

**Memorandum**

Date OCT 10 2001

From Janet Rehnquist
Inspector General *Janet Rehnquist*

Subject Implementation of Medicare's Postacute Care Transfer Policy (A-04-00-01220)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General's (OIG) final report entitled, *Implementation of Medicare's Postacute Care Transfer Policy*.

Our review examined the nationwide implementation of Medicare's postacute care transfer policy (required by the Balanced Budget Act of 1997) which is intended to reduce inpatient payment rates when prospective payment system (PPS) hospitals discharge beneficiaries in 10 specified diagnosis related groups (DRG) to certain postacute care settings; i.e., PPS-exempt hospitals or units, skilled nursing facilities, and home health agencies. These situations are often described as "qualified discharges."

Our review indicated that the Centers for Medicare & Medicaid Services (CMS) has no controls or edits in place in the common working file (CWF) to prevent excessive payments to PPS hospitals for erroneously-coded qualified discharges that are followed by postacute care.

After computer-matching discharges for these 10 DRGs which met certain criteria with subsequent postacute care claims, we selected a random sample of 200 claims for detailed review. We determined that 198 of the 200 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded by the hospital because the beneficiary subsequently received postacute care. The erroneously-coded claims in our sample resulted in excessive DRG payments of \$702,634.

Based on the sample results, we estimate that for the period of October 1, 1998 through September 30, 1999, the Medicare program paid approximately \$52.3 million in excessive DRG payments to PPS hospitals as a result of these erroneous codings.

The overpayments occurred because CMS has not implemented payment controls in the CWF to prevent or correct hospital overpayments involving qualified discharges, CMS's fiscal intermediary (FI) contractors have not implemented payment controls in their internal systems related to these specific discharges, and controls were not always in place at the hospitals to assure that the discharge code on the Medicare claim was correct.

The results of this review are consistent with two previous audits of qualified discharges, limited in geographical scope, conducted by OIG. In those audits we determined that 2 of CMS's contractors responsible for the processing and payment of PPS hospital claims had not placed edits in their respective internal systems to prevent excess payments associated with the designated 10 specific DRGs (*Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross Blue Shield of Georgia - A-04-00-01210*, and *Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options - A-04-00-02162*). The CMS concurred with our findings and associated recommendations in these reports. The \$2.9 million in excessive DRG payments noted in these two reports is in addition to the \$52.3 million found in our national review.

As a long-term remedy, we recommend that CMS establish edits in the CWF to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim.

Pending implementation of CWF edits, we recommend that CMS adopt these interim remedies:

- . Issue a memorandum alerting FIs to the problems identified in our review and direct the FIs to re-emphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care (CMS had agreed to issue a memorandum based on the recommendations in our previous limited audits);
- . Instruct and monitor FIs' actions to recover the \$702,634 in overpayments identified in our sample;
- . Review the remaining 14,690 claims identified in our sampling universe to identify and recover additional overpayments; and
- . Conduct matches similar to the one we conducted to identify and recover additional overpayments for claims subsequent to September 30, 1999. Potential savings could rival those of this review.

The OIG is willing to assist CMS in developing its post-payment review methodology by providing details regarding the development of the computer matching techniques used to conduct this review.

Officials in your office have concurred with our findings and recommendations.

Page 3 - Thomas Scully

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-04-00-01220 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**IMPLEMENTATION OF MEDICARE'S
POSTACUTE CARE TRANSFER POLICY**



**JANET REHNQUIST
INSPECTOR GENERAL**

**OCTOBER 2001
A-04-00-01220**

**Memorandum**

Date OCT 10 2001

From Janet Rehnquist
Inspector General *Janet Rehnquist*

Subject Implementation of Medicare's Postacute Care Transfer Policy (A-04-00-01220)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

This final report provides you with the results of our nationwide review of the implementation of Medicare's postacute care transfer policy. This policy implements a Balanced Budget Act (BBA) of 1997 requirement which is intended to reduce inpatient payment rates when prospective payment system (PPS) hospitals discharge beneficiaries in 10 specified diagnosis related groups (DRG) to certain postacute care settings; i.e., PPS-exempt hospitals or units, skilled nursing facilities (SNF), and home health agencies (HHA). These situations are often described as "qualified discharges."

