

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS CAN USE OIG AUDIT
REPORTS TO IMPROVE ITS
OVERSIGHT OF HOSPITAL COMPLIANCE**

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Office of Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: October 2022

Report No. A-04-21-08084

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

During calendar years (CYs) 2016 through 2018, Medicare paid hospitals approximately \$555.2 billion: we performed a series of hospital compliance audits to determine whether hospitals are billing appropriately for certain claims. We did this audit to determine the Centers for Medicare & Medicaid Services' (CMS's) actions taken regarding recommendations in these 12 audits. We also considered the results from the first and second level of appeals to determine whether identified claims errors were sustained. Finally, we wanted to confirm that CMS is making the best use of our reports to enhance its oversight of the Medicare program.

Our objectives were to: (1) summarize the results, after considering the status of appeals, of our hospital compliance audits covering Medicare claims paid from 2016 through 2018; (2) identify CMS's actions taken to ensure that our recommendations were implemented; and (3) determine how CMS could improve program oversight using our hospital compliance audits.

How OIG Did This Audit

We summarized the results of the previous 12 audits, determined the appeals status of any improperly paid claims, determined what actions CMS has taken with respect to the recommendations made in these 12 audits, and identified internal controls that CMS has in place to prevent payment of high-risk Medicare claims determined to be in error in these 12 reports.

CMS Can Use OIG Audit Reports To Improve Its Oversight of Hospital Compliance

What OIG Found

Of the 387 improperly paid claims identified in our previous 12 hospital compliance audits, 333 were inpatient claims that resulted in \$5,260,147 in net overpayments, and 54 were outpatient claims that resulted in \$53,729 in net overpayments. Of these 387 improperly paid claims, 229 claims were appealed at the first level, of which 22 overpayment determinations were overturned. In addition, 126 claims were appealed at the second level, of which 6 overpayment determinations were overturned. As a result, 359 overpayment determinations remained, resulting in sustained overpayments totaling \$5,041,721. After considering the results of the first and second levels of appeal, we determined that the total overpayments received by the 12 hospitals was \$82 million. CMS has taken some actions to ensure that the recommendations in our previous 12 hospital compliance audits were implemented. With respect to our recommendations to repay funds, CMS provided us with insufficient information; therefore, we could not identify the actions CMS had taken to ensure that our recommendations were implemented. With respect to our recommendations to follow the 60-day rule, CMS provided us with insufficient information; therefore, we could not ensure that our recommendations were implemented. With respect to our recommendations to strengthen internal controls, CMS acted on most of these recommendations. As a result of CMS's incomplete responses, we are not able to verify that some hospitals have repaid funds or implemented our recommendations to follow the 60-day rule and strengthen internal controls. CMS has not used the results from our 12 issued audit reports in its internal control activities. CMS could use our hospital compliance audit reports to enhance its oversight of the Medicare program.

What OIG Recommends and CMS Comments

We recommend that CMS: (1) continue to follow up on the overpayment recovery recommendations contained in the 12 audits covered by this report and (2) improve tracking and responding on the status of claims identified in our reports as they proceed through the appeals process. We made additional procedural recommendations that are included in the body of the report.

CMS concurred with three of our recommendations, but did not explicitly state that it concurred or did not concur with two of our recommendations. CMS instead requested that we remove these two recommendations. We maintain that these recommendations are valid. CMS's comments are summarized in the body of our report.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare payments to hospitals make up a large portion of fee-for-service (FFS) payments each year.¹ During calendar years (CYs) 2016 through 2018, Medicare paid hospitals approximately \$555.2 billion, which represents 49 percent of all fee-for-service payments; accordingly, we performed a series of hospital compliance audits to determine whether hospitals are billing appropriately for certain high-risk claims. This audit is based on 12 of those hospital compliance audits. (See Appendix B for a list of reports on those audits and Appendix C for a list of high-risk claims reviewed.) We did this audit to determine the Centers for Medicare & Medicaid Services' (CMS's) actions taken regarding the recommendations in these 12 audits.² We also considered the results from the first and second level of appeals for claims that were determined to be errors in those 12 audits to determine whether those errors were sustained. Finally, we wanted to confirm that CMS is making the best use of our reports in this series to enhance its oversight of the Medicare program.

OBJECTIVES

Our objectives were to: (1) summarize the results, after considering the status of appeals, of our hospital compliance audits covering Medicare claims paid from 2016 through 2018; (2) identify CMS's actions taken to ensure that our recommendations were implemented; and (3) determine how CMS could improve program oversight using our hospital compliance audits.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. CMS administers the Medicare program.

CMS uses Medicare contractors to, among other things, process and pay claims submitted by hospitals. These contractors are referred to as Medicare administrative contractors (MACs). CMS relies on MACs to collect overpayments and verify that hospitals implement audit recommendations. MACs are responsible for identifying which overpayments can be

¹ FFS is a system of health care payment in which a provider is paid a fee for individual or bundled services based upon a fee schedule.

² See <https://oig.hhs.gov/newsroom/podcasts/hospital-compliance/> for a list of all hospital compliance audits completed previously by the OIG. See appendix B for the 12 hospitals included in this report.

collected.³ MACs provide CMS with updates on the status of provider appeals. In addition, MACs are responsible for monitoring whether hospitals perform self-assessments of claims to identify and return overpayments pursuant to the 60-day rule in response to Office of Inspector General (OIG) audit recommendations.⁴

MACs are responsible for administering the first level of provider appeals, which is referred to as a redetermination. CMS uses separate contractors to administer the second level of provider appeals, which is referred to as a reconsideration. These contractors are referred to as Qualified Independent Contractors (QICs).⁵

Hospital Inpatient Prospective Payment System

Under the inpatient prospective payment system, CMS pays hospitals a predetermined rate per discharge. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Inpatient Rehabilitation Facility Prospective Payment System

Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intensive rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for IRFs. CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the payment system, CMS established a Federal prospective payment rate for each of the distinct case-mix groups (CMGs). A beneficiary is assigned to a CMG based on the beneficiary's clinical characteristics and expected resource needs.

³ OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations.

⁴ Under the 60-day rule, providers must exercise reasonable diligence to identify and repay overpayments during a 6-year lookback period based upon credible information of potential overpayments. A typical OIG 60-day rule audit recommendation recommends that the provider, "based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation."

⁵ The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal.

Hospital Inpatient Psychiatric Facility Prospective Payment System

CMS pays inpatient psychiatric facilities (IPFs) a standardized Federal per diem payment per discharge that is payment in full for the inpatient operating and capital-related costs of furnishing Medicare-covered services in an IPF. The payment for an individual patient is adjusted for factors such as the DRG classification, patient's age, length of stay, and the presence of specified comorbidities. CMS provides additional payments for cost outlier cases and electroconvulsive therapy treatments. There are facility-level adjustments for factors that include the presence of a qualifying emergency department. The IPFs covered under the prospective payment system are freestanding psychiatric facilities, distinct part psychiatric units of acute care hospitals, and distinct part units of critical access hospitals.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for hospital outpatient services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.⁶ All services and items within an APC group are comparable clinically and require comparable resources.

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§§ 1815(a) and 1833(e)).

Federal regulations state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

Claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)). The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare

⁶ The health care industry uses HCPCS codes to standardize coding for medical procedures, services, products, and supplies.

contractors may process them correctly and promptly. The Manual states that providers must use HCPCS codes for most outpatient services (chapter 23 § 20.3).⁷

We believe that the 12 previous audits referenced in this report constituted credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of: (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.⁸

The 6-year lookback period is not limited by our audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.⁹

Results of Our Previous Audits and CMS's Audit Resolution Responsibility

We previously conducted audits at 12 hospitals for claims paid in calendar years 2016 through 2018. We used statistical sampling for each audit and reviewed a total of 1,290 inpatient and outpatient claims totaling \$26,130,620. We identified 387 improperly paid claims, totaling \$5,313,876 in net overpayments. Based on our sample results, we estimated that these 12 hospitals were overpaid \$85.5 million.¹⁰ (See Table 1 on the following page for a list of the 12 hospitals and the overpayments identified.)

⁷ "Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the [HCPCS]" (42 CFR § 419.2(a)). Moreover, claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)).

⁸ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

⁹ 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—part 1, Pub. No. 15-1, § 2931.2; and 81 Fed. Reg. at 7670.

