Date  MAR 21 2002

From Janet Rehnquist
Inspector General

Subject Medicare Prospective Payment System Transfers Reported as Left Against Medical Advice Hospital Discharges (A-06-99-00045)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's (OIG) final report entitled, "Medicare Prospective Payment System Transfers Reported as Left Against Medical Advice Hospital Discharges." We initiated this review as part of our continuing audit work related to prospective payment system (PPS) transfers. Our prior reviews identified significant overpayments related to Medicare inpatient hospital transfers incorrectly reported as discharges. However, our audit work to date has not addressed left against medical advice (LAMA) discharges with a same day admission to another PPS hospital.

The objectives of our review were to (1) determine whether changes or improvements are needed in the Centers for Medicare & Medicaid Services (CMS) policy pertaining to PPS hospital reporting of patient transfers with respect to LAMA discharges and (2) quantify the financial impact of PPS hospitals incorrectly reporting transfers as LAMA discharges.

Our review showed that between January 1, 1996 and June 30, 1998 Medicare paid 1,610 PPS hospitals an additional $6.8 million because they reported as LAMA discharges, patients who were admitted to another PPS hospital on the same day. Ordinarily, the occurrence of a discharge from one PPS hospital and an admission to a second PPS hospital on the same day would identify a potential incorrectly reported PPS transfer. In November 1990, CMS issued instructions to fiscal intermediaries (FI) for processing claims containing incorrect hospital coding of patient discharges. However, these instructions did not address claims that were coded as LAMA discharges. Consequently, LAMA discharges are not subject to FI review. As a result, these claims may have been paid at an amount that was usually higher than the amount that would have been paid had these discharges been treated as PPS transfers.

Based on our review of CMS's instructions, we believe that: (1) not including LAMA discharges in the computerized systems edits designed to detect same day discharges and readmissions to a second PPS hospital; and (2) the absence of reviews by FIs and/or peer
review organizations (PRO) contributed to potential overpayments. We also noted that in the hospitals reviewed, the hospitals were as knowledgeable of and participated in the patient admissions to the second PPS hospitals for transfers reported as LAMA discharges, as they were for other PPS transfers.

Based on CMS statistical data over a 5-year period, there was an average of about 60,000 LAMA discharges each year. About 1,500 of these discharges per year were potential PPS transfers because the patients were admitted to another PPS hospital on the same day. Prior OIG and CMS joint projects resulted in significant overpayment recoveries from hospitals which incorrectly reported PPS transfers as discharges and as a result, FIs closely monitor and review such transfers.

Accordingly, we recommended that CMS: (1) review the instructions for incorrect hospital coding of patient discharges in order to determine whether it should be revised to address PPS transfers reported as LAMA discharges; (2) develop adequate internal controls and monitoring safeguards at FIs and/or PROs to address PPS transfers reported as LAMA discharges; and (3) require FIs and/or PROs to conduct a review of LAMA discharges with a same day admission at another PPS hospital and recover overpayments where appropriate.

The CMS concurred with two of our recommendations. However, CMS expressed concern that the number of improper LAMA discharges over the period covered by our report did not show sufficient evidence to show an abusive situation. The CMS believed that its scarce resources may be better employed elsewhere. The CMS also stated that it believes that existing instructions in the provider manuals are sufficient to guide providers in the proper use of the patient status codes. The full text of CMS’s comments is included as an APPENDIX to the report.

During the period of our audit, the majority of incorrectly reported LAMA discharges were reported by about one-third of PPS hospitals. However, we are concerned that additional hospitals may significantly increase the number of PPS transfers incorrectly reported as LAMA discharges. If this occurs, no payment edits or medical review procedures currently exist at the Medicare contractors to detect a shift in usage of LAMA discharges. We believe this increases the risk that errors and abuse of LAMA discharges may go undetected.

With respect to the examples included in our report, the patients went from one PPS hospital to another PPS hospital with no indication of any intermediate stop. However, despite the knowledge of and participation in the transfer, the transferring hospitals reported the patients as discharged against medical advice. We are prepared to work with CMS to concentrate recovery efforts on the small number of providers that routinely report PPS transfers as LAMA discharges.
We would appreciate your views and information on the status of any action taken or contemplated on the 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-06-99-00045 in all correspondence relating to this report.

