Inadequate Edits and Oversight Caused Medicare To Overpay More Than $267 Million for Hospital Inpatient Claims With Post-Acute-Care Transfers to Home Health Services

What OIG Found
Medicare improperly paid most inpatient claims subject to the transfer policy when beneficiaries resumed home health services within 3 days of discharge but the hospitals failed to code the inpatient claim as a discharge to home with home health services or when the hospitals applied condition codes 42 (home health not related to inpatient stay) or 43 (home health not within 3 days of discharge). Of the 150 inpatient claims in our sample, Medicare properly paid 3; however, it improperly paid 147 with $722,288 in overpayments. Medicare should have paid these inpatient claims using a graduated per diem rate rather than the full payment. Based on our sample results, we estimated that Medicare improperly paid $267 million during a 2-year period for hospital services that should have been paid a graduated per diem payment.

What OIG Recommends and CMS Comments
We recommend that CMS direct its Medicare contractors, for the claims that are within the 4-year reopening period, to: (1) recover a portion of the $722,288 in overpayments identified in our sample, (2) reprocess the remaining inpatient claims in our sample frame with an incorrect patient discharge status code or condition code 43 to recover a portion of the estimated $225.7 million in overpayments, and (3) analyze the remaining inpatient claims in our frame with condition code 42 and recover a portion of the estimated $40.6 million in potential overpayments. Also, we recommend that CMS correct its related system edits, improve its provider education related to the Medicare transfer policy, and use data analytics to identify hospitals disproportionally using condition code 42. Finally, we recommend that CMS consider reducing the need for clinical judgment when processing claims under the post-acute-care transfer policy by taking the necessary actions, including seeking legislative authority if necessary, to deem any home health service within 3 days of discharge to be “related.”

CMS concurred with all but our last recommendation and described actions that it had taken or planned to take to address the recommendations. We maintain that CMS should further explore reducing the need for clinical judgment when processing claims under the post-acute-care transfer policy and revised our recommendation to have CMS consider this change.

The full report can be found at https://oig.hhs.gov/oas/reports/region4/41804067.asp.