EXECUTIVE SUMMARY

The objectives of this review were to determine what controls and edits, if any, the Centers for Medicare & Medicaid Services (CMS) has in place to assure the proper payment of qualified discharges, and to quantify the overpayments resulting from qualified discharges erroneously coded as Patient Status Code "01 - Discharge to Home."

Summary of Findings

Our review indicated that CMS has no controls or edits in place in the common working file (CWF) to prevent excessive payments to PPS hospitals for erroneously-coded qualified discharges that are followed by postacute care.

After computer-matching discharges for these 10 DRGs which met certain criteria with subsequent postacute care claims, we selected a random sample of 200 claims for detailed review. We determined that 198 of the 200 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded by the hospital because the beneficiary subsequently received postacute care. The erroneously-coded claims in our sample resulted in excessive DRG payments of \$702,634.

Based on the sample results, we estimate that for the period of October 1, 1998 through September 30, 1999, the Medicare program paid approximately \$52.3 million in excessive DRG payments to PPS hospitals as a result of these erroneous codings.

The overpayments occurred because CMS has not implemented payment controls in the CWF to prevent or correct hospital overpayments involving the qualified discharges, CMS's fiscal intermediary (FI) contractors have not implemented payment controls in their internal systems related to these specific discharges, and controls were not always in place at the hospitals to assure that the discharge code on the Medicare claim was correct.

The results of this review are consistent with two previous audits of qualified discharges, limited in geographical scope, conducted by the Office of Inspector General (OIG). In those audits, we determined that two of CMS's contractors for the processing and payment of PPS hospital claims had not placed edits in their respective internal systems to prevent excess payments associated with the designated 10 specific DRGs (*Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross Blue Shield of Georgia - A-04-00-01210*, and *Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options - A-04-00-02162*). The CMS concurred with our findings and associated recommendations in these reports. The \$2.9 million in excessive DRG payments noted in these two reports is in addition to the \$52.3 million found in our national review.

As a long-term remedy, we recommend that CMS establish edits in the CWF to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim.

Pending implementation of CWF edits, we recommend that CMS adopt these interim remedies:

- C Issue a memorandum alerting FIs to the problems identified in our review and direct the FIs to re-emphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care (CMS had agreed to issue a memorandum based on the recommendations of our two previous limited audits);
- C Instruct and monitor FIs' actions to recover the \$702,634 in overpayments identified in our sample;
- C Review the remaining 14,690 claims identified in our sampling universe to identify and recover additional overpayments; and
- C Conduct matches similar to the one we conducted to identify and recover additional overpayments for claims subsequent to September 30, 1999. Potential savings could rival those of this review.

The OIG is willing to assist CMS in developing its post-payment review methodology by providing details regarding the development of the computer matching techniques used to conduct this review.

The CMS has concurred with the findings and recommendations of this report. The complete text of CMS's response to the OIG draft report is found in APPENDIX C.

BACKGROUND

Generally, discharges and transfers under PPS are defined under 42 CFR 412.4(a) and (b). A discharge is generally a situation in which a beneficiary is formally released from a PPS hospital after receiving complete acute care treatment. A case is generally considered to be a transfer for purpose of payment when the beneficiary is transferred from one PPS inpatient unit to another PPS unit within the same PPS hospital or to another PPS hospital for related care. Medicare regulations found in 42 CFR 412.4(f) provide that, in a transfer situation, payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

In the framing of the BBA of 1997, the Congress was concerned that Medicare was overpaying hospitals for patients who are discharged to a postacute care setting after a very short acute care hospital stay. The Congress believed that Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting. To address these concerns, the Congress enacted section 4407 of the BBA of 1997.