¹⁰ For each individual report, we recommended recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

Table 1: Audits Summarized in This Report

Hospital Name	OIG Audit Common Identification Number	Number of Claims Reviewed	Number of Improperly Paid Claims	Net Overpayments in Sample	Estimated Overpayments
Sunrise Hospital & Medical Center	A-04-19-08075	100	54	\$999,950	\$27,001,618
Alta Bates Summit Medical Center	A-04-19-08071	100	46	1,571,741	19,241,056
Texas Health Presbyterian Hospital Dallas	A-04-18-08068	100	41	500,323	13,305,419
The Ohio State University Hospital	A-05-18-00042	145	47	335,832	5,764,048
Carolinas Hospital	A-04-18-08063	100	45	431,757	4,364,334
Forbes Hospital	A-03-18-00005	100	37	590,647	4,054,009
St. Vincent Hospital	A-05-18-00040	145	58	293,404	3,764,735
St. Francis Hospital	A-05-18-00048	100	14	204,265	3,327,408
Northwest Medical Center	A-04-18-08064	100	20	201,624	2,020,665
Edward W. Sparrow Hospital	A-05-18-00045	100	9	47,317	1,983,289
Providence Medical Center	A-07-18-05113	100	13	57,800	515,917
Flagstaff Medical Center	A-07-18-05112	100	3	79,216	154,913
Total		1,290	387	\$5,313,876	\$85,497,411

We provided CMS with copies of our audit reports after they were issued to the hospitals. The Federal Acquisition Streamlining Act (FASA) of 1994, as amended by the National Defense Authorization Act for fiscal year 1996, provides statutory deadlines for the prompt resolution of audit recommendations. As amended, FASA requires Federal agencies to make management decisions on all findings and recommendations included in each Inspector General report within 6 months of issuance. FASA also requires Federal agencies to complete a final action on each management decision within 12 months of the issuance of each Inspector General report. In addition, section 8(a)(4) of OMB Circular A-50 Revised, Audit Followup (OMB A-50), requires

that agency management maintain accurate records regarding the status of audit report recommendations from resolution through corrective action.

As the agency that administers the Medicare program, CMS is tasked with resolving all recommendations arising out of our audits of Medicare FFS claims no matter the auditee (e.g., CMS, MAC, hospital, or physician). Consistent with the requirements of the FASA and OMB A-50, CMS policy states that all audit recommendations included in our reports should be resolved within 6 months of the report issuance date. CMS uses the OIG Clearance Document (OCD) to report its management decisions and final actions taken on both monetary and nonmonetary audit recommendations (the Department of Health and Human Services' *Financial Accounting Policy Manual*, § 10-41-V). Also, CMS reports the status of OIG audit recommendations on the quarterly *Audit Status Follow-Up Report* (ASFR). For the 12 audits covered in this report, CMS provided status updates to us either through OCDs or ASFRs. These documents detail the actions CMS has taken or instructed the MACs to take and the status of the recommendations.¹¹

CMS may concur with a recommendation to collect overpayments but elect to sustain an amount that differs from the amount recommended for collection. CMS shows the amount that it agrees to recover as a sustained amount on the OCD. CMS considers recommendations to be cleared when it reports actions to be taken on recommendations, when it submits the completed OCD to us, and when we accept the actions detailed on the OCD. CMS considers recommendations to be closed when the agreed-upon actions have been implemented.

HOW WE CONDUCTED THIS AUDIT

In this audit we summarized the results of the previous 12 audits, including: (1) compiling the number and dollar amount of improperly paid claims identified in each of the high-risk areas,¹² and (2) calculating a combined estimate of overpayments identified. Furthermore, we determined the appeals status of any improperly paid claims that we had previously identified as incorrectly billed and determined the impact of these appeals on the amount of outstanding estimated overpayments.¹³ We did not select additional Medicare claims for review. In addition, we met with CMS officials and obtained and reviewed documentation to determine the actions CMS has taken with respect to the recommendations made in these 12 audits.

¹¹ CMS reports its concurrence or nonconcurrence decisions, along with any amount sustained (disallowed costs), for each recommendation listed in the OCD and ASFR. OIG uses these OCDs and ASFRs to determine the final disposition of OIG audit recommendations and to report information to Congress regarding OIG recommendations in its *Semiannual Report to Congress*.

¹² See Appendix C for a list of hospital claims at high risk for improper billing, and which were audited in the previous 12 hospital compliance audits.

¹³ See Appendix D for our mathematical calculation plan.

Finally, we identified internal controls that CMS has in place to prevent payment of high-risk Medicare claims determined to be in error in these 12 audits.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

See Appendix A for the details of our scope and methodology.

FINDINGS

Of the 387 improperly paid claims identified in our previous 12 hospital compliance audits, 333 were inpatient claims which resulted in \$5,260,147 in net overpayments, and 54 were outpatient claims which resulted in \$53,729 in net overpayments. Also, of these 387 improperly paid claims, 229 claims were appealed at the first level, of which 22 overpayment determinations were overturned. In addition, 126 claims were appealed at the second level, of which 6 overpayment determinations were overturned. As a result, 359 overpayment determinations remained, resulting in sustained overpayments totaling \$5,041,721. The most common error types for these improper payments included incorrectly billed IRF services and incorrectly billed HCPCS codes. (See Figures 1 and 2.) After considering the results of the first and second levels of appeal, we determined that the total overpayments received by the 12 hospitals was \$82,010,316, only 4.08 percent less than our original estimate of \$85,497,411.

CMS has taken some actions to ensure that our recommendations in our previous 12 hospital compliance audits were implemented. With respect to our recommendations that each of the 12 hospitals repay funds, CMS provided us with insufficient information; therefore, we could not identify the actions CMS had taken to ensure that our recommendations were implemented. Specifically, the OCDs and ASFRs that CMS provided had insufficient, up-to-date information regarding the status of our repayment recommendations and lacked detail regarding the actions CMS had taken or instructed the MACs to take to determine whether our recommendations were implemented. With respect to our recommendations that each of the 12 hospitals follow the 60-day rule, CMS provided us with insufficient information; therefore, we could not ensure that our recommendations were implemented. Specifically, the OCDs and ASFRs did not indicate to what extent the MACs had reviewed hospitals' responses to the 60-day rule letter to determine whether the actions met the 60-day rule requirements. Furthermore, CMS's status updates to the OIG were lacking in detail because they provided no evidence that CMS or its MACs had taken action to obtain responses from the six hospitals that have not responded to the 60-day notice sent by their MACs. Furthermore, CMS's 60-day rule Standard Operating Procedures (SOP) required MACs to report provider compliance for 8 consecutive quarters, which is not enough time to cover the entire appeals process that may

take several years.¹⁴ With respect to our recommendations that each of the 12 hospitals strengthen internal controls, CMS acted on most of these recommendations. As a result of CMS's incomplete responses, we are not able to verify that some hospitals have repaid funds or implemented our recommendations to follow the 60-day rule and strengthen internal controls.

CMS has not used the results from our 12 issued audit reports in its internal control activities. CMS could use our hospital compliance audit reports to enhance its oversight of the Medicare program. Specifically, CMS could perform or direct its contractors to perform specific reviews related to the types of errors identified in the 12 hospital compliance audits summarized in this report. CMS relies on other internal controls to prevent or detect some of the same types of errors identified in these reports, such as the use of the Comprehensive Error Rate Testing (CERT) program,¹⁵ contractor reviews, and Medicare guidance to providers. CMS has said that it does not have enough resources or staff available to centrally track every issue or error identified in our reports. If CMS used our provider-specific audit reports, it could improve Medicare program oversight by focusing on services at high risk for improper payment. In addition, CMS's actions could lead to improvements in hospital specific internal controls.

SUMMARY OF IMPROPERLY PAID CLAIMS

Our audits of the 12 hospitals identified a total of 387 improperly paid claims. Of these 387 improperly paid claims, 333 were inpatient claims and 54 were outpatient claims. The hospitals disagreed with most of our determinations and, therefore, appealed 223 of the 333 inpatient claims and 6 of the 54 outpatient claims.

Of the 12 hospitals covered by our previous audits, 10 hospitals have appealed some or all of the claims determined to be improperly paid. Of the 387 improperly paid claims that we reported, the hospitals appealed 229 at the first level, of which 207 were affirmed by the MAC (i.e., 90 percent uphold rate).¹⁶ Of the 207 appealed determinations that upheld our audit findings, the hospitals appealed 126 at the second level, of which 120 were affirmed by the QIC (i.e., 95 percent uphold rate).¹⁷ See Appendix E for details.

¹⁴ Consortium of Financial Management and Fee for Service Operations Standard Operating Procedure – 60-Day Rule Recommendations (July 30, 2018).

¹⁵ CMS estimates the Medicare FFS program improper payment rate through the CERT program. Each year, the CERT program reviews a statistically valid stratified random sample of Medicare FFS claims to determine whether they were paid properly under Medicare coverage, coding, and payment rules.

¹⁶ As of February 25, 2022, 10 hospitals filed and completed first-level appeals of claims that we determined were improperly paid.

