE  
READMISSIONS IN PENNSYLVANIA  
DURING CALENDAR YEAR 1998**



**JANET REHNQUIST  
INSPECTOR GENERAL**

**AUGUST 2002  
A-03-01-00011**

# *Notices*

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## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.





AUG 22 2002

TO: Sonia Madison  
Regional Administrator  
Centers for Medicare & Medicaid Services'  
Philadelphia Regional Office

FROM: Regional Inspector General for Audit Services

SUBJECT: Review of Medicare Same-Day, Same-Provider Acute Care Readmissions in Pennsylvania During Calendar Year 1998 (A-03-01-00011)

This final report presents the results of our REVIEW OF MEDICARE SAME-DAY, SAME-PROVIDER ACUTE CARE READMISSIONS IN PENNSYLVANIA DURING CALENDAR YEAR 1998. The objective of our review was to determine whether Medicare payments made to acute care hospitals in Pennsylvania during Calendar Year (CY) 1998 were appropriate for beneficiaries who were discharged and readmitted to the same hospital on the same day.

Our limited review of same-day, same-provider readmissions found that 63 readmissions totaling \$290,744 were billed incorrectly because the beneficiary was either admitted to a non-acute care unit within the hospital or was never actually discharged from the initial admission. Our review also identified a methodology that involves minimal effort that the Centers for Medicare & Medicaid Services (CMS) could use to identify same-day, same-provider readmissions that are vulnerable to billing errors nationwide. The hospitals in our review were very cooperative in identifying and correcting the billing errors. We believe that CMS could expect the same level of cooperation should it undertake a similar review nationwide.

To correct the deficiencies identified in our review, we recommend that CMS's Philadelphia regional office (RO): (1) monitor the fiscal intermediary's (FI) collection of \$290,744 in overpayments identified by this review, (2) consider working with CMS central office (CO) to conduct a nationwide review of CY 2001 same-day, same-provider readmissions to determine if similar billing errors exist, and (3) consider requiring FIs establish an edit check in their claims processing system to identify for review all same-day, same-provider acute care readmissions where the beneficiary was coded as being discharged to another provider before being readmitted.

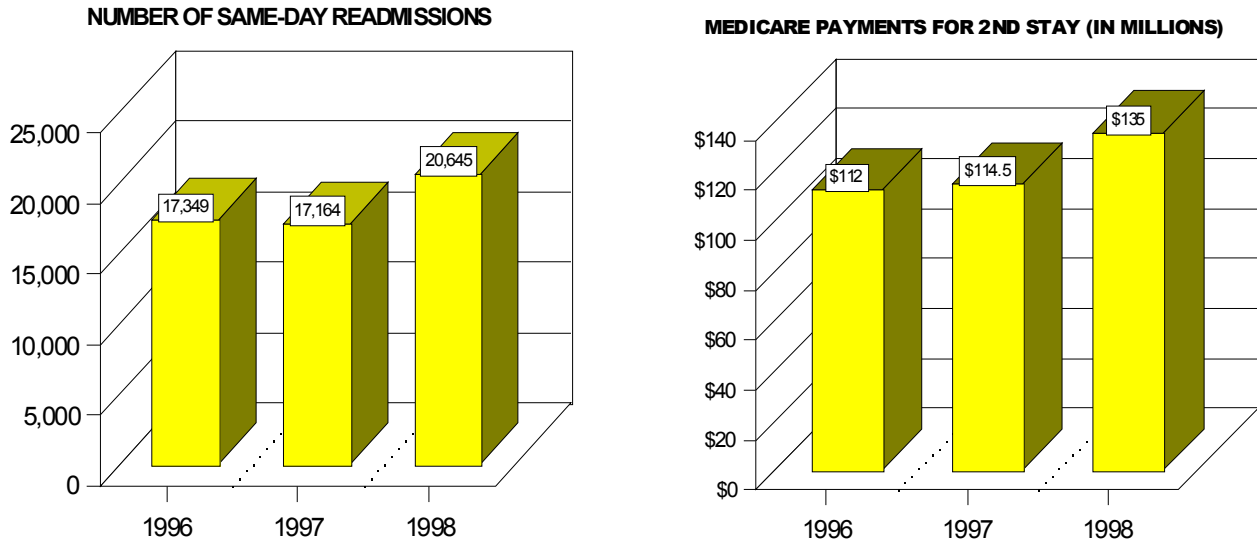
In a written response to our draft report, CMS concurred with our findings. The CMS agreed to implement all three recommendations. The full text of CMS's comments is included with this report as an Appendix.

