




APR 21 2003

**TO:** Thomas Scully  
Administrator  
Centers for Medicare and Medicaid Services

**FROM:** Dennis J. Duquette   
Acting Principal Deputy Inspector General

**SUBJECT:** Compliance With Medicare's Postacute Care Transfer Policy for Fiscal Year 2000  
(A-04-02-07005)

Attached is a copy of our final report providing the results of our self-initiated *Review of Compliance with Medicare's Postacute Care Transfer Policy for Fiscal Year 2000*.

The Centers for Medicare and Medicaid Services (CMS) generally did not concur with our long-term recommendation as originally written and we have modified that recommendation in response. The CMS concurred with our remaining recommendations and has supplied additional detail regarding procedural improvements either recently undertaken or currently being developed. The CMS also expressed an interest in conferring with the Office of Inspector General to develop an approach to identify hospitals with patterns of inaccurately coded transfers that result in excess payments. We welcome the opportunity to work further with CMS on this issue. The CMS comments are included as an appendix to our report.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me or George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104 or through e-mail at [greeb@oig.hhs.gov](mailto:greeb@oig.hhs.gov). To facilitate identification, please refer to report number A-04-02-07005 in all correspondence.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**COMPLIANCE WITH MEDICARE'S  
POSTACUTE CARE TRANSFER  
POLICY FOR FISCAL YEAR 2000**



**JANET REHNQUIST**  
Inspector General

**APRIL 2003**  
**A-04-02-07005**

# *Notices*

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at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

## **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.



## EXECUTIVE SUMMARY

### OBJECTIVE

The objective of this review was to determine compliance with Medicare's postacute care transfer policy.

### FINDINGS

One hundred eighty-eight of 200 sampled claims from the 10 diagnosis related groups (DRG) that are subject to the transfer policy resulted in excessive DRG payments due to erroneous coding of transfers as discharges by hospitals.

The Centers for Medicare and Medicaid Services (CMS) has no controls or edits to detect excessive payments to prospective payment system (PPS) hospitals for erroneously coded qualified discharges that are followed by postacute care. As a result:

- the erroneously coded claims in our sample resulted in excessive DRG payments of \$736,543; and
- for fiscal year (FY) 2000, the Medicare program paid approximately \$61 million in excessive DRG payments to PPS hospitals as a result of these erroneous codings.

Combining this \$61 million with the estimate of \$55 million in erroneous payments that were previously identified for FY 1999<sup>1</sup>, we estimate that CMS has overpaid hospital claims by approximately \$116 million for the initial 2-year period of the postacute care transfer policy.

### RECOMMENDATIONS

We recommend:

- as a long-term remedy, that CMS establish an alert mechanism within the Common Working File to compare applicable inpatient claims with subsequent postacute claims. This will allow potentially erroneous inpatient hospital claims to be detected, reviewed, and appropriately adjusted on an ongoing basis.

Pending implementation of the long-term recommendation above, we recommend that CMS:

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<sup>1</sup>In FY 1999, three audits were conducted that comprise the \$55 million in erroneous payments: *Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross Blue Shield of Georgia – A-04-00-01210*, *Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options – A-04-00-02162*, and *Implementation of Medicare's Postacute Care Transfer Policy – A-04-00-01220*.

- instruct and monitor the fiscal intermediaries' (FI) actions to recover the \$736,543 in overpayments identified in our sample;
- instruct FIs to review the remaining 16,326 claims identified in our sampling universe to identify and recover additional overpayments; and
- conduct matches similar to the one that we conducted on a post-payment, periodic basis, in order to identify and recover additional overpayments for claims subsequent to September 30, 2000. Potential savings could rival those of this review.

The CMS generally did not concur with our long-term recommendation as originally written and we have modified that recommendation in response. The CMS generally concurred with our remaining recommendations and has supplied additional detail regarding procedural improvements either recently undertaken or currently being developed. The CMS's responses are summarized in the Findings and Recommendations section of this report, and the response is included as APPENDIX C. The CMS response also included technical comments, which we have incorporated into our report where appropriate.

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## **Glossary of Abbreviations and Acronyms**

BBA	Balanced Budget Act of 1997
CC	Complications and Comorbidities
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CWF	Common Working File
DRG	Diagnosis Related Group
FI	Fiscal Intermediary
FY	Fiscal Year
HHA	Home Health Agency
OIG	Office of Inspector General
PPS	Prospective Payment System
RHHI	Regional Home Health Intermediary
SAF	Standard Analytical File
SNF	Skilled Nursing Facility

# INTRODUCTION

## BACKGROUND

### *Postacute Care Transfer Policy*

Discharges and transfers under the inpatient hospital prospective payment system (PPS) are defined in 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 normally 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 diagnosis related groups (DRG) payment that would have been made if the patient had been discharged without being transferred.