Attachments
MEDICARE PROSPECTIVE PAYMENT SYSTEM TRANSFERS REPORTED AS LEFT AGAINST MEDICAL ADVICE HOSPITAL DISCHARGES
Date MAR 21 2002

From Janet Rehnquist
Inspector General

Subject Medicare Prospective Payment System Transfers Reported as Left Against Medical Advice Hospital Discharges (A-06-99-00045)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

This report provides you with the results of our review of Medicare prospective payment system (PPS) transfers reported as left against medical advice (LAMA) hospital discharges. The incorrect reporting by hospitals of PPS transfers as LAMA discharges may become an area of widespread abuse. In previous joint recovery projects, the Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) addressed the widespread abuse of the PPS transfer policy whereby hospitals incorrectly reported transfers as discharges. To date, recoveries and savings under the joint projects have exceeded $220 million.

In a follow-up review to our original work, we found that miscoding of PPS transfers continues to be a problem and we are working with CMS to recover the overpayments identified. Our work to date, however, did not address LAMA discharges with same day admissions to another PPS hospital because CMS's instructions do not apply to claims coded as LAMA discharges.

The objectives of our review were to (1) determine whether changes or improvements are needed in CMS's policy pertaining to PPS hospital reporting of patient transfers with respect to LAMA discharges and (2) quantify the financial impact of PPS hospitals incorrectly reporting transfers as LAMA discharges.

We determined that between January 1, 1996 and June 30, 1998 Medicare paid 1,610 PPS hospitals an additional $6.8 million because they reported as LAMA discharges, patients who were admitted to another PPS hospital on the same day.

Under Federal regulations, a PPS hospital that transfers a Medicare patient to another PPS hospital receives a per diem payment, up to the amount of the full diagnosis related group (DRG) payment. However, transfers between PPS hospitals where the transferring
hospital reports the patient discharged against medical advice are not subject to the PPS transfer payment policy. Thus, the transferring hospital receives the full DRG payment. When this occurs, Medicare may be paying monies to transferring hospitals, in excess of the per diem. Since Medicare pays the full DRG to a PPS hospital when it reports a LAMA discharge, a transferring hospital seeking additional reimbursements need only report its PPS transfers as LAMA discharges in order to receive the usually higher DRG payment.

To address incorrect hospital coding of patient discharges, CMS issued instructions to the fiscal intermediaries (FI) to assist them in detecting incorrectly reported PPS transfers. These instructions, however, do not apply to claims coded as LAMA discharges. We believe that the potential risk of abuse or error for PPS transfers reported as LAMA discharges increased since these instructions were issued without the establishment of an oversight function by FIs and/or peer review organizations (PRO). Based on the results of our review, we believe that: (1) not including LAMA discharges in the computerized systems edits designed to detect same day discharge and readmission to a second PPS hospital; and (2) the absence of reviews by FIs and/or PROs of claims coded as LAMA discharges contributed to potential overpayments.

Based on CMS statistical data over a 5-year period, there was an average of about 60,000 LAMA discharges each year. About 1,500 of these discharges per year resulted in a same day admission at another PPS hospital. Prior OIG and CMS joint projects resulted in significant overpayment recoveries from hospitals which incorrectly reported PPS transfers as discharges and as a result, FIs closely monitor and review such transfers.

The CMS concurred with two of our recommendations (see APPENDIX). However, CMS expressed concern that the number of improper LAMA discharges over the period covered by our report did not show sufficient evidence to show an abusive situation. The CMS believed that its scarce resources may be better employed elsewhere. The CMS also stated that it believes that existing instructions in the provider manuals are sufficient to guide providers in the proper use of the patient status codes.

During the period of our audit, the majority of incorrectly reported LAMA discharges were reported by about one-third of PPS hospitals. However, we are concerned that additional hospitals may significantly increase the number of PPS transfers incorrectly reported as LAMA discharges. If this occurs, no payment edits or medical review procedures currently exist at the Medicare contractors to detect a shift in usage of LAMA discharges. We believe this increases the risk that errors and abuse of LAMA discharges may go undetected.

With respect to the examples included in our report, the patients went from one PPS hospital to another PPS hospital with no indication of any intermediate stop. However, despite the knowledge of and participation in the transfer, the transferring hospitals reported the patients as discharged against medical advice. We are prepared to work with CMS to concentrate
recovery efforts on the small number of providers that routinely report PPS transfers as LAMA discharges.

INTRODUCTION

BACKGROUND

Law and Regulations

Section 1886(d) of the Social Security Act, enacted by the Social Security Amendments of 1983 (Public Law 98-21) established a PPS for Medicare payments for inpatient hospital services. The PPS became effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, FIs pay PPS hospitals a predetermined rate for each beneficiary discharged. The payment amount varies by the DRG assigned to the patient's treatment. The list of DRGs currently contains approximately 500 specific categories.