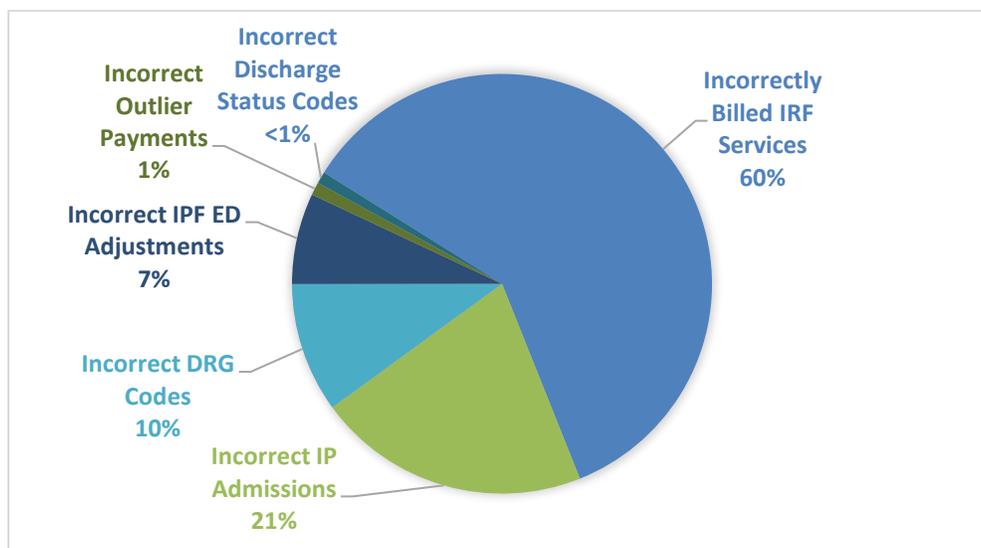
¹⁷ As of February 25, 2022, seven hospitals filed and completed second-level appeals of claims that we determined were improperly paid.

We determined that, when adjusted to reflect the results of the first and second levels of appeal, the total overpayments received by the 12 hospitals was \$82,010,316, only 4.08 percent less than our original estimate of \$85,497,411.

Improperly Paid Inpatient Claims Error Types

The hospitals incorrectly billed Medicare for 333 of the 1,125 inpatient claims that we reviewed. These improperly paid claims resulted in net overpayments of \$5,260,147. Figure 1 summarizes the error types and percentages of improperly paid inpatient claims identified in our 12 audit reports. See Appendix F for criteria used to evaluate claims and Appendix G for the results of our audit by risk area.

Figure 1: Error Types and Percentages of Improperly Paid Inpatient Claims



Incorrectly Billed Inpatient Rehabilitation Facility Services

For 200 of the 333 improperly paid inpatient claims (60 percent), the hospitals incorrectly billed IRF services. Specifically:

- For 162 of the 200 improperly paid claims, the hospitals incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for acute inpatient rehabilitation. IRF services for these beneficiaries were not reasonable and necessary because these beneficiaries did not require the active and ongoing therapeutic intervention of multiple therapy disciplines, generally did not require and could not reasonably be expected to actively participate in or benefit from an intensive rehabilitation therapy program, were not sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program, or did not require supervision by a rehabilitation physician.

- For 25 of the 200 improperly paid claims, the hospitals incorrectly billed Medicare Part A for beneficiary stays that did not comply with Medicare documentation requirements.
- For 8 of the 200 improperly paid claims, the hospitals incorrectly billed Medicare Part A for beneficiary stays that included incorrect CMGs, resulting in incorrect payments to the hospitals. Specifically, the CMG was not applied correctly based on the patient’s clinical characteristics and expected resource needs.
- For 5 of the 200 improperly paid claims, the hospitals had a combination of the three issues listed above.

As a result of these improperly paid claims, the hospitals received net overpayments of \$4,490,835.

Of the 200 improperly paid IRF claims that we reported and that CMS sustained, the hospitals appealed 172 at the first level, of which 161 were affirmed by the MAC (i.e., 94 percent uphold rate).¹⁸ Of the 161 appealed determinations that upheld our audit findings, the hospitals appealed 108 at the second level, of which 107 were affirmed by the QIC (i.e., 99 percent uphold rate).¹⁹ We have not received any additional appeals information as of February 25, 2022.

After considering the results of the first and second levels of appeal, we determined that the hospitals incorrectly billed IRF services for 188 of the 200 initially reported improperly paid claims (94 percent uphold rate). As a result, overpayments for the 188 improperly paid claims totaled \$4,339,717, a 3.37 percent decrease from our original determination of \$4,490,835.

Incorrect Inpatient Admissions

For 71 of the 333 improperly paid inpatient claims (21 percent), the hospitals incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services.

As a result of these improperly paid claims, the hospitals received net overpayments of \$539,865.

Of the 71 improperly paid claims that we reported and that CMS sustained, the hospitals appealed 44 at the first level, of which 35 were affirmed by the MAC (i.e., 80 percent uphold

¹⁸ As of February 25, 2022, nine hospitals had completed first-level appeals of claims that we determined were improperly paid due to incorrectly billed IRF services.

¹⁹ As of February 25, 2022, six hospitals had completed second-level appeals of claims that we determined were improperly paid due to incorrectly billed IRF services.

rate).²⁰ Of the 35 appealed determinations that upheld our audit findings, the hospitals appealed 17 at the second level, of which 12 were affirmed by the QIC (i.e., 71 percent uphold rate).²¹ We have not received any additional appeals information as of February 25, 2022.

After considering the results of the first and second levels of appeal, we determined that the hospitals incorrectly billed Medicare Part A for beneficiary stays that did not meet Medicare criteria for inpatient status and should have been billed as outpatient or outpatient with observation services for 57 of the 71 initially reported improperly paid claims (80 percent uphold rate). As a result, overpayments for the 57 improperly paid claims totaled \$425,481, a 21.19 percent decrease from our original determination of \$539,865.

Incorrect Diagnosis-Related Group Codes

For 34 of the 333 improperly paid inpatient claims (10 percent), the hospitals submitted claims to Medicare that were incorrectly coded, resulting in incorrect DRG payments to the hospitals. Specifically, the medical records did not support certain procedure or diagnosis codes.

As a result of these improperly paid claims, the hospitals received net overpayments of \$224,471.

Of the 34 improperly paid claims that we reported and that CMS sustained, the hospitals appealed 7 at the first level, of which 6 were affirmed by the MAC (i.e., 86 percent uphold rate).²² None of these determinations were appealed at the second level. We have not received any additional appeals information as of February 25, 2022.

After considering the results of the first level of appeal, we determined that the hospitals incorrectly submitted claims to Medicare that were incorrectly coded and resulted in incorrect DRG payments to the hospitals for 33 of the 34 initially reported improperly paid claims (97 percent uphold rate). As a result, overpayments for the 33 improperly paid claims totaled \$217,877, a 2.94 percent decrease from our original determination of \$224,471.

Incorrect Inpatient Psychiatric Facility Emergency Department Adjustments

For 24 of the 333 improperly paid inpatient claims (7 percent), the hospital-based IPF incorrectly billed the source-of-admission code “Code 4 – Transfer from a hospital – Different Facility.” The hospital should have billed using source-of-admission code “Code D – Transfer

²⁰ As of February 25, 2022, eight hospitals had completed first-level appeals of claims that we determined were improperly paid due to incorrectly billed stays that did not meet Medicare criteria.

²¹ As of February 25, 2022, five hospitals had completed second-level appeals of claims that we determined were improperly paid due to incorrectly billed stays that did not meet Medicare criteria.

²² As of February 25, 2022, four hospitals had completed first-level appeals of inpatient claims that we determined were improperly paid due to coding issues.

from hospital inpatient in the same facility.” As a result of the incorrectly billed admission source, the hospital-based IPF improperly received a facility-based payment adjustment for costs of maintaining a qualified emergency department services even though CMS does not apply the emergency department adjustment when an individual patient is discharged to the IPF from the acute care hospital of which the IPF is part.

As a result of these improperly paid claims, the hospital received net overpayments of \$2,491. We have not received any appeals information as of February 25, 2022.

Incorrect Outlier Payments

For 3 of the 333 improperly paid inpatient claims (1 percent), a hospital submitted claims to Medicare that resulted in incorrect outlier payments. Specifically, the hospital incorrectly billed units of service and charges on the claims, which resulted in incorrect outlier payments.

As a result of these improperly paid claims, the hospital received net underpayments of \$3,006. We have not received any appeals information as of February 25, 2022.