## INTRODUCTION

### BACKGROUND

Medicare pays for inpatient hospital acute care through the inpatient prospective payment system (IPPS). Under IPPS, hospitals are paid a predetermined amount for each hospital discharge involving a Medicare beneficiary, based upon the diagnostic related group (DRG). According to Provider Reimbursement Manual section 3001, certain hospitals and hospital units are not subject to IPPS. These providers are reimbursed based on reasonable cost determined on a per diem, per unit, per capita, or other basis. The Balanced Budget Act of 1997 authorized the implementation of a prospective payment system for certain hospitals and hospital units not subject to IPPS.

Acute care hospitals nationwide submitted over 17,000 inpatient claims in CYs 1996 and 1997, respectively and over 20,000 inpatient claims in CY 1998 in which the beneficiary was discharged and subsequently readmitted on the same day to the same hospital. The hospitals received over \$112 million in CY 1996, \$114 million in 1997, and \$135 million in CY 1998 for the second admission, as shown in the charts below. The \$135 million in 1998 was significantly larger than similar Medicare payments in the prior 2 years.



### Prior OIG Reports

The Office of Inspector General (OIG) previously issued two reports on situations in which Medicare beneficiaries were discharged and subsequently readmitted to the same hospital on the same day. The first report, *Monitoring Quality of Care and Overpayment Issues Associated With Hospital Readmissions Under the Medicare Prospective Payment System* (A-01-98-00504),

showing the results of testing the OIG pilot protocol in selected states, identified three types of systemic errors:

- ✓ 12 percent of the errors involved beneficiaries who were prematurely discharged from the hospital.
- ✓ 8 percent of the errors involved beneficiaries who were incorrectly shown as being discharged when, in fact, they did not leave the hospital.
- ✓ 5 percent of the errors involved beneficiaries whose medical conditions did not require a readmission after the discharge.

The second report, *Analysis of Readmissions Under the Medicare Prospective Payment System for Calendar Years 1996 and 1997* (A-14-99-00401), was an expansion whereby we analyzed Medicare same-day readmissions data on a nationwide basis for CYs 1996 and 1997. The objective of this second review (conducted at the request of CMS) was to identify high incidences of same-day readmissions so additional reviews could be initiated to better monitor the quality of hospital care.

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

The objective of our review was to determine whether Medicare payments made to acute care hospitals in Pennsylvania during CY 1998 were appropriate for beneficiaries who were discharged and readmitted to the same hospital on the same day.

To accomplish our objective, we:

- ✓ extracted CY 1998 inpatient claims from CMS's Standard Analytical File in which the discharge date of service and subsequent admission date of service were the same, and the provider numbers were the same.
- ✓ identified applicable criteria for identifying and reviewing readmissions.
- ✓ identified all CY 1998 same-day, same-provider readmissions for review at one FI.
- ✓ analyzed discharge codes to determine where beneficiaries were discharged to between the initial admission and the readmission.
- ✓ visited one FI and one peer review organization (PRO) in Pennsylvania to determine whether they are reviewing readmissions.
- ✓ reviewed medical records to determine whether same-day, same-provider readmissions were billed correctly. We did not determine the medical necessity of the readmissions.

Our review was conducted in accordance with the generally accepted government auditing standards. Our review of internal controls was limited to determining whether CMS, the PRO, or the FI are reviewing same-day, same-provider readmissions. We began our review in January 2001. Our review was conducted at the FI in Pittsburgh, Pennsylvania; the PRO in Harrisburg, Pennsylvania; and at selected hospitals in Pennsylvania.

### FINDINGS AND RECOMMENDATIONS

Our review showed that:

1. Acute care hospitals were overpaid \$290,744 because they incorrectly billed Medicare for a second inpatient admission (readmission) when the beneficiary was actually transferred to a non-acute care unit within the same hospital, or the patient readmission claim should have been a continuation of the initial admission.
2. Nationwide, same-day, same-provider readmissions vulnerable to billing errors can be identified and corrected using the methodology developed during our review.