Under Federal regulations (42 CFR 412.4(f)), a PPS hospital that transfers a Medicare patient to another PPS hospital receives a per diem payment determined by dividing the full payment rate for the discharge by the geometric mean length of stay for the applicable DRG assigned to the case. Payment to a transferring hospital, except for extraordinarily high-cost cases that meet the criteria for cost outliers, may not exceed the full DRG payment rate.

Fiscal Intermediary Responsibility

The FIs receive Medicare claims from participating PPS hospitals and process and pay the claims according to Medicare regulations and CMS instructions. Through a Program Memorandum (dated November 1990) and the Medicare Intermediary Manual, CMS issued instructions to its FIs for processing claims containing incorrect hospital coding of patient discharges. However, the instructions do not apply to claims coded as LAMA discharges. As a result, both hospitals are paid the full amount for the applicable DRG.

Peer Review Organization Responsibility

The PROs are responsible for ensuring that medical care furnished to Medicare beneficiaries is medically necessary and reasonable, provided in the most appropriate setting, and the quality of such services meets professionally recognized standards of health care. In addition, PROs review items or services provided to Medicare beneficiaries to determine whether a hospital misrepresented admission or discharge information, or caused unnecessary multiple admissions of an individual. Under the current scope of work, however, PROs are
not required to review potential PPS transfers reported as LAMA discharges.

**OBJECTIVES, SCOPE, AND METHODOLOGY**

The objectives of our review were to (1) determine whether changes or improvements are needed in CMS's policy pertaining to PPS hospital reporting of patient transfers with respect to LAMA discharges and (2) quantify the financial impact of PPS hospitals incorrectly reporting transfers as LAMA discharges.

To accomplish our objectives, we analyzed CMS's Medicare PPS payment data for LAMA discharges for the period January 1, 1996 through June 30, 1998. For this period, we identified 3,741 LAMA discharges with a same day admission to another PPS hospital.

Our audit was made in accordance with generally accepted government auditing standards. We did not review the overall internal control structure of PPS hospitals. We did not perform an analysis of the systems edits for PPS transfers to meet the objectives of our review. Our review of internal controls was limited to a review of CMS documents and instructions pertaining to the claims processing and systems edits for PPS transfers.

Our field work involved limited on-site review at a number of PPS hospitals across the nation. Under a separate cover, we will provide CMS with the necessary claims information to conduct a post-payment review of medical records and to recover overpayments, where appropriate.

**RESULTS OF REVIEW**

We determined that between January 1, 1996 and June 30, 1998 Medicare paid 1,610 PPS hospitals an additional $6.8 million because they incorrectly reported as LAMA discharges, patients who were admitted to another PPS hospital on the same day. Ordinarily, the occurrence of a discharge and admission at a second PPS hospital on the same day would identify a potential incorrectly reported PPS transfer. The CMS issued instructions to its FIs for processing claims which contain PPS transfers that have been incorrectly reported as hospital discharges. However, these instructions do not apply to claims coded as LAMA discharges. Consequently, LAMA discharges are not subject to FI review. As a result, these claims may have been paid at an amount which was usually higher than the amount that would have been paid had these discharges been treated as PPS transfers.

We believe that: (1) not including LAMA discharges in the computerized system edits designed to detect same day discharge and readmission to a second PPS hospital; and (2) the
absence of reviews by FIs and/or PROs of claims coded as LAMA discharges contributed to potential overpayments.

Based on CMS statistical data over a 5-year period, there was an average of about 60,000 LAMA discharges each year. About 1,500 of these discharges per year resulted in a same day admission at another PPS hospital. Prior OIG and CMS joint projects resulted in significant overpayment recoveries from hospitals which incorrectly reported PPS transfers as discharges and as a result, FIs closely monitor and review such transfers. However, we are concerned that hospitals may now significantly increase the number of PPS transfers incorrectly reported as LAMA discharges. If this occurs, no payment edits or medical review procedures currently exist at the Medicare contractors to detect a shift in usage of the LAMA discharge code to incorrectly report PPS transfers. We believe this increases the risk that errors and abuse for LAMA discharges may go undetected.

Use of LAMA Code May Be Inappropriate in Many Instances

At selected hospitals, we performed a detailed review of medical records for potential PPS transfers reported as LAMA discharges. In a majority of the medical records reviewed, we found that the hospitals were involved with the planning and transferring of the patient to another PPS hospital. This involvement raised significant concerns since the LAMA discharge code may have been used by some of these hospitals to incorrectly report PPS transfers and thereby receive full DRG payments. Where warranted, appropriate referrals were made to our Office of Investigations.