Section 4407 of the BBA of 1997 expanded the definition of transfer by adding section 1886(d)(5)(J) of the Social Security Act. Under this provision, if a beneficiary has a qualified discharge from 1 of 10 DRGs selected by the Secretary to a postacute care provider, the discharge will be treated as a transfer case beginning with discharges on or after October 1, 1998. Section 1886(d)(5)(J)(ii) defines a qualified discharge as a discharge from a PPS hospital of an individual whose hospital stay is classified in 1 of the 10 selected DRGs if, upon discharge, the individual is:

- Ⓒ admitted to a hospital or hospital unit that is not reimbursed under PPS;
- Ⓒ admitted to a SNF; or

- C provided home health services if the services relate to the condition or diagnosis for which the individual received inpatient hospital services and if these services are provided within an appropriate period as defined by the Secretary. (According to 42 CFR 412.4(c)(3), the transfer policy is applicable if the individual was discharged to home under a written plan of care for the provision of home health services and the services begin within 3 days after the date of discharge.)

Section 1886(d)(5)(J)(iii)(I) gives the Secretary broad authority to select the 10 DRGs based on a high volume of discharges and a disproportionate use of postacute care services. According to 42 CFR 412.4(d), the 10 DRGs selected by the Secretary pursuant to this authority, are as follows:

<u>DRG</u>	<u>Title</u>
014	Specific Cerebrovascular Disorders Except Transient Ischemic Attack
113	Amputation for Circulatory System Disorders Excluding Upper Limb and Toe
209	Major Joint and Limb Reattachment Procedures of Lower Extremity
210	Hip and Femur Procedures Except Major Joint Age > 17 with Complications and Comorbidities (CC)
211	Hip and Femur Procedures Except Major Joint Age > 17 without CC
236	Fractures of Hip and Pelvis
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC
429	Organic Disturbances and Mental Retardation
483	Tracheostomy Except for Face, Mouth, and Neck Diagnoses

Medicare DRGs are sets of diagnoses that are expected to require about the same level of hospital resources to treat beneficiaries. Under PPS, hospitals are paid a predetermined amount based on the DRG for each Medicare patient.

Responsibilities for Postacute Care Transfer Claims

The CMS contracts with intermediaries, usually insurance companies, to assist in administering the Medicare program. The intermediary for inpatient hospital facilities is referred to as an FI. The intermediary for HHAs is referred to as a regional home health intermediary (RHHI). Computer system edits at the FI level will not address claims from hospitals for which the original FI does not act as intermediary. In addition, since FIs do not make payments for home health services they do not have automated access to HHA payment data. Likewise, the RHHIs do not have automated access to inpatient hospital claims and payment data. Therefore, FIs are unable to automatically identify in their systems postacute home health care, and RHHIs are unable to automatically identify in their

systems inpatient hospital care. The lack of complete data by FIs was identified by CMS as a vulnerability when implementing the postacute care transfer policy.

In the preamble to the final rule published in the Federal Register on July 31, 1998 [63 Federal Register 40,976 (1998)], CMS indicated that hospitals maintain their responsibility to code the discharge bill based on the discharge plan for the patient, and if the hospital subsequently learns that postacute care was provided, the hospital should submit an adjustment bill. The CMS acknowledged that hospitals will not always know if postacute care was rendered. However, the rule states that CMS will monitor activity in this area to determine if hospitals are acting in good faith.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of this review were to determine what controls and edits, if any, CMS has in place to assure the proper payment of qualified discharges, and to quantify the overpayments resulting from qualified discharges erroneously coded as Patient Status Code “01 - Discharge to Home.”

Scope

Our audit focused on Medicare inpatient claims with the 10 specified DRGs from PPS hospitals nationwide for the period of October 1, 1998 through September 30, 1999. Discharges from providers in the States of Georgia and Florida were excluded from our review because they were the subject of previous reviews in this area. Discharges from providers in the State of Maryland were excluded from our review because the State of Maryland utilizes an alternative payment methodology to PPS.

During this period, 1,090,141 discharges occurred nationally within these 10 DRGs. Of these discharges, 14,890 were followed by postacute care treatment that fell within the window of time necessary to categorize the discharge as a qualified discharge/postacute care transfer, and met all of the criteria necessary to potentially result in an overpayment. Using a statistically valid random sample (see APPENDIX A for details), we projected the amount of and number of excessive payments made to the hospitals. (See APPENDIX B for details.)