Incorrect Discharge Status Codes

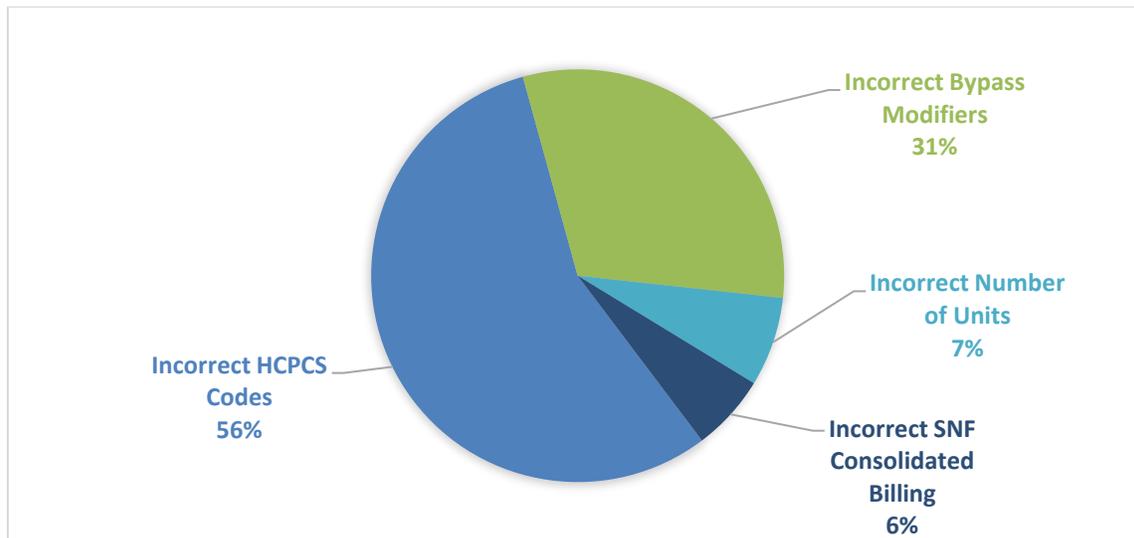
For 1 of the 333 improperly paid inpatient claims (less than 1 percent), a hospital incorrectly billed Medicare for a patient discharge to home that should have been billed as a transfer to a SNF. Thus, the hospital should have received the per diem payment instead of the full DRG payment.

As a result of this improperly paid claim, the hospital received an overpayment of \$5,491. We have not received appeal information as of February 25, 2022.

Improperly Paid Outpatient Claims Error Types

The hospitals incorrectly billed Medicare for 54 of the 165 outpatient claims that we reviewed. These improperly paid claims resulted in net overpayments of \$53,729. Figure 2 on the following page summarizes the error types and percentages of improperly paid outpatient claims identified in our 12 audit reports. See Appendix F for outpatient criteria used to evaluate claims and Appendix G for the results of our audit by risk area.

Figure 2: Error Types and Percentages of Improperly Paid Outpatient Claims



Incorrect HCPCS Codes

For 30 of the 54 improperly paid outpatient claims (56 percent), the hospitals submitted outpatient claims to Medicare that were incorrectly coded. These errors included claims with HCPCS codes that were not supported by the medical records and claims with the improper number of units billed.

As a result of these improperly paid claims, the hospitals received net overpayments of \$43,098.

Of the 30 improperly paid claims that we reported and that CMS sustained, a hospital appealed 1 at the first level, of which the claim was affirmed by the MAC (i.e., 100 percent uphold rate).²³ We have not received any additional appeal information as of February 25, 2022.

After considering the results of the first level of appeal, we determined that the hospitals submitted outpatient claims to Medicare that were incorrectly coded for all of the initially reported improperly paid claims (100 percent uphold rate). As a result, overpayments for the 30 improperly paid claims totaled \$43,098.

Incorrect Bypass Modifiers

For 17 of the 54 improperly paid outpatient claims (31 percent), the hospitals submitted outpatient claims to Medicare for HCPCS codes improperly appended with a bypass modifier. Bypass modifiers allow hospitals to bill for procedural services different than the primary

²³ As of February 25, 2022, one hospital has completed the first-level appeal of claims that we determined were improperly paid due to incorrectly billed HCPCS codes.

service on the claim. These different procedural services would otherwise be unallowable on the same claim. Bypass modifiers include modifier 59, XE, XS, XU, and XP.²⁴ The inclusion of these bypass modifiers resulted in the hospitals receiving payment for services that were not allowable.

As a result of these improperly paid claims, the hospitals received net overpayments of \$6,019.

Of the 17 improperly paid claims that we reported and that CMS sustained, the hospitals appealed 5 at the first level, of which 4 were affirmed by the MAC (i.e., 90 percent uphold rate).²⁵ None of these determinations were appealed at the second level. We have not received any additional appeals information as of February 25, 2022.

After considering the results of the first level of appeal, we determined that the hospitals submitted outpatient claims to Medicare for HCPCS codes with a bypass modifier that was not supported as a distinct procedural service for 16 of the 17 initially reported improperly paid claims (94 percent uphold rate). As a result, overpayments for the 16 improperly paid claims totaled \$5,961, a 1 percent decrease in from our original determination of \$6,019

Incorrect Number of Units

For 4 of the 54 improperly paid outpatient claims (7 percent), a hospital incorrectly billed Medicare for multiple units of outpatient surgery procedures when it should have billed for only 1 unit.

As a result of these improperly paid claims, the hospitals received net overpayments of \$4,436. We have not received any appeals information as of February 25, 2022.

Incorrect SNF Consolidated Billing

For 3 of the 54 improperly paid outpatient claims (6 percent), a hospital submitted outpatient claims to Medicare rather than billing the appropriate SNFs for services that were subject to the consolidated billing requirements. Payment for the majority of services provided to beneficiaries in a SNF must be included in a bundled payment made through the MAC to the

²⁴ “The ‘59’ modifier is used to indicate a distinct procedural service. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision or excision, or separate injury (or area of injury in extensive injuries)” (the Manual, ch. 23, § 20.9.1.1(B)). Effective January 1, 2015, CMS established four new HCPCS modifiers to define subsets of the “59” modifier. The four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services are: Modifier XE-Separate Encounter, Modifier XS-Separate Structure, Modifier XP-Separate Practitioner, and Modifier XU-Unusual Non-Overlapping Service. CMS will continue to recognize the “59” modifier, but providers should use one of the more descriptive modifiers when it is appropriate (Pub 100-20, “One Time Notification,” Transmittal 1422 Aug. 15, 2014).

²⁵ As of February 25, 2022, two hospitals have completed first-level appeals of claims that we determined were improperly paid due to incorrectly billed outpatient claims with a modifier.

SNF. These bundled services must be billed by the SNF to the MAC in a consolidated bill. Hospitals that provide services to these beneficiaries in a SNF cannot bill separately for these services.²⁶

As a result of these improperly paid claims, the hospitals received net overpayments of \$176. We have not received any appeals information as of February 25, 2022.

CMS HAS TAKEN SOME ACTIONS IN RESPONSE TO OUR RECOMMENDATIONS

The 12 audits covered in this report resulted in a total of 36 recommendations. Although the specific recommendations in each report were different, they fell into three general categories: (1) recommendations to repay funds; (2) recommendations to exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day repayment rule; and (3) recommendations to strengthen internal controls to ensure full compliance with Medicare requirements.

With respect to our recommendations that each of the 12 hospitals repay funds, CMS failed to provide the OIG with sufficient and current status information. With respect to our recommendations that each of the 12 hospitals follow the 60-day rule, CMS failed to provide the OIG with sufficient information, and its SOPs did not require status updates from MACs for a long enough time to capture the outcomes of appeals. With respect to our recommendations that each of the 12 hospitals strengthen internal controls, CMS acted on most of our recommendations. As a result of CMS's actions, we are not able to verify that some hospitals have repaid funds or implemented our recommendations to follow the 60-day rule or strengthen internal controls.

CMS's Responses on Our Recommendations To Repay Funds Did Not Provide Enough Detail

CMS provided us with insufficient information; therefore, we could not identify the actions CMS had taken to ensure that our recommendations to providers to repay overpayments were implemented. Specifically, the OCDs and ASFRs that CMS provided in response to these 12 audits had insufficient, up-to-date information regarding the status of our repayment recommendations and lacked detail regarding the actions CMS had taken or instructed the MACs to take to determine whether our recommendations were implemented. For example, hospitals have a right to appeal CMS overpayment determinations and do not need to return overpayments until after the second level of appeal. For one audit CMS informed us that "the provider filed an appeal to the QIC," and in another audit CMS informed us "provider reported to CMS that they filed an appeal to the Administrative Law Judge," but did not specify which claims the providers appealed and the results of these appeals.²⁷ CMS did not provide detailed

²⁶ 42 CFR § 411.15(p).