The following are three examples in which the transferring hospital had knowledge of and/or participated in the patient's transfer to another PPS hospital on the same day.

In the first example, the transferring hospital did not have an inpatient room available for the patient, who had been in the emergency room for 24 hours. The medical record showed that the treating physician contacted another PPS hospital to determine whether the hospital could accept the patient. Specifically, the medical record stated:

▶ Upon request of patient, (hospital name) was contacted since there is a good possibility of transferring patient to (name of hospital). At present, he has been in emergency room for 24 hours waiting for a bed.

Even with this level of participation in securing the admission to the other PPS hospital, the transfer was reported as a LAMA discharge, rather than as a transfer to another PPS hospital. Additionally, the facts of the case raise questions as to the propriety of an inpatient versus an outpatient billing.
In the second example, the patient was brought to the first hospital by ambulance. Subsequently, the patient's family indicated that they wanted a neurologist at another hospital to render the treatment needed by the patient. The attending physician contacted the neurologist in order to determine if the neurologist would accept, admit, and treat the patient. The medical record contained ample evidence of knowledge and participation of the transferring hospital, and the discharge should have been reported as a PPS transfer. Specifically, the medical record stated:

- Patient's family wanted to sign the patient out against medical advice and take her to (name of hospital). The physician spoke with the neurologist at (name of hospital), who agreed to accept the patient. The patient's family signed the patient discharged against medical advice. All the risks of self discharge were explained.

In this case, the hospital reported the patient discharged against medical advice. We found little difference in the knowledge and participation of the transferring hospital where the family or patient initiated the transfer, or where a physician initiated the transfer simply because he/she preferred the treatment team or facilities available at the other hospital.

In the third example, the discharge was reported as discharged to home, rather than as a PPS transfer. Specifically, the medical record stated:

- In view of very little significant improvement in the patient's respiratory status, even though the x-ray cleared on subsequent film, he was transferred to (name of doctor), Pulmonologist, at (name of hospital) on (date). Pertinent copies of the chart were sent along with the patient, via (name of ambulance company).

The hospital reported the patient as discharged to home. This example is presented to demonstrate that no matter how a PPS transfer is misreported, the transferring hospital's level of knowledge of or participation in the transfer is clearly contained in the medical record. Based on the medical record, those completing the inpatient claim form could have properly reported the patient transferred to another PPS hospital.

In addition, our concern that some hospitals might increase their use of the LAMA discharge code to incorrectly report PPS transfers and continue receiving full DRG payments is highlighted by the results of our review of incorrectly reported PPS transfers. For example, during the previous administrative recovery project, approximately $242,000 was recovered from one hospital for incorrectly reporting PPS transfers as discharges. During that period, the hospital did not use the LAMA discharge code. Subsequently, the hospital often used the LAMA discharge code to incorrectly report PPS transfers. The hospital again received approximately $232,000 in overpayments for incorrectly reporting PPS transfers. However,
in this period about two-thirds of the overpayment was directly related to the use of the LAMA discharge code.

Because CMS’s instructions for incorrect hospital coding of patient discharges do not apply to claims coded as LAMA discharges, FIs are not alerted to potential incorrectly reported PPS transfers. A PPS hospital wishing to receive the full DRG amount for a PPS transfer need only code the claim as LAMA discharge. In this way, the hospital would avoid detection of significant overpayments by its FI's claims processing system.

Claims Processing Systems Controls and FI and PRO Oversight of LAMA Discharges

Between January 1, 1996 and June 30, 1998, 3,741 potential incorrectly reported PPS transfers were paid as LAMA discharges because there was a same day admission at another PPS hospital. These claims were submitted by 1,610 PPS hospitals to which Medicare paid an additional $6.8 million for discharges that may have been transfers between PPS hospitals.

The LAMA discharges are not subject to (1) computerized system edits designed to detect the same day discharge from one PPS hospital and admission to another PPS hospital and/or (2) review by the FI and/or PRO. The exception in the systems edits and the lack of FI/PRO oversight of LAMA discharges preclude FIs from detecting and correcting this condition when it occurs.