In the framing of the Balanced Budget Act (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.

Section 4407 of the BBA 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 skilled nursing facility (SNF); or
- 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 Centers for Medicare and Medicaid Services (CMS) contracts with intermediaries, usually insurance companies, to assist in administering the Medicare program. The intermediary for inpatient hospital facilities is referred to as a fiscal intermediary (FI). The intermediary for home health agencies (HHA) 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 [63 Federal Register 40,954, 40979-80 (July 31, 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.

Three previous audits conducted by the Office of Inspector General (OIG) in this same area are *Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross Blue Shield of Georgia – A-04-00-01210*, *Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options – A-04-00-02162*, and *Implementation of Medicare's Postacute Care Transfer Policy – A-04-00-01220*. The CMS concurred with our findings and associated recommendations in these reports. These reports are published on our website at <http://oig.hhs.gov>.

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

### ***Objective***

The objective of this review was to determine compliance with Medicare's postacute care transfer policy.

### ***Scope***

Our audit focused on Medicare inpatient claims with the 10 specified DRGs from PPS hospitals nationwide for the period of October 1, 1999 through September 30, 2000. Discharges from providers in the state of Maryland were excluded from our review because it utilizes an alternative payment methodology to PPS.

During this period, 1,029,144 discharges occurred nationally within these 10 DRGs. Of these discharges, 16,526 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 dollar amount and number of excessive payments made to the hospitals (see APPENDIX B for details).

### ***Methodology***

We initiated our review by obtaining a list of final action files of inpatient data from PPS hospitals for the 10 DRGs for the period October 1, 1999 through September 30, 2000 from CMS's National Claims History Standard Analytical Files (SAF). This database contained 1,029,144 claims totaling \$10,910,934,739. We reduced these 1,029,144 claims to 74,323 claims totaling \$567,112,873 based on the following criteria:

- included only claims with the Patient Status Code of "01- Discharge to Home";
- eliminated claims from Maryland (not PPS);
- eliminated all records where full payment was due and no overpayment could have occurred;
- eliminated all claims where the Medicare payment amount equaled zero; and
- included only those claims that were a final bill.

These 74,323 claims were pared to 73,141 unique Health Insurance Claim Numbers which were then compared to CMS's SAF database of Medicare claims in order to determine if any of the claims were "matched" by:

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

The resulting matches left the population of 16,526 claims totaling \$183,505,316 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, 1999 through September 30, 2000. Our audit was performed at the OIG Atlanta regional office and Tallahassee field office.

Our review allowed us to establish a reasonable assurance regarding the authenticity and accuracy of the data obtained from the 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.

## **FINDINGS AND RECOMMENDATIONS**

Based on our discussions with CMS headquarters personnel, we determined that CMS has no controls or edits in place in the Common Working File (CWF) to detect 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 188 of 200 sampled claims from the 10 DRGs that are subject to the transfer policy resulted in excessive DRG payments due to erroneous coding of transfers as discharges by hospitals. The 188 erroneously coded claims in our sample resulted in excessive DRG payments of \$736,543.

Based on the sample results of the 16,526 claims included in our universe, we estimate that 15,534 were erroneously coded for the period of October 1, 1999 through September 30, 2000. We also estimate that the Medicare program paid \$60,860,570 in excessive DRG payments to PPS hospitals as a result of these erroneous codings (see APPENDIX B for details).

Combining this \$61 million with the estimate of \$55 million in erroneous payments that were previously identified for FY 1999<sup>2</sup>, we estimate that CMS has overpaid hospital claims by approximately \$116 million for the initial 2-year period of the postacute care transfer policy.

Our prior reviews demonstrated that CMS has not implemented payment controls in the CWF to detect 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 three previous audits of qualified discharges.

## **CRITERIA**

Medicare regulations found in 42 CFR 412.4(e) provide for the full DRG payment to be made to a hospital that discharges an inpatient. In contrast, under 412.4(f), a hospital that transfers an inpatient to one of the three post-acute settings named below 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 when the services relate to the condition or diagnosis for which the individual received inpatient hospital 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 1 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 [63 Federal Register 40,954, 40979-80 (July 31, 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

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<sup>2</sup> Ibid.

that postacute care was provided, the hospital should submit an adjustment bill. The CMS acknowledged that hospitals would 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.