²⁷ ASFR for A-04-19-08075 (Dec. 31, 2021) and OCD for A-03-18-00005 (July 15, 2021).

information, such as the claim number, reason for appeal, or the status of any action that it or the MACs had taken with respect to collecting our identified overpayments for these 12 audits.²⁸ CMS did not monitor these appeals other than to put the MACs and QICs in contact with the auditors who performed the audit. CMS stated that, beyond checking the status in its system of record, further communication from CMS to an appellant during the appeals process would have been inappropriate. CMS further indicated that any actions that take place after the appeals process has concluded would be handled as part of debt collection and oversight.

CMS does not review the substantive decisions made by independent appeal adjudicators at the various levels, and it does not have the authority to overturn the results (the Act § 1869). CMS stated that by the second level of appeal it can track all determinations in its system of record. CMS is responsible for collecting and responding to our status requests regarding actions taken on identified overpayments. Therefore, if CMS does not provide us with complete information, to the extent available in its system of record, we cannot verify that it has collected or is in the process of collecting sustained overpayments.

CMS's Responses on Our Recommendations That Hospitals Follow the 60-Day Rule Did Not Provide Enough Detail and Its Standard Operating Procedures Were Limited

In response to our recommendations that the hospitals follow the 60-day rule, CMS delegated the responsibility to the appropriate MAC to monitor whether hospitals performed a self-assessment of claims and returned overpayments pursuant to the 60-day rule. For each of the 12 hospitals we audited, CMS instructed the applicable MAC to notify the hospital that the OIG identified potential overpayments and request an attestation that the hospital determined either that no claims were submitted in error or that they identified and were returning applicable overpayments to the MAC and provide supporting documentation. The MACs requested that the hospital provide a written description of: (1) how it conducted the self-assessment; (2) the universe of claims any samples were drawn from, sample size, and dates of the claims identified and reviewed in the self-assessment; (3) its statistically valid sampling methodology used to identify the universe and sample; and (4) how it completed its self-assessment if it did not use sampling and estimation, including a statement that it individually reviewed the entire universe of those claims it identified for review, if applicable. The MACs requested the hospitals to notify them in no later than 240 days with the results of their inquiry, whether they concur with the OIG's finding, and the documentation that describes their method and amount of repayment. As shown in Table 2 on the following page, of the 12 hospitals covered in this report, CMS documentation (i.e., OCDs and ASFRs) reflects the following:

²⁸ Examples include ASFRs for A-04-18-08068 (Sept. 30, 2020) and A-04-18-08064 (Dec. 31, 2020). This is also consistent with findings from another audit: *The Centers for Medicare & Medicaid Services Reported Collecting Just Over Half of the \$498 Million of Medicare Overpayments Identified by OIG Audits* (A-04-18-03085).

- Four hospitals have completed their self-assessments, and they have repaid a total of \$2,210,374 in overpayments to their MACs. CMS closed the 60-day rule recommendations for these four hospitals.
- Six hospitals did not respond to the 60-day rule notice sent by their MACs. CMS cleared the 60-day rule recommendations for these six hospitals.
- Two hospitals have delayed their self-assessments until their requested appeals are completed. CMS cleared the 60-day rule recommendations for these two hospitals.

Table 2: Hospital Actions Regarding 60-day Rule

Hospital Count	MAC Letter to Provider	Investigation Deadline	Repayment Deadline	Repaid Date	Status	Amount Repaid
1	12/25/2019	6/22/2020	8/21/2020		Appealing	
2	3/18/2020	9/14/2020	11/13/2020		No Response	
3	1/16/2020	7/14/2020	9/12/2020		No Response	
4	2/14/2020	8/12/2020	10/11/2020	3/17/2021	Refund Provided	\$1,137,640
5	4/21/2020	10/18/2020	12/17/2020	12/17/2020	Refund Provided	933,490
6	6/18/2020	12/15/2020	2/13/2021	4/21/2021	Refund Provided	90,398
7	12/4/2020	6/2/2021	8/1/2021		No Response	
8	10/30/2020	4/28/2021	6/27/2021		Appealing	
9	12/3/2020	6/1/2021	7/31/2021		No Response	
10	11/24/2020	5/23/2021	7/22/2021	7/22/2021	Refund Provided	48,846
11	1/5/2021	7/4/2021	9/2/2021		No Response	
12	4/30/2021	10/27/2021	12/26/2021		No Response	
					Total Repaid	\$2,210,374

Notice: As of December 31, 2021, for the six hospitals that have not responded to CMS, the length of time from MAC letter to the provider ranged from 8 to 23 months, with an average of 15 months. CMS's SOP only benchmarks up to 6 months for a hospital to perform its review with an additional 2 months to report and repay.

CMS Responses Regarding the 60-Day Rule Did Not Provide Enough Detail

CMS provided us with insufficient information; therefore, we could not identify the actions CMS had taken to ensure that our recommendations to providers to exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation were implemented. Specifically, the OCDs and ASFRs provided in response to these 12 audits did not indicate to what extent the MACs had reviewed hospitals' responses to the 60-day rule letter to determine whether the actions met the 60-day rule requirements. Furthermore, CMS's status updates to the OIG were lacking in detail because they provided no

evidence that CMS or its MACs had taken action to obtain responses from the six hospitals that have not responded to the 60-day notice sent by their MACs. CMS's 60-day rule SOP does not specify what information MACs are required to provide to CMS regarding our recommendation. Therefore, we do not know the status of 6 of the 12 hospitals' implementation of our 60-day rule recommendation (as shown in Table 2).

CMS's Standard Operating Procedures Were Limited

CMS's SOP require MACs to report quarterly to CMS on the status of the actions the MACs have taken to address our recommendation to follow the 60-day rule for up to 8 consecutive quarters (2 years). Eight consecutive quarters is not enough time to complete the entire appeals process, which may take several years. As shown in Table 2 above, two hospitals have delayed their self-assessments until their appeals have been completed. CMS's SOP does not specifically address what actions MACs should take with respect to implementation of the 60-day rule for hospitals that are appealing reported errors. In addition, CMS's SOP does not adequately address the length of time these appeals will take, and, therefore, does not ensure that MACs continue to follow up with these hospitals at the conclusion of the appeals process.

If CMS does not update its SOP to include additional information on the status of OIG's recommendation and require MACs to report quarterly for more than 8 consecutive quarters when hospital appeals are pending, CMS risks not capturing all overpayments identified by the hospitals in response to our 60-day rule recommendation.

CMS Acted on Most of Our Recommendations to Hospitals To Strengthen Internal Controls

In response to our recommendations that the hospitals implement additional controls, CMS relied on each hospital to provide documentation that it had taken action to strengthen internal controls related to compliance with Medicare requirements. If documentation was submitted, CMS reviewed it and confirmed that necessary steps were taken to strengthen controls. Of the 12 hospitals covered in this report, CMS confirmed the following:

- Ten hospitals have taken action to strengthen controls. CMS reviewed documents and attestations to verify that the 10 hospitals' improvements to internal controls were responsive to our recommendations. Some examples taken to strengthen controls included shortening the time it takes for staff to review admissions and patient placement, implementing quarterly reviews of samples of hospital claims, hiring external firms to audit hospital coding staff (i.e., hospital employees who complete the Medicare claims bill), and providing applicable training to coding and billing staff.
- The remaining two hospitals have delayed responding to our recommendation on strengthening internal controls until they have completed the appeals process.

CMS CAN IMPROVE PROGRAM OVERSIGHT BY USING OUR HOSPITAL COMPLIANCE AUDIT REPORTS

CMS could use our hospital compliance audit reports to enhance its oversight of the Medicare program. The *Standards for Internal Control in the Federal Government* (Green Book) provides a framework for management to follow in developing effective controls for program operations.²⁹ These controls include the risk assessment component, which states that management should identify, analyze, and respond to risks related to achieving the defined objectives and consider all internal and external factors to identify risks throughout the entity (¶¶ 7.01 and 7.04). CMS performs risk assessments to identify Medicare areas that require further oversight to improve the accuracy of Medicare claims, including the CERT program, contractor controls, and certain Medicare guidance to providers.³⁰ CMS relies on contractors to perform a number of oversight activities, including following up on overpayments and imposing and tracking corrective action plans for nonmonetary findings. Apart from these contractor actions, CMS did not perform any specific reviews of these providers or follow up on the issues we identified in these 12 hospital compliance audits. The audit report findings that we discuss in this report provide relevant information about identified risks that are related to certain types of Medicare claims. For example, our reports indicate that 60 percent of the identified improperly paid claims were related to some type of IRF error, and fewer than 1 percent were related to incorrect discharge status codes (Figure 1). Accordingly, we would expect that if CMS were to consider the results of our audits as part of its risk assessment process, it would identify (or, in this case, reinforce) a need for additional program safeguards for IRF related claims.³¹

CMS has not used the results from our 12 issued audit reports in its internal control activities because CMS said that it does not have enough resources or staff available to centrally track every issue or error identified in our reports. CMS stated that it prefers to focus its internal control efforts on nationwide OIG reports rather than provider-specific audits.