Methodology

We have conducted two previous audits in this area, during which we gained an understanding of the potential scope of the issues surrounding postacute care transfers. Discussions with FI personnel in our previous audits indicated that they were aware of the 10 DRG transfer provision of the BBA of 1997 and had made appropriate system modifications. The changes had been made to the Fiscal Intermediaries Shared System (FISS). The FIs relied on the FISS software at the Florida Data Center for editing and processing of claims.

After reviewing payment system documentation concerning the transfer provisions and conducting substantive tests, we concluded that the FIs' payment systems had been modified to correctly pay qualified transfer claims when they had been correctly coded and submitted by hospitals. No further audit work was conducted in this area. However, we also concluded that the FIs' payment systems were not capable of detecting, and properly paying, claims which providers erroneously coded as discharge to home. Based on discussions with FI personnel, published CMS guidance, and educational material given to the providers by the FIs, we determined that substantial reliance was being placed on the providers' diligence, willingness, and capability to appropriately code discharges.

Further review in this area during our previous audits in Florida and Georgia resulted in OIG identifying overpayments of \$2,042,060 and \$890,000, respectively. We, therefore, concluded that a review of the overpayments incurred for these 10 DRGs on a national basis was warranted. We initiated our review by obtaining a list of all paid claims for the 10 DRGs for the period October 1, 1998 through September 30, 1999 from CMS's Medicare Provider Analysis and Review (MEDPAR) file. This database contained 1,090,141 claims totaling \$5,943,981,961. We reduced these 1,090,141 claims to 69,819 claims totaling \$538,683,401 based on the following criteria:

- C included only claims with the discharge code of "01- Discharge to Home";
- C eliminated claims from Florida, Georgia, and Maryland;
- C eliminated all records where full payment was due and no overpayment could have occurred (transfers as defined under 42 CFR 412.4(f));
- C eliminated all discharges from hospitals that were not participating in the PPS; and
- C eliminated all claims where the Medicare payment amount equaled zero.

These 69,819 claims were then compared to CMS's Standard Analytic File (SAF) database of Medicare claims in order to determine if any of the claims were "matched" by:

- C an admission to a non-PPS hospital or unit of a hospital on the same day of discharge (i.e., "From Date" on claim 2 matches "Thru Date" on claim 1);
- C an admission to a SNF on the same day of discharge (i.e., "From Date" on claim 2 matches "Thru Date" on claim 1); or

- C treatment by an HHA within 3 days of the date of discharge (i.e., "From Date" on claim 2 # "Thru Date" on claim 1 + 3).

The resulting matches left the population of 14,890 claims totaling \$174,563,932 from which our sample was drawn. (See APPENDIX A for a more detailed discussion of our sampling methodology.)

Our review was limited to the period of October 1, 1998 through September 30, 1999, which was the first full year that the 10 DRG postacute care transfer provision was in effect. Our audit was performed at the OIG Atlanta regional office and Tallahassee field office between June 2000 and January 2001.

Our review allowed us to establish a reasonable assurance regarding the authenticity and accuracy of the data obtained from the MEDPAR and SAF files. Our audit was not directed towards assessing the completeness of these files.

We conducted our audit in accordance with generally accepted government auditing standards.

DETAILED RESULTS OF REVIEW

Our review indicated that CMS has no controls or edits in place in the CWF to prevent excessive payments to PPS hospitals for erroneously-coded qualified discharges that are followed by postacute care.

After computer-matching all discharges for these 10 DRGs which met certain criteria with subsequent postacute care claims, we selected a random sample of 200 claims for detailed review. We determined that 198 of 200 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded by the hospital because the beneficiary subsequently received postacute care. The 198 erroneously-coded claims in our sample resulted in excessive DRG payments of \$702,634. The remaining two sampled claims did not result in an overpayment.

Based on the sample results, we estimate that for the period of October 1, 1998 through September 30, 1999, of the 14,890 claims included in our universe, 14,741 were erroneously coded. We also estimate that the Medicare program paid \$52,311,082 in excessive DRG payments to PPS hospitals as a result of these erroneous codings. (See APPENDIX B for details.)