Program Memorandum A-01-39, issued on March 22, 2001, 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. In addition, in Program Memorandum A-01-39, CMS stated to its respective contractors that “As a result of these OIG reports, this Program Memorandum is requiring that you publish instructions in your next regularly scheduled provider bulletin, to hospitals and postacute care facilities, with respect to their responsibility for ensuring correct and appropriate discharge status coding on claims, according to the 10 Diagnosis Related Group (DRG) postacute care transfer provision in §1886(d)(5)(I) of the Social Security Act (Act).”

### ***MOST CLAIMS REVIEWED WERE NOT PROPERLY CODED***

In our sample of 200 claims coded as discharge to home, 188 claims were improperly coded as discharges to home rather than transfers to postacute care. These 188 erroneously coded claims resulted in the discharging hospitals receiving excessive payments relating to the 10 qualified discharge DRGs.

There were a total of 12 claims that, upon review, resulted in non-errors:

- Eight sample items that had been cancelled after the audit period were not treated as errors and were excluded from being recalculated. While these claims were initially incorrectly coded, it appears the original discharging facility corrected its error.
- Four sample items were determined to be non-errors and were excluded from being recalculated.

The 188 erroneous claims included:

- 105 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 \$276,981 in excess payments to the discharging provider.
- 42 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 \$269,449 in excess payments to the discharging provider.
- 41 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 \$190,113 in excess payments to the discharging provider.

## ***CMS HAS NOT IMPLEMENTED PAYMENT CONTROLS***

Our prior reviews demonstrated that CMS has not implemented payment controls in the CWF to detect 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 discussions with CMS headquarters personnel, we found that CMS had not implemented payment controls in the CWF to detect or correct hospital overpayments pursuant to the recommendation in our previous nationwide report (*Implementation of Medicare's Postacute Care Transfer Policy -- A-04-00-01220*). We also 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.

## **MEDICARE PAID MORE THAN \$60 MILLION IN EXCESSIVE DRG PAYMENTS**

For the period October 1, 1999 through September 30, 2000, 188 of 200 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded by the hospital. The 188 erroneously coded claims in our sample resulted in excessive DRG payments of \$736,543.

Based on the sample results, we estimate that 15,534 claims for these DRGs were erroneously coded nationally. We also estimate that the Medicare program paid approximately \$60,860,570 in excessive DRG payments to PPS hospitals nationwide as a result of these erroneous codings.

## **OTHER MATTERS**

We also note that CMS has recently taken action to distribute the schedule of potentially erroneous claims developed by OIG during our previous nationwide review of FY 1999 discharges. We commend CMS on initiating this recovery effort.

The OIG reiterates its willingness 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.

## **RECOMMENDATIONS**

### ***OIG's Recommendation***

As a long-term remedy, we recommend that CMS establish an alert mechanism in the CWF to compare applicable inpatient claims with subsequent postacute claims. This will allow potentially erroneous inpatient hospital claims to be detected, reviewed, and appropriately adjusted on an ongoing basis.

### ***CMS's Comment***

The CMS acknowledges that it has concurred with this recommendation in previous reports that OIG has issued on this subject. However, CMS is concerned that this approach may be difficult to implement and may not provide good protection for the Medicare system when fully implemented. The CMS concurs with the interim recommendations made by OIG (see following sections), and has expressed an interest to confer with OIG regarding a long-term approach to identify hospitals with patterns of inaccurately coded transfers.

### ***OIG's Response***

We have modified our recommendation, but still recommend that an alert mechanism be established within the CWF with the capability of notifying the discharging inpatient hospitals' FI of a potential postacute care claim, at least on a post-payment basis. As a part of this review, the audit team took some steps to identify providers who appear to have patterns of inaccurately coded discharges, and OIG is willing to share this data with CMS. However, due to the estimated dollar amount of erroneous payments in just the first 2 years of the postacute care transfer policy, we believe that continual monitoring of the process is warranted. In the absence of either a prepayment edit or post-payment alert in the CWF, we reemphasize the remaining recommendations in this report (see below). The OIG welcomes the opportunity to work with CMS to develop a long-term approach to detect and/or prevent erroneous codings of transfers as discharges.

### ***OIG's Recommendation***

Instruct and monitor the FI actions to recover the \$736,543 in overpayments identified in our sample.

### ***CMS's Comment***

The CMS concurred with this recommendation.

### ***OIG's Recommendation***

Instruct FIs to review the remaining 16,326 claims identified in our sampling universe to identify and recover additional overpayments.

### ***CMS's Comment***

The CMS concurred with this recommendation.

### ***OIG's Recommendation***

Conduct matches similar to the one that we conducted on a post-payment, periodic basis, in order to identify and recover additional overpayments for claims subsequent to September 30, 2000. Potential savings could rival those of this review.