If CMS used our provider-specific audit reports, it could improve Medicare program oversight by focusing on high-risk error types. In addition, CMS's actions could lead to improvements in

²⁹ GAO-14-704G, published September 2014, page 9. The Green Book sets the internal control standards for Federal entities. The Green Book defines internal control as a process used by management to help an entity achieve its objectives. Internal control comprises the plans, methods, policies, and procedures used to fulfill the mission, strategic plan, goals, and objectives of the entity (Green Book § 1 – Fundamental Concepts of Internal Control, OV1.03). Although there are different ways to present internal control, the Green Book approaches internal control through a hierarchical structure of 5 components and 17 principles.

³⁰ Each year, the CERT program reviews a random sample of Medicare claims to determine whether they were paid properly under Medicare coverage, coding, and payment rules. Based on the results of the CERT program, CMS instructs contractors to target specific subsets of errors (i.e., high risk claims). CMS contractors conduct prepayment and postpayment monitoring reviews to identify errors and prevent improper payments.

³¹ CMS has already determined that IRF related claims should be considered for a future risk assessment based on previous OIG audits and other factors.

hospital specific internal controls. Although we are not categorizing this as an internal control weakness, without considering the issues that we identified in our hospital compliance audit reports, CMS's internal control activities are not as effective as they could be.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- continue to follow up on the overpayment recovery recommendations contained in the 12 audits covered by this report,
- improve tracking and responding on the status of claims identified in our reports as they proceed through the appeals process,
- direct its MACs to follow up with 8 of the 12 hospitals that have not responded to the recommendation to follow the 60-day rule or have not followed up at the conclusion of the appeals process (for those that are appealing the results of their audits),
- revise its SOP to require MACs to follow up with providers at the conclusion of the appeals process and require the MACs to provide additional detail to CMS regarding specific followup actions taken, and
- consider the results of this audit and future hospital compliance audits in its risk assessment process.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS COMMENTS

In written comments on our draft report, CMS did not explicitly state that it concurred or did not concur with our first and fifth recommendations, but instead requested that we remove these recommendations. CMS concurred with our second, third, and fourth recommendations. CMS also provided technical comments that we addressed as appropriate. CMS's comments, excluding the technical comments, are included in their entirety as Appendix H.

With respect to our first recommendation to continue to follow up on the overpayment recovery recommendations contained in the 12 audits covered by this report, CMS stated that this recommendation was duplicative of prior recommendations from the 12 audit reports. CMS reiterated steps that it continues to take in response to the original underlying 12 audits, including collecting 91 percent of the sustained amount of overpayments identified in these audits.

With respect to our fifth recommendation to consider the results of this audit and future hospital compliance audits in its risk assessment process, CMS stated that it "takes multiple

factors into consideration when undertaking policy changes and new internal control activities. These factors already include results of OIG reports on individual providers as appropriate, as part of the larger picture of provider activity.” However, according to CMS, “OIG rollup reports and other reports that provide evidence of system-wide patterns most effectively complement our own internal risk assessment process, and provide the strongest support for policy changes and additional internal control activities.”

CMS concurred with our second recommendation to improve tracking and responding on the status of claims identified in our reports as they proceed through the appeals process. CMS noted that its new recommendation tracking system known as the Audit Management System will make this process easier.

CMS concurred with our third recommendation to direct its MACs to follow up with 8 of the 12 hospitals that have not responded to the recommendation to follow the 60-day rule or have not followed up at the conclusion of the appeals process (for those that are appealing the results of their audits). CMS listed specific steps that it would take to implement this recommendation.

CMS concurred with our fourth recommendation to revise its SOP to require MACs to follow up with providers at the conclusion of the appeals process and require the MACs to provide additional detail to CMS regarding specific follow up actions taken.

OFFICE OF INSPECTOR GENERAL RESPONSE

We thank CMS for its responses and for the specific actions it described that it will take (or has taken) in response to the three recommendations with which it concurred.

With respect to our first recommendation that CMS continue to follow up on the overpayment recovery recommendations contained in the 12 audits covered by this report, we are not requesting any additional funds be repaid beyond what was identified in the previous 12 audits and we commend CMS for its ongoing actions (including collecting 91 percent of the sustained amount of overpayments identified in these audits). However, we maintain the need for continued attention to these audits throughout the remainder of the appeals process to ensure that all identified (and sustained) overpayments are repaid to the Medicare program and the repayments are properly documented.

With respect to our fifth recommendation that CMS consider the results of this audit and future hospital compliance audits in its risk assessment process, we acknowledge CMS’s ongoing use of OIG rollup reports (such as this one) and nationwide audit reports in its risk assessment process. Although the results of a single, provider-specific audit would not be expected to have as much impact, we continue to recommend that CMS consider a process to track the results

from similar, provider-specific audits and consider what effect the cumulative impact of those audits may have on its oversight of the Medicare program.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

This audit covered 12 previous audits that identified a total of \$347.3 million in Medicare payments made to the 12 hospitals for 23,599 inpatient and outpatient claims from January 1, 2016, through December 31, 2018 (audit period). For the 12 previous audits, we selected for review stratified random samples with payments totaling \$26.1 million. This audit did not involve the review of any additional claims.

We limited our review to summarizing the results identified in our 12 previous audits and to actions that CMS has taken or planned to take to address the causes of errors identified in those reports. We noted the current status of reported errors and estimates after any completed level of claims appeals (if applicable). In the 12 previous audits we, with the assistance of an independent medical review contractor, evaluated compliance with selected billing requirements and determined whether the claims were supported by medical records.

During our audit, we did not assess the overall internal control structure of CMS or the Medicare program. To evaluate CMS's internal controls related to resolution of audit findings identified at hospitals, we:

- interviewed CMS officials regarding CMS's process for ensuring our recommendations are implemented and
- reviewed CMS's policies and procedures.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- completed an internal control assessment to document CMS's controls in place over the processing of the 12 previous audit reports and claims types identified as high risk in this audit;
- calculated the initial estimated overall Medicare overpayments identified in the 12 previous audits as well as the current status of those overpayments (i.e., still outstanding, under appeal, or collected) subsequent to all completed appeals (Appendix E);
- reviewed CMS's responses to our 12 previous audit reports;³²

³² See Appendix B for a list of the reports.

- reviewed documentation that CMS provided to us on the status of its actions taken in response to the 12 previous audits;
- reviewed our correspondence with the MACs for the 12 previous audits related to:
 - our sampling approach,
 - the status of claims that were appealed,
 - our requests for additional supporting documentation, and
 - the MACs' requests for reestimation of overpayment amounts; and
- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: HOSPITAL COMPLIANCE AUDITS COVERED IN THIS REPORT

Report Title	Report Number	Date Issued
<i>Medicare Hospital Provider Compliance Audit: Carolinas Hospital</i>	<u>A-04-18-08063</u>	11/26/2019
<i>Medicare Hospital Provider Compliance Audit: Northwest Medical Center</i>	<u>A-04-18-08064</u>	11/26/2019
<i>Medicare Hospital Provider Compliance Audit: St. Vincent Hospital</i>	<u>A-05-18-00040</u>	11/27/2019
<i>Medicare Hospital Provider Compliance Audit: Texas Health Presbyterian Hospital Dallas</i>	<u>A-04-18-08068</u>	12/10/2019
<i>Medicare Hospital Provider Compliance Audit: Forbes Hospital</i>	<u>A-03-18-00005</u>	3/27/2020
<i>Medicare Hospital Provider Compliance Audit: The Ohio State University Hospital</i>	<u>A-05-18-00042</u>	5/22/2020
<i>Medicare Hospital Provider Compliance Audit: Flagstaff Medical Center</i>	<u>A-07-18-05112</u>	9/1/2020
<i>Medicare Hospital Provider Compliance Audit: Alta Bates Summit Medical Center</i>	<u>A-04-19-08071</u>	9/30/2020
<i>Medicare Hospital Provider Compliance Audit: St. Francis Hospital</i>	<u>A-05-18-00048</u>	10/16/2020
<i>Medicare Hospital Provider Compliance Audit: Edward W. Sparrow Hospital</i>	<u>A-05-18-00045</u>	11/12/2020
<i>Medicare Hospital Provider Compliance Audit: Providence Medical Center</i>	<u>A-07-18-05113</u>	12/16/2020
<i>Medicare Hospital Provider Compliance Audit: Sunrise Hospital & Medical Center</i>	<u>A-04-19-08075</u>	3/31/2021