Our review of the controls over LAMA discharges showed that vulnerabilities exist whereby a hospital, desiring to incorrectly code PPS transfers and receive the full DRG payment, need only report the discharges as LAMA. In fact, CMS issued instructions to FIs related to detecting incorrectly reported PPS transfers, but specifically excepted claims reported as LAMA discharges. These instructions, however, were issued without the establishment of an oversight function to detect incorrectly reported LAMA discharges.

In addition, LAMA discharges are not subject to review by PROs. The PROs' current scope of work does not provide for a review of LAMA discharges. According to the PRO manual, PRO's PPS transfer reviews involve planned admissions at a second hospital, code 02 (discharged/transferred to another short-term acute hospital) or 05 (discharged/transferred to another type institution). In order for PROs to identify transfers for review, codes 02 or 05 must be entered on the bill.

As part of our review of individual hospitals, we discussed the documentation contained in a number of the medical records with the cognizant PRO. These records supported claims which were coded as LAMA discharges, and involved patients who were admitted to another
PPS hospital on the same day. The PRO was in general agreement that most of the medical records clearly indicated that reporting a PPS transfer rather than a LAMA discharge was appropriate.

CONCLUSIONS AND RECOMMENDATIONS

We believe that excepting LAMA discharges from the FIs computer edits and from the PROs oversight responsibility, increases the risk that errors and abuse of LAMA discharges may go undetected.

Accordingly, we recommended that CMS:

1. Review the instructions for incorrect hospital coding of patient discharges in order to determine whether it should be revised to address PPS transfers reported as LAMA discharges;

2. Develop adequate internal controls and monitoring safeguards at FIs and/or PROs to address PPS transfers reported as LAMA discharges; and

3. Require FIs and/or PROs to conduct a review of LAMA discharges with a same day admission at another PPS hospital and recover overpayments where appropriate.

CMS'S COMMENTS

In their written response to our draft report, CMS agreed to:

- Review the program instructions to determine if any clarifications are appropriate regarding hospital coding of the patient discharges identified in our report;

- Direct FIs and/or PROs to conduct a review of LAMA discharges with a same day admission at another PPS hospital. The CMS stated that it will direct FIs to review a sample of LAMA discharges with a same day admission at another PPS hospital to determine the appropriateness of the claims. If the sample review shows a significant problem, CMS will conduct a full review of all LAMA discharges with a same day admission to another PPS hospital; and

- Direct the FIs to work with OIG to recover identified overpayments resulting from inappropriately coded LAMA discharges that in fact were transfers to another PPS hospital.
The CMS also expressed concern that the number of improper LAMA discharges over the period covered by our report was not sufficient evidence of an abusive situation. The CMS, therefore, believed that its scarce resources may be better employed elsewhere.

The CMS did not agree with our recommendation to develop adequate internal controls and monitoring safeguards at FIs and/or PROs to address PPS transfers reported as LAMA discharges. The CMS stated that it has adequate patient status codes and instructions in its provider manuals for institutional providers to correctly code when a patient leaves against medical advice. The CMS further stated that there is nothing more an FI can do to enforce CMS policy other than to request a complete PRO medical review. The full text of CMS's comments is included as an APPENDIX to the report. The CMS also provided technical comments to our report.

**OIG'S RESPONSE**

During the period of our audit, the majority of incorrectly reported LAMA discharges were reported by about one-third of PPS hospitals. However, we are concerned that additional hospitals may significantly increase the number of PPS transfers incorrectly reported as LAMA discharges. If this occurs, no payment edits or medical review procedures currently exist at the Medicare contractors to detect a shift in usage of LAMA discharges. We believe this increases the risk that errors and abuse of LAMA discharges may go undetected.

With respect to the examples included in our report, the patients went from one PPS hospital to another PPS hospital with no indication of any intermediate stop. However, despite the knowledge of and participation in the transfer, the transferring hospitals reported the patients as discharged against medical advice.

We are prepared to assist CMS in identifying providers warranting review by FIs. We will work with CMS to concentrate recovery efforts on the small number of providers that appear to routinely use LAMA discharges when it appears it would have been more appropriate to report a PPS transfer. We believe that this approach will be more productive than sampling LAMA discharges with a same day admission at another PPS hospital.

In addition, we continue to believe that CMS should develop adequate internal controls and monitoring safeguards at FIs and/or PROs to address PPS transfers reported as LAMA discharges. The examples included in our report showed that hospitals reporting their patients discharged (using the LAMA or other discharge code) had sufficient knowledge of and participation in the patients' transfers. The claims data showed that the patients went from one PPS hospital to another PPS hospital with no indication of any intermediate stops. In addition, we continue to believe that there are steps, other than to request a complete PRO medical review, that FIs can take to enforce CMS policy. The PROs should become involved only when a complete medical review is necessary. We were able to determine whether the
hospital had sufficient knowledge of and participated in the patient's transfer without a complete review of the medical records. As a result, we believe that applying the PPS transfer edit to LAMA discharges would not adversely impact the workload burden of either FIs or PROs.