***CMS's Comment***

The CMS concurred in part with this recommendation, and indicated that they are interested in pursuing a partnership with OIG to address the issue.



# APPENDICES

**SAMPLING METHODOLOGY**

**OBJECTIVE:**

The objective of this review was to determine compliance with Medicare's postacute care transfer policy.

**POPULATION:**

The population was 16,526 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, 1999 through September 30, 2000, and met other criteria that indicated they were likely to include overpayments. The claims totaled \$183,505,316.

**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	\$2,559,662.58	188	\$736,543.27

#### Variable Projections

Point estimate	\$ 60,860,570
90 Percent Confidence Interval	
Lower Limit	\$ 37,140,457
Upper Limit	\$ 84,580,684

#### 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, Office of Audit Services 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:	188
Point Estimate Percent:	94.0 percent
Point Estimate Number:	15,534
90 Percent Confidence Interval	
Lower Limit Percent:	90.482 percent
Lower Limit Number:	14,953
Upper Limit Percent:	96.484 percent
Upper Limit Number:	15,945



FEB 21 2003

**DATE:****TO:** Janet Rehnquist  
Inspector General  
Office of Inspector General**FROM:** Thomas A. Scully  
Administrator  
Centers for Medicare & Medicaid Services  
*Tom Scully***SUBJECT:** Office of Inspector General (OIG) *Draft Report, "Compliance with Medicare's Postacute Care Transfer Policy for Fiscal Year 2000" (A-04-02-07005)*

Thank you for the opportunity to review the above-mentioned draft report. The findings and recommendations of this report are similar to those of three previous reports; i.e., A-04-00-02162, A-04-00-01220, and A-04-00-01210. Specifically, the OIG audit sampled 200 claims from a population of 16,526 claims where a discharge home was indicated. The audit found that for 188 of these claims, a subsequent claim for the patient was submitted by a postacute care provider, resulting in an overpayment. The report makes several recommendations to ensure that hospitals accurately code discharge status for these situations. These recommendations and our responses are outlined below.

**OIG Recommendation**

As a long-term remedy, the Centers for Medicare & Medicaid Services (CMS) should establish edits in the Common Working File to compare applicable inpatient claims with subsequent postacute claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made on an ongoing basis to the discharging hospital's inpatient claim.<sup>1</sup>

**Response**

A similar recommendation was included in each of the three previous reports, and CMS has indicated it intended to pursue this approach. However, at this time, we are concerned that this approach may be problematic for several reasons. First, the fiscal intermediary (FI) that processes the hospital claim may not be the same FI that processes the postacute provider claim. This may lead to uneven enforcement across hospitals. Second, such an edit has existed for some time for transfers from one acute care hospital to another. Nevertheless, OIG continued to find high rates of inappropriately coded transfers being paid as discharges. Therefore, we would like to confer with OIG about the potential for working cooperatively to identify hospitals with patterns of inaccurately coded transfers resulting in excess payments. As we indicated in 63 Fed. Reg. 25576, 25593 (May 8, 1998), such hospitals may be investigated for fraudulent or abusive

<sup>1</sup>The OIG modified the recommendation in response to the comments from CMS that follow.

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billing practices. We believe such an approach would be more effective in the long run than edits in the Common Working File.

Recommendation

Instruct and monitor FIs' actions to recover the \$736,543 in overpayments identified in the sample.

Response

We concur that CMS should direct the Medicare FIs to recover the \$736,543 in overpayments.

Recommendation

Review the remaining 16,326 claims identified in the sample to identify and recover additional overpayments.

Response

We agree that resources should be expended to review the remaining 16,326 claims, and CMS should direct the Medicare FIs to recover any overpayments resulting from these reviews.

Recommendation

Conduct matches similar to the one OIG conducted to identify and recover additional overpayments for claims subsequent to September 30, 2000.

Response

We agree that CMS needs to aggressively monitor the implementation of this policy, and, as noted above, we are interested in exploring a potential cooperative arrangement with OIG to identify, investigate, and sanction abusive hospitals.

The CMS agrees that resources should be expended to conduct additional matches on a post-payment, periodic basis similar to the one conducted by the OIG. The CMS will direct the Medicare FIs to recover any overpayments resulting from these reviews.

After issuance of the final report, CMS plans to obtain the necessary data from OIG (provider numbers, claims information, HIC numbers, etc.) so that the CMS Medicare contractors can initiate and complete recovery action of any additional overpayments. At that time, CMS will forward this report and the necessary data to the regional offices (ROs) for appropriate action. The CMS will also provide the ROs with the name of the OIG person to be contacted if any questions should arise.