APPENDIX C: HOSPITAL CLAIMS AT HIGH RISK FOR INCORRECT BILLING

Our analysis of Medicare Part A claims and our audits conducted prior to 2019 at acute care hospitals identified categories of claims at high risk for noncompliance with Medicare requirements. For the purposes of this report, we refer to these categories as “risk areas,” which are listed below, and which were the focus of the 12 hospital compliance audits covering Medicare claims paid from 2016 through 2018 that are summarized in this report:

- inpatient rehabilitation facility claims,
- inpatient claims billed with high CERT DRG codes,
- inpatient claims billed with high-severity level DRG codes,
- inpatient claims paid in excess of billed charges,
- inpatient claims billed with adverse events,
- inpatient claims billed with elective procedures,
- inpatient claims billed with mechanical ventilation,
- inpatient claims covering same day discharge and readmission,
- inpatient psychiatric facility claims,
- inpatient claims paid in excess of \$150,000,
- inpatient claims paid in excess of \$25,000,
- outpatient claims paid in excess of charges,
- outpatient claims billed with right heart catheterizations HCPCS codes,
- outpatient surgery claims billed with units greater than one,
- outpatient claims billed with bypass modifiers,
- outpatient skilled nursing facility (SNF) consolidated billing claims, and

- outpatient claims paid in excess of \$25,000.

APPENDIX D: MATHEMATICAL CALCULATION METHODOLOGY

Our objectives were to: (1) summarize the results, after considering the status of appeals, of our hospital compliance audits covering Medicare claims paid from 2016 through 2018; (2) identify CMS’s actions taken to ensure that our recommendations were implemented; and (3) determine how CMS could improve program oversight using our hospital compliance audits. To meet our first objective, we calculated the weighted value of errors (i.e. the weight of each single sampled claim in relation to all claims sampled from all audits) from 12 hospital compliance audits, both before and after appeals, if applicable. We used the results of our calculations to determine:

1. the overall initial estimated error rates of claims prior to any appeal, both the total number of claims in error and the dollar value of those errors, based solely on the results of our 12 audits;
2. the overall revised estimated error rates of claims, both total number of claims in error and the dollar value of those errors, sustained in the 12 audits after first- and second-level appeals (if applicable); and
3. the estimated error rates, both number and dollar value, by claim type (e.g., IRF claim, postacute care claim, etc.) also referred to as “risk areas.”

Mathematical Calculation Methodology

We obtained detailed information about the sample items for all 12 individual reports summarized in this audit report. We weighted each sample item in accordance with its respective weight in the original sample. We totaled the weighted value of each individual sample item in order to obtain a combined point estimate of overpayments for all errors reported in these 12 audits.

We tracked the status of each reported error through the appeals process as of February 25, 2022. We totaled the weighted value of each individual sample item in order to obtain a combined point estimate of overpayments after appeal for all errors reported in these 12 audits.

Sources of Data

The source of data for this mathematical calculation plan is the results from our 12 previous audits. Specifically:

- | | |
|-------------------------------------|-------------------------------|
| 1. Alta Bates Summit Medical Center | A-04-19-08071 |
| 2. Carolinas Hospital | A-04-18-08063 |
| 3. Edward W. Sparrow Hospital | A-05-18-00045 |
| 4. Flagstaff Medical Center | A-07-18-05112 |
| 5. Forbes Hospital | A-03-18-00005 |
| 6. Northwest Medical Center | A-04-18-08064 |

7. Providence Medical Center	A-07-18-05113
8. St. Francis Hospital	A-05-18-00048
9. St. Vincent Hospital	A-05-18-00040
10. Sunrise Hospital and Medical Center	A-04-19-08075
11. Texas Health Presbyterian Hospital Dallas	A-04-18-08068
12. The Ohio State University Hospital	A-05-18-00042

- A. Each of these audits were conducted in accordance with generally accepted government auditing standards (GAGAS). Each audit began with an initial sampling frame consisting of provider-specific final paid claims in various identified risk areas and used a stratified sampling approach. For sampled claims, we identified errors related to incorrect claims coding, insufficient medical documentation, and lack of medical necessity. We used the errors in our samples to estimate the value and number of errors in our sampling frames.

- B. Upon completion of these audits, CMS and hospitals were notified of the results and CMS instructed its MACs to recover the estimated overpayment amounts identified for each hospital. Many hospitals exercised their right to appeal the denial of some claims, in which case the improperly paid claims were reviewed by the hospitals' respective MACs.³³ Upon completion of initial appeals, MACs requested, and we provided, revised estimates of overall errors for each hospital.

- C. If claims were denied at the first level of appeal, a hospital could exercise its right to a second level of appeal, in which case the improperly paid claims were reviewed. Upon completion of this second level of appeal, the CMS contractor handling the appeal requested, and we provided, revised estimates of overall errors by hospital.

The source of claims data for the previous 12 audits was the National Claims History (NCH) 100% Nearline File. The NCH 100% Nearline File houses all Common Working File (CWF) processed Part A and Part B detailed Medicare claims transaction records (this includes initial, interim, and debit/credit adjustments), beginning with service year 1991.

³³ Not all hospitals appealed the initial or first-level appeal claims denials or did not appeal all claims denied, or the appeals were not final as of the time of our calculations. This audit relied only on appeals that have been finalized and for which we have provided updated estimates.

APPENDIX E: RESULTS OF APPEAL BY HOSPITAL

Table 4: Appeal Results by Hospital

Hospital	Reported Errors	First Level Claims Appealed	First Level Claims Upheld	Second Level Claims Appealed	Second Level Claims Upheld	Value of Overpayments After Appeals
Alta Bates Summit Medical Center	46	36	36			\$1,571,741
Sunrise Hospital & Medical Center	54	41	41	41	41	999,950
Texas Health Presbyterian Hospital Dallas	41	24	24	23	23	500,323
Forbes Hospital	37	36	28	25	24	476,958
Carolinas Hospital	45	32	29	23	19	407,123
The Ohio State University Hospital	47	11	7	7	7	304,710
St. Vincent Hospital	58	16	14	1	0	228,664
St. Francis Hospital	14	7	7			204,264
Northwest Medical Center	20	13	9	6	6	176,261
Flagstaff Medical Center	3					79,216
Edward W. Sparrow Hospital	9					47,317
Providence Medical Center	13	13	12			45,194
Totals	387	229	207	126	120	\$5,041,721
Notice: The table above provides appeal information as of November 1, 2021. Upheld claims are claims for which the error determination was sustained upon appeal.						

APPENDIX F: CRITERIA USED TO EVALUATE CLAIMS

CRITERIA ASSOCIATED WITH INPATIENT CLAIMS

Incorrectly Billed Inpatient Rehabilitation Facility Services

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, § 1862(a)(1)(A)).

For an IRF claim to be considered reasonable and necessary, Federal regulations require that there be a reasonable expectation that, at the time of admission, the patient: (1) requires the active and ongoing therapeutic intervention of multiple therapy disciplines; (2) generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program; (3) is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation program; and (4) requires physician supervision by a rehabilitation physician (42 CFR § 412.622(a)(3)(i-iv)).³⁴

Federal regulations require that the patient’s medical record must contain certain documentation to ensure that the IRF coverage requirements are met. The record must include: (1) a comprehensive preadmission screening that is completed within the 48 hours preceding the admission, (2) a post-admission physician evaluation that is completed within 24 hours of admission and documents the patient’s status on admission to the IRF, and includes a comparison with the information in the preadmission screening, and (3) an individualized overall plan of care that is completed within 4 days of admission to the IRF (42 CFR § 412.622(a)(4)(i-iii)). In addition, Federal regulations require that the Hospital use a patient classification system to classify patients in inpatient rehabilitation facilities into mutually exclusive CMGs. CMGs are classes of Medicare patient discharges organized according to functionally related groups based on a patient’s impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functionally related groups to estimate variations in resource use (42 CFR § 412.620).

According to Federal regulations, the patient must require an interdisciplinary team approach to care, as evidenced by documentation in the medical record of weekly interdisciplinary team meetings. The meetings must be led by a rehabilitation physician, and further consist of a registered nurse, a social worker or case manager, and a licensed or certified therapist from each therapy discipline involved in treating the patient (42 CFR § 412.622(a)(5)(A)).³⁵

³⁴ 42 CFR § 412.622(a)(3)(iv) was amended effective October 1, 2018, to provide that the postadmission physician evaluation described in 42 CFR § 412.622(a)(4)(ii) may count as one of the face-to-face visits (83 Fed. Reg. 38514, 38573 (Aug. 6, 2018)).