The overpayments occurred because CMS has not implemented payment controls in the CWF to prevent or correct hospital overpayments involving the qualified discharges; CMS's FI contractors have not implemented payment controls in their internal systems related to these specific discharges; and controls were not always in place at the hospitals to assure that the discharge code on the Medicare claim was correct.

The results of this review are consistent with two previous audits of qualified discharges, limited in geographical scope, conducted by OIG. In those audits, we determined that 2 of CMS's contractors responsible for the processing and payment of PPS hospital claims had not placed edits in their respective internal systems to prevent excess payments associated with the designated 10 specific DRGs (*Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross Blue Shield of Georgia - A-04-00-01210*, and *Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options - A-04-00-02162*). The \$2.9 million in excessive DRG payments noted in these two reports is in addition to the \$52.3 million found in our national review.

Criteria

Medicare regulations found in 42 CFR 412.4(f) provide that, in a transfer situation, payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Effective with discharges on or after October 1, 1998, a discharge from a PPS hospital with 1 of the 10 specified DRGs to a postacute care setting will be treated as a transfer case. The applicable postacute care settings are a hospital or hospital unit that is not reimbursed under PPS, a SNF, or home under a written plan of care for the provision of home health services and the services begin within 3 days of the discharge.

Reimbursement for qualified discharges is made under one of two payment methods, each of which is designed to more closely match the reimbursement to the hospital's cost of providing care to the patient. In the event that the cost of providing care to a patient meets the criteria to be deemed an outlier, additional payment is allowed for the qualified discharges.

For DRGs 014, 113, 236, 263, 264, 429, and 483, hospitals are reimbursed at a graduated per diem rate for each day of the beneficiary's stay. Under this calculation method, the full DRG payment amount is divided by the geometric mean length of stay for the specific DRG to which the case is assigned. Twice the per diem amount is paid for the first day, and the per diem rate is paid for each of the remaining days, not to exceed the full DRG payment. For DRGs 209, 210, and 211, the reimbursement is calculated as follows: on day one of a postacute care transfer, hospitals would receive one-half the DRG payment amount plus the per diem payment for the DRG. For each subsequent day prior to transfer, hospitals receive one-half the per diem up to the full DRG payment.

In the preamble to the final rule published in the Federal Register on July 31, 1998 [63 Federal Register 40,976 (1998)], CMS indicated that hospitals maintain their responsibility to code the discharge bill based on the discharge plan for the patient, and if the hospital subsequently learns that postacute care was provided, the hospital should submit an adjustment bill. The CMS acknowledged that hospitals will not always know if postacute care was rendered. However, the rule states that CMS will monitor activity in this area to determine if hospitals are acting in good faith.

Medicare Bulletin #1817 advised providers that the use of Patient Status Code 01 is only appropriate for these 10 DRGs in instances where a patient is discharged from an inpatient facility and, (1) is not admitted on the same day to another inpatient facility or SNF, or (2) does not receive any home health services within a 3-day period from the date of discharge.

Condition

In our sample of 200 claims coded as discharge to home, 198 claims were improperly coded as discharges to home rather than to other postacute care. These 198 erroneously-coded claims resulted in the discharging hospitals receiving excessive payments relating to the 10 qualified discharge DRGs. The erroneous claims included:

- C 108 claims which were followed by a claim for home health services within 3 days of the discharge date on the sample claim. These erroneously-coded claims resulted in \$351,094 in excess payments to the discharging provider.
- C 51 claims which were followed by a subsequent admission to a hospital or hospital unit that is excluded from PPS. These erroneously-coded claims resulted in \$239,804 in excess payments to the discharging provider.
- C 39 claims which were followed by an admission to a SNF on the same day as the discharge date on the sample claim. These erroneously-coded claims resulted in \$111,736 in excess payments to the discharging provider.