Hospitals Were Overpaid \$290,744 For Same-day, Same-Provider Readmissions

We reviewed 98 same-day, same-provider readmissions and found 63 claims totaling \$290,744 were billed incorrectly because the beneficiary was either admitted to a non-acute care unit within the hospital or was never actually discharged from the initial admission. Our results were as follows:

<i>Same-Day, Same-Provider Readmission Type</i>	<i>Readmissions Reviewed</i>	<i>Billing Errors</i>	<i>Value of Billing Errors</i>
<i>Same-DRG, Discharged Home</i>	5	2	\$10,679
<i>Same-DRG, Discharged to Another Provider</i>	62	30	\$158,381
<i>Different-DRG, Discharged to Another Provider</i>	11	11	\$48,715
<i>Internal Hospital Reviews, Discharged to Another Provider</i>	20	20	\$72,969

The OIG has developed an approach, which we believe will assist CMS in identifying and reviewing same-day, same-provider acute care readmissions nationwide that are vulnerable to billing errors. The claims we identified as vulnerable were same-day, same-provider acute care readmissions in which the beneficiary was coded as being discharged to another provider<sup>1</sup> before

<sup>1</sup> Discharge codes 02-transfer to acute care hospital, 03-transfer to skilled nursing facility (SNF), 04-transfer to intermediate care facility, and 05-transfer to another type of institution.

being readmitted. Our approach required minimal resources and identified a 56 percent error rate<sup>2</sup> for these types of claims.

OIG's Approach to Identifying and Reviewing Billing Errors

At 1 Pennsylvania FI, we identified Medicare payments of approximately \$6.6 million for 881 same-day, same-provider acute care readmissions during CY 1998. We determined that 134 readmissions were for the same DRG, and 747 readmissions were for a different DRG than the original admission.

We analyzed the 134 same-DRG readmissions and identified 27 claims where the readmission was within 1 hour of the initial discharge. Our review also determined that for 22 of the 27 readmissions, the discharge code for the initial admission indicated the beneficiary was discharged to another provider before being readmitted to the same hospital. For five readmissions, the beneficiary was coded as being discharged home before being readmitted.

We contacted the five hospitals where the beneficiary was coded as being discharged home and requested medical record documentation to confirm the correct billing. We found two readmissions were billed incorrectly totaling \$10,679 in overpayments. One billing error resulted when a beneficiary was discharged to the hospital-based SNF after the first admission but the hospital billed for an acute care readmission. The second billing error occurred when a hospital billed for a second admission that should have been a continuation of the initial admission.

Since 22 of the 27 readmissions we initially selected for review were coded as being discharged to another provider before being readmitted to the hospital, we re-analyzed the 134 same-DRG readmissions to identify similar readmissions. We identified 40 additional readmissions. Adding these readmissions to the ones already selected, we reviewed 62 readmissions where the beneficiary was coded as being discharged to another provider before being readmitted to the hospital.

Our review found that 10 of the 62 readmissions were from 1 hospital. For the remaining 52 readmissions, no hospital had more than 4 readmissions. We sent letters to 31 hospitals requesting medical record documentation to support the billing for 45 of the 52 readmissions.<sup>3</sup>

All hospitals responded to our request, and we determined that 20 readmissions were billed incorrectly totaling \$105,356 in overpayments. We found 17 billing errors resulted when a beneficiary was discharged to a non-acute care unit within the hospital after the first admission but the hospital billed for an acute care readmission. The remaining three billing errors occurred when a hospital billed for a second admission that should have been a continuation of the initial admission.

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<sup>2</sup> This error rate is based on our review of 73 (62 same-DRG and 11 different-DRG) readmissions. It does not include the 5 same-DRG readmissions where the beneficiary was discharged home or the 20 readmissions from the internal hospital reviews.

<sup>3</sup> Five claims were for hospitals that closed, and two claims were adjusted by the hospital prior to our review.