With respect to CMS's technical comments, we made revisions to our report, as appropriate.
DATE: SEP 19 2001

TO: Janet Rehnquist
Inspector General

FROM: Rueben J. King-Shaw, Jr.
Chief Operating Officer and Deputy Administrator
Centers for Medicare & Medicaid Services


Thank you for the opportunity to comment on the above-referenced report. The OIG states in its report that as much as $6.8 million in additional payments may have been made inappropriately for left against medical advice (LAMA) discharges. Correspondingly, OIG recommends that the Centers for Medicare & Medicaid Services (CMS) review the instructions for incorrect hospital coding of patient discharges; develop adequate internal controls and monitoring safeguards at fiscal intermediaries (FIs) and/or peer review organizations (PROs) to address prospective payment system (PPS) transfers reported as LAMA discharges; and require FIs and/or PROs to conduct a review of LAMA discharges with a same day admission at another PPS hospital and recover overpayments where appropriate.

The CMS will make every effort to ensure that LAMA discharges are properly reported. However, these 3,741 discharges occurred over a 2 1/2-year period in 1,610 hospitals; an average of approximately one per hospital per year. Given this fact, this is hardly evidence of an abusive situation. The CMS believes that our scarce resources may be better employed elsewhere.

With these reservations in mind, we offer our comments regarding OIG's specific recommendations in the report.

OIG Recommendation
CMS should review the instructions for incorrect hospital coding of patient discharges in order to determine whether it should be revised to address PPS transfers reported as LAMA discharges.
CMS Response
We concur. The CMS will review the program instructions to determine if any clarifications are appropriate regarding hospital coding of patient discharges identified by the OIG.

OIG Recommendation
CMS should develop adequate internal controls and monitoring safeguards at FIs and/or PROs to address PPS transfers reported as LAMA discharges.

CMS Response
The CMS has an adequate status code and instructions in our provider manuals for institutional providers to correctly code when a patient leaves against medical advice. There is nothing more the FIs can do to enforce CMS policy other than to request a complete PRO medical review.

OIG Recommendation
CMS should require FIs and PROs to conduct a review of LAMA discharges with a same-day admission at another PPS hospital and recover overpayments where appropriate.

CMS Response
The CMS will direct the FIs to identify LAMA discharges with a same-day admission at another PPS hospital, select a representative sample, and make an initial determination regarding the appropriateness of the claims. The CMS will direct the FIs to forward any cases where a medical review is necessary to the PROs. If, after this review, CMS believes a significant problem exists in this area, it will conduct a full review of all LAMA discharges with a same-day admission to another PPS hospital.

We concur that CMS should direct the FIs to recover the identified overpayments resulting from an inappropriate coded LAMA discharge that is in fact a transfer to another hospital. When the final report is issued, OIG will furnish the data necessary (provider numbers, claims information, health insurance claim numbers, etc.) for the Medicare contractors to initiate and complete recovery action. At that time, we will forward the final report and information needed by the Medicare contractors to effectuate recovery of the overpayments to the regional offices for appropriate action. We will also identify an OIG contact if any questions arise. We appreciate OIG’s offer to provide CMS with the detailed claims information to assist in the recovery process.
Page 3- Janet Rehnquist

Technical Comments

1. The OIG has presented three anecdotes of inappropriate coding to provide examples of the concerns they are expressing. As a technical consideration, we would ask if the implications of EMTALA were considered for the example of the emergency room discharges. If a hospital has the capacity to treat a patient, there are prohibitions against transferring the patient in an emergency situation.

2. Page 2, 4th paragraph, please correct cite as follows "(Public Law 89-21)" to "(Public Law 98-21)".

3. Page 4, 1st paragraph, under "Results of Review", please realign paragraph to include all PPS claims and payments.

4. Page 5, 1st arrow, was the patient sent home or directly to the hospital; 2nd arrow, should include an explanation of existing policy.

5. Page 6, 1st bullet doesn't show transfer to hospital. It just shows records sent to doctor at another hospital. Why?

6. Page 6, under "Claims Processing Systems Controls", we recommend that this paragraph discuss the whole perspective by telling how many total discharges there were verses how many LAMA discharges.