The remaining two sampled claims did not result in an overpayment. Correct payment occurred despite an erroneous billing code because:

- C One of these sampled claims had been re-coded as “06 - Discharge to Home Health Agency,” subsequent to our sample selection but prior to our fieldwork completion date.
- C The other sampled claim had initially been identified as receiving home health services within 3 days of discharge from the hospital. However, a more detailed analysis of the CWF revealed that this criteria had not been met. The HHA had included a wider range of days in its claim

for the services than had actually been incurred in the provision of home health. Therefore, home health services appeared to have been provided by the agency within 3 days of discharge, when they had not.

Cause

The overpayments occurred because CMS has not implemented payment controls in the CWF to prevent or correct hospital overpayments involving qualified discharges, CMS's FI contractors have not implemented payment controls in their internal systems, and controls were not always in place at the hospitals to assure that the discharge code on the Medicare claim was correct.

During the performance of our prior audits, we found that CMS had not implemented payment controls in the CWF to prevent or correct hospital overpayments. In our discussions of these draft reports with CMS, we found that CMS was aware of the weaknesses in the system. However, as stated in the implementing regulations, CMS holds the hospitals responsible for properly coding the bill based on its discharge plan or submitting an adjusted bill if the hospital later learns that the discharge plan was not followed.

Effect

For the period of October 1, 1998 through September 30, 1999, 198 of 200 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded by the hospital. The 198 erroneously-coded claims in our sample resulted in excessive DRG payments of \$702,634.

Based on the sample results, we estimate that 14,741 claims for these DRGs were erroneously coded nationally. We also estimate that the Medicare program paid approximately \$52,311,082 in excessive DRG payments to PPS hospitals nationwide as a result of these erroneous codings.

RECOMMENDATIONS AND CMS RESPONSE

As a long-term remedy, we recommend that CMS establish edits in the CWF to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim. Pending implementation of CWF edits, we recommend that CMS adopt interim remedies as shown below. The CMS concurred with our recommendations and the complete text of CMS's response is included in APPENDIX C to this report.

Our interim remedies and the appropriate CMS response are:

Recommendation

Issue a memorandum alerting FIs to the problems identified in our review and direct the FIs to re-emphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care (CMS had agreed to issue a memorandum based on the recommendations in our previous limited audits).

CMS Response

The CMS concurred with this recommendation. A program memorandum was released to FIs on March 22, 2001 requesting that the FIs publish instructions in the next regularly scheduled bulletin to hospitals and postacute care facilities with respect to the facilities' responsibility for ensuring correct and appropriate discharge status coding on claims.

Recommendation

Instruct and monitor FIs' actions to recover the \$702,634 in overpayments identified in our sample.

CMS Response

The CMS concurred with this recommendation. Upon issuance of the final report, CMS will obtain details from OIG regarding the specifics of the overpayments identified and will instruct the FIs to recover these funds.

Recommendation

Review the remaining 14,690 claims identified in our sampling universe to identify and recover additional overpayments.

CMS Response

The CMS concurred with this recommendation and will direct the FIs to recover any overpayments resulting from future reviews.

Recommendation

Conduct matches similar to the one we conducted to identify and recover additional overpayments. Potential savings could rival those of this review. The OIG will assist CMS in developing its post-payment review methodology by providing details regarding the development of the computer matching techniques used to conduct this review.

CMS Response

The CMS concurred with this recommendation and will direct the FIs to recover any overpayments resulting from future reviews.

APPENDICES

SAMPLING METHODOLOGY

OBJECTIVE:

The objectives of this review were to determine what controls and edits, if any, CMS has in place to assure the proper payment of *qualified discharges*, and to quantify the overpayments resulting from *qualified discharges* erroneously coded as Patient Status Code “01 - Discharge to Home.”

POPULATION:

The population was 14,890 claims for discharges of the 10 DRGs specified by the Secretary that were also classified as “Discharge to Home” by the discharging institution. These claims were paid by the FIs to hospitals during the period October 1, 1998 through September 30, 1999, and met other criteria that indicated they were likely to include overpayments. The claims totaled \$174,563,932.

SAMPLE UNIT:

The sampling unit was a DRG claim.

SAMPLE DESIGN

A simple random sample was used.

SAMPLE SIZE:

We selected 200 claims from the universe.