We visited the hospital with 10 readmissions and reviewed the medical records for both the initial admission and the readmission. According to hospital personnel and our review of medical records, the 10 beneficiaries were discharged from the hospital and admitted to the hospital-based SNF. Hospital personnel agreed there was no acute care readmission and reimbursements totaling \$53,025 were incorrect. The billing errors occurred because admission personnel inadvertently billed the SNF admission under the hospital's provider number. When the beneficiary was admitted to the SNF, admission personnel entered an incorrect insurance plan code generating the incorrect provider number for billing. Hospital officials informed us they would work with the FI to correct the overpayments. In addition, they planned to review all SNF admissions from 1997, 1999, and 2000.

Because of the high error rate at this hospital, we selected 11 same-day, same-provider, different-DRG readmissions to this hospital. We requested the hospital review the readmissions and provide us with copies of medical records for both the initial admissions and readmissions. The hospital reported that these 11 readmissions also were billed incorrectly because of the same registration error. Our review confirmed that the beneficiaries were not readmitted to the hospital; rather in nine cases beneficiaries were discharged to the hospital's SNF and in two cases beneficiaries were discharged to the hospital's rehabilitation unit. The hospital was incorrectly reimbursed \$48,715 for these readmissions.

Hospital Internal Reviews  
Identified Additional Billing Errors

As a result of our review of same-day, same-provider readmissions, two hospitals conducted their own reviews of all admissions to their non-acute care units where the billing errors we identified by our review occurred. The hospital we visited informed us that it conducted a review of SNF unit and rehabilitation unit admissions for CYs 1997, 1999, and 2000. The hospital reported an additional eight billing errors totaling \$31,621. A second hospital informed us it conducted a review of SNF unit admissions from July 1997 to May 2001. The hospital identified 12 additional billing errors totaling \$41,348.

As part of our review, we had planned to visit a hospital with 26 same-day, same-provider, different-DRG readmissions. Medicare reimbursed this hospital \$926,586 for these readmissions. Prior to our site visit, we learned that the hospital adjusted 15 of the 26 readmissions. Hospital officials stated that during a March 2000 internal review, they discovered the use of an incorrect insurance code at registration. This error resulted in rehabilitation patients being billed under the hospital provider number rather than the rehabilitation unit provider number. The hospital cancelled the 15 rehabilitation claims with the incorrect provider number and re-billed the services using the correct provider number. The 15 readmission claims cancelled totaled \$775,407, and the rehabilitation unit services that were re-billed totaled \$116,656. Therefore, these adjustments resulted in Medicare recouping \$658,751 in overpayments. The provider number was correct for the remaining 11 readmissions because the beneficiary was readmitted back to the hospital.



We found the hospitals we contacted during our limited review were very cooperative in analyzing the readmissions included in our review. We believe based on our experience that, given an opportunity, hospitals are willing to review same-day, same-provider readmissions where a beneficiary was discharged to another institution, to ensure that Medicare is billed correctly.

**Some Same-Day Readmissions Are Vulnerable to Billing Errors**

In summary, we found that some same-day, same-provider acute care readmissions are vulnerable to billing errors. We identified the majority of our billing errors by analyzing same-day, same-provider readmissions where claims data indicated a beneficiary was discharged to another provider after the initial admission and prior to being readmitted. We believe that these types of readmissions are vulnerable to billing errors. Our review found that 41 of 73 readmissions (56 percent), where the claims data indicated a beneficiary was discharged to another provider before being readmitted, were billed incorrectly.

In addition, two hospitals in our review conducted internal reviews of readmissions where the beneficiary was coded as being discharged to a non-acute care unit before being readmitted. These two reviews found an additional 20 billing errors.

To determine how many readmission claims were coded this way nationwide, we obtained same-day, same-provider data from CMS’s Standard Analytical File. We found that acute care hospitals nationwide were reimbursed over \$135 million for 20,645 same-day, same-provider readmissions during CY 1998. The following table identifies the discharge code, the number of same-day, same-provider readmissions and the Medicare payment for the readmissions:

<i>Discharge Code</i>	<i>Same-day, Same-provider Readmissions</i>	<i>Medicare Payments</i>
<i>01 – Home</i>	8,764	\$55,698,269
<b><i>02 - Transfer to Acute Care Hospital</i></b>	<b>1,567</b>	<b>\$12,282,378</b>
<b><i>03 – Skilled Nursing Facility</i></b>	<b>3,674</b>	<b>\$23,814,991</b>
<b><i>04 - Intermediate Care Facility</i></b>	<b>471</b>	<b>\$2,652,879</b>
<b><i>05 - Another Type of Institution</i></b>	<b>3,879</b>	<b>\$25,499,686</b>
<i>06 - Home Health Care</i>	1,674	\$10,922,904
<i>07 – Left Against Medical Advice</i>	555	\$3,748,658
<i>Other Miscellaneous Codes</i>	<u>61</u>	<u>\$459,914</u>
<b><i>Total</i></b>	<b>20,645</b>	<b>\$135,079,679</b>

Our review showed that same-day readmissions where the initial admission had a discharge code of 02, 03, 04, and 05 and the claims data reflected a readmission back to the same hospital are vulnerable to billing errors. These 4 discharge codes accounted for 9,591 same-day, same-

provider readmissions totaling \$64,249,934 in CY 1998 Medicare payments. If similar billing errors occurred nationwide, the potential for significant overpayments exists.

We believe these types of readmissions are vulnerable to improper payment. Based on the methodology used in this review, only minimal effort was required to identify billing errors, and hospitals were very cooperative in resolving these errors. We believe only minimal resources will be needed to use the same methodology to review similar claims nationwide, and we believe that hospitals would provide the same level of cooperation that we found during our limited review.

## **CONCLUSION AND RECOMMENDATIONS**

We determined that hospitals were overpaid \$290,744 as a result of incorrectly billed hospital readmissions. We identified these overpayments by reviewing readmissions where the beneficiary was discharged and readmitted within 1 hour or where the beneficiary was coded as being discharged to another provider prior to being readmitted. The OIG, as well as hospital personnel, reviewed medical records to determine if the beneficiary was readmitted to the hospital or was transferred to a non-acute care unit of the hospital. No medical review was required.

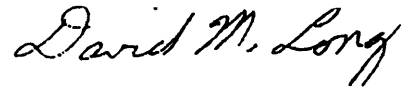
We believe the potential exists that same-day, same-provider readmissions, where the beneficiary was coded as being discharged to another provider prior to being readmitted, are vulnerable to the types of billing errors identified in our review. If similar billing errors occurred nationwide, the potential for significant overpayments exists.

We, therefore, recommend that CMS Philadelphia RO:

1. monitor the FI's collection of \$290,744 in overpayments identified by this review.
2. consider working with CMS CO to conduct a nationwide review of CY 2001 same-day, same-provider acute care readmissions to determine if similar billing errors exist.
3. consider the feasibility of establishing an edit check in the FIs' claims processing system to identify for review all same-day, same-provider acute care readmissions where the beneficiary was coded as being discharged to another provider before being readmitted.

**CMS'S COMMENTS**

In a written response to our draft report, CMS concurred with our findings. The CMS agreed to implement all three recommendations. The full text of CMS's comments is included with this report as an Appendix.

A handwritten signature in black ink that reads "David M. Long". The signature is written in a cursive style with a large, prominent 'D' and 'L'.

David M. Long



# Memorandum

Centers for Medicare & Medicaid Services

Region III

Suite 216, The Public Ledger Bldg

150 S. Independence Mall West

Philadelphia, PA 19106-3499

Refer to: DFM(16)  
File Code A030100011

Date: JUL 22 2002

To: Eugene Berti, Audit Manager  
Office of Inspector General - Philadelphia Region

From: Acting Associate Regional Administrator  
Division of Financial Management

Subject: Draft Audit Report – Review of Medicare Same-Day, Same-Provider Acute Care  
Readmissions in Pennsylvania CIN: A-03-01-00011

Thank you for the opportunity to review the draft audit report – “Review of Medicare Same-Day, Same-Provider Acute Care Readmissions in Pennsylvania”. We shall move to implement all three recommendations in this report.

We shall monitor Veritus to ensure the identified overpayments of \$290,744 are collected. We shall recommend to our Central Office staff that similar reviews for same-day, same-provider acute care readmissions be conducted nationally. Lastly, we shall recommend to our Central Office staff that edits be implemented in the claims processing system to rectify this problem.

Once issued, please forward a copy of your final report to us so that we may begin to work on these issues. Thank you for bringing this matter to my attention.

  
Catherine McCoy