ESTIMATION METHODOLOGY

Using the Department of Health and Human Services, OIG, Office of Audit Services RAT-STATS Variable Appraisal Program for unrestricted samples, we projected the excessive payments to discharging hospitals resulting from erroneously-coded claims. The erroneous payments were calculated by using the payment methods for these 10 DRGs as adopted under section 1886(d)(5)(J) of the Social Security Act.

APPENDIX B

SAMPLE RESULTS AND PROJECTIONS

Sample Results

<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Non-Zero Errors</u>	<u>Value of Errors</u>
200	\$2,564,280	198	\$702,634

Variable Projections

Point estimate	\$ 52,311,082
90% Confidence Interval	
Lower Limit	\$ 35,519,828
Upper Limit	\$ 69,102,336

Attributes Projection


We also used our random sample of 200 claims to project the percentage and number of claims in error. We used the Department of Health and Human Services, OIG, RAT-STATS Attribute Appraisal Program for unrestricted samples to project the percentage and number of claims in error. The results of these projections are presented below:

Sample Claims in Error:	198
Point Estimate Percent:	99%
Point Estimate Number:	14,741
90% Confidence Interval	
Lower Limit Percent:	96.897%
Lower Limit Number:	14,428
Upper Limit Percent:	99.825%
Upper Limit Number:	14,864



DATE: JUL 13 2001

TO: Michael F. Mangano
Acting Inspector General
Office of Inspector General

FROM: Michael McMullan 
Acting Deputy Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *Implementation of Medicare's Postacute Care Transfer Policy* (A-04-00-01220)

Thank you for the opportunity to review the above-mentioned draft report. The OIG examined the nationwide implementation of Medicare's postacute care transfer policy as required by the Balanced Budget Act of 1997. The OIG reports that the Centers for Medicare & Medicaid Services (CMS) has no controls or edits in place in the common working file to prevent excessive payments to prospective payment system (PPS) hospitals for erroneously-coded qualified discharges that are followed by postacute care. Based on OIG's sample results, it estimates that for the period October 1, 1998, through September 30, 1999, the Medicare program paid approximately \$52.3 million in excessive diagnosis related group (DRG) payments to PPS hospitals as a result of these erroneous codings.

The OIG has issued the following recommendations:

OIG Recommendation:

CMS should issue a memorandum alerting fiscal intermediaries (FIs) to the problems identified in our review and directing the FIs to reemphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care.

CMS Response:

We concur. A program memorandum (PM), A-01-39, was released to FIs on March 22. The PM requested that the FIs publish instructions in the next regularly scheduled bulletin to hospitals and postacute care facilities with respect to the facilities' responsibility for ensuring correct and appropriate discharge status coding on claims. These instructions are in accordance with the 10 DRG, postacute care transfer, provision in Section 1886(d)(5)(l) of the Social Security Act.

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS). We are exercising fiscal restraint by exhausting our stock of stationery.

Page 2 – Michael F. Mangano

OIG Recommendation:

CMS should instruct and monitor FIs' actions to recover the \$702,634 in overpayments identified in our sample.

CMS Response:

We concur. CMS will direct the Medicare FIs identified in the report to recover the \$702,634 in overpayments. This report is a draft and will not be sent to the regional offices (ROs) at this time. After issuance of a final report, OIG will be required to furnish the data necessary for the Medicare contractors to initiate and complete recovery action. At that time, CMS will forward the final report and the information needed by the Medicare contractors to effectuate recovery of the overpayments to the ROs for appropriate action. CMS will also forward the name of the OIG person to be contacted if questions arise.

OIG Recommendation:

CMS should review the remaining 14,690 claims identified in our sampling universe to identify and recover additional overpayments.

CMS Response:

We concur. CMS will direct the Medicare FIs to recover any overpayments resulting from future reviews.

OIG Recommendation:

CMS should conduct matches similar to the one we conducted to identify and recover additional overpayments for claims subsequent to September 30, 1999. Potential savings could rival those of that review.

CMS Response:

We concur. CMS will direct the Medicare FIs to recover any overpayments resulting from future reviews.