³⁵ 42 CFR § 412.622(a)(5)(A) was redesignated as § 412.622(a)(5)(i) and amended effective October 1, 2018, to provide that the rehabilitation physician may lead the interdisciplinary team meeting remotely (83 Fed. Reg. 38514, 38573 (Aug. 6, 2018)).

Incorrect Inpatient Admissions

Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1815(a)).

A payment for services furnished to an individual may be made only to providers of services that are eligible and only if, “with respect to inpatient hospital services . . . which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual’s medical treatment . . .” (the Act, § 1814(a)(3)). Federal regulations require an order for inpatient admission by a physician or other qualified provider at or before the time of the inpatient admission (42 CFR §§ 412.3(a)-(c)).

In addition, the regulations provide that an inpatient admission, and subsequent payment under Medicare Part A, is generally appropriate if the ordering physician expects the patient to require care for a period of time that crosses two midnights (42 CFR § 412.3(d)(1)). Furthermore, the regulations provide that the expectation of the physician “should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration” (42 CFR § 412.3(d)(1)(i)).

Incorrect Diagnosis-Related Group Codes

The Act precludes payment to any provider without information necessary to determine the amount due the provider (§ 1815(a)). DRG codes are assigned to specific hospital discharges based on claims data submitted by hospitals (42 CFR § 412.60(c)), so claims data must be accurate. Consequently, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

Incorrect Inpatient Psychiatric Facility Emergency Department Adjustments

According to 42 CFR § 412.424(d)(1)(v), CMS adjusts the Federal per diem base rate upward for the first day of a Medicare beneficiary’s IPF stay to account for the costs associated with maintaining a qualifying emergency department. CMS makes this additional payment regardless of whether the beneficiary uses emergency department services. However, the IPF should not receive the additional payment if the beneficiary is discharged from the acute-care section of the same hospital. In that case, the costs of emergency department services are covered by the Medicare payment to the hospital for the immediately preceding acute-care stay.

CMS designated source-of-admission code D for a hospital-based IPF to enter on its Medicare claim form to indicate that a beneficiary was admitted from the acute-care section of the same hospital.³⁶ This code is designed to ensure that the hospital-based IPF does not receive an additional payment for the costs of emergency department services that Medicare covers in its payment to the acute-care hospital.

Incorrect Outlier Payments

The Act requires Medicare to pay an additional amount beyond the basic DRG payment for outlier cases (§ 1886(d)(5)(A)). In addition, section 1815(a) of the Act states: “The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.”

Incorrect Discharge Status Codes

A discharge of a hospital inpatient is considered to be a transfer when the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to: (1) a hospital or a hospital unit excluded from the prospective payment system, (2) a skilled nursing facility, or (3) a patient’s home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (42 CFR § 412.4(c)).

A hospital that transfers an inpatient under these circumstances is paid a graduated per diem rate for each day of the patient’s stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

CRITERIA ASSOCIATED WITH OUTPATIENT CLAIMS

Incorrect HCPCS Codes

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

³⁶ The Medicare Claims Processing Manual (Manual), chapter 3 § 190.6.4.1 (Rev. 3030, effective Oct. 1, 2015). In Change Request 3881, dated Oct. 21, 2005, and effective Apr. 1, 2006, CMS established the more specific source-of-admission code D to identify an IPF claim for a beneficiary who was admitted from the acute-care section of the same hospital. An IPF’s proper use of this code is intended to alert the Medicare contractor not to apply the emergency department adjustment.

The Manual, chapter 1, section 80.3.2.2, requires providers to complete bills accurately so that Medicare contractors may process them correctly and promptly. In addition, the Manual, chapter 4, section 20.1, states that acute-care hospitals and long-term-care hospitals must report HCPCS codes. Rehabilitation hospitals, psychiatric hospitals, hospital-based rural health clinics, hospital-based federally qualified health centers, and critical access hospitals also must report HCPCS codes. HCPCS codes are required for all outpatient hospital services unless specifically accepted in the Manual. Thus, codes are required for surgery, radiology, other diagnostic procedures, clinical diagnostic laboratory, durable medical equipment, orthotic-prosthetic devices, take-home surgical dressings, therapies, preventative services, immunosuppressive drugs, other covered drugs, and most other services.

Incorrect Bypass Modifiers

The Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§§ 1815(a) and 1833(e)). Claims must be filed on forms prescribed by CMS in accordance with CMS instructions (42 CFR § 424.32(a)(1)). Acute care hospitals are required to report HCPCS codes, of which CPT codes are a subset, on outpatient claims (the Manual, chapter 4, § 20.1), and providers are required to complete claims accurately so that Medicare contractors may process them correctly and promptly (the Manual, chapter 1, § 80.3.2.2).

Incorrect Number of Units

The Manual states that the definition of service units is the number of times the service or procedure being reported was performed (chapter 4 § 20.4). In addition, the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1 § 80.3.2.2).

Incorrect SNF Consolidated Billing

Under the consolidated billing provisions of sections 1862(a)(18) and 1842(b)(6)(E) of the Act, SNFs are responsible for billing Medicare for most services, including outpatient hospital services, provided to a SNF resident during a stay covered by Part A. Pursuant to Medicare regulations (42 CFR § 411.15(p)) and manual provisions implementing the SNF consolidated billing requirement,³⁷ outside suppliers, including outpatient hospitals, must bill according to the consolidated billing provisions for services furnished to SNF residents and must be paid by the SNF rather than by Medicare Part B.

³⁷ The Manual, chapter 6, §§ 10 and 20.

APPENDIX G: RESULTS OF AUDIT BY RISK AREA

Table 3: Audit Results by Risk Area

Risk Area	Selected Claims	Claims With Over-payments	Value of Overpayments
IRF Claims	312	194	\$4,415,560
Inpatient Claims Billed with CERT DRG Codes	269	59	325,547
Inpatient Claims Billed with High-Severity Level DRG Codes	113	31	239,226
Inpatient Claims Paid in Excess of Charges	29	7	160,768
Inpatient Adverse Events	45	6	50,640
Inpatient Elective Procedures	289	7	35,758
Inpatient Mechanical Ventilation	17	2	25,938
Inpatient Same Day Discharge and Readmit	3	1	6,256
IPF Emergency Adjustments	34	24	2,490
Inpatient Claims Paid in Excess of \$150,000	7	0	0
Inpatient Claims Paid in Excess of \$25,000	7	2	(2,036)
Inpatient Totals	1,125	333	\$5,260,147
Outpatient Claims			
Outpatient Claims Paid in Excess of Charges	6	5	\$28,633
Outpatient Right Heart Catheterizations	19	18	14,938
Outpatient Surgeries Billed with Units Greater than 1	13	10	9,655
Outpatient Claims with Bypass Modifiers	56	18	327
Outpatient SNF Consolidated Billing Claims	7	3	176
Outpatient Claims Paid in Excess of \$25,000	64	0	0
Outpatient Totals	165	54	\$53,729
Inpatient and Outpatient Totals	1,290	387	\$5,313,876

Notice: The table above presents the results of the 12 audits by risk area. In it, we have organized inpatient and outpatient claims by the risk areas reviewed. However, we have organized this report's findings by the types of billing errors found at the hospitals. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.



APPENDIX H: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: September 26, 2022

TO: Amy Frontz
Deputy Inspector General for Audit Services

FROM: Chiquita Brooks-LaSure *Chiquita LaSure*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *CMS Can Use OIG Audit Reports To Improve Its Oversight of Hospital Compliance*, A-04-21-08084

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report on their findings related to a series of provider compliance audits. CMS is committed to protecting the fiscal integrity of the Medicare Trust funds.

OIG's review examined 12 provider compliance audits to determine CMS's actions on the recommendations as well as our internal controls related to preventing the errors OIG identified. It is important to note that CMS has established policies and procedures in place to address OIG's findings and uses its resources to collect identified overpayments in a manner that is cost effective and ensures that CMS complies with the statutory and regulatory framework of overpayment collections.

A network of Medicare Administrative Contractors (MACs) serve as the primary operational contacts between the Medicare Fee-For-Service (FFS) program and health care providers enrolled in the program. Each year, the MACs process more than one billion Medicare FFS claims and pay out approximately \$400 billion in Medicare FFS benefits. In addition to processing claims and making payments, the MACs recover overpayments and develop and execute strategies to prevent improper payments, among other activities.

Upon receipt of an OIG report involving overpayments, CMS reviews the claims to determine the amount for collection, or the "sustained" amount. This amount may differ from the OIG recommended collection amount for various reasons, including if claims are being appealed or claims have exceeded the relevant reopening period and cannot be reopened. When sustained amounts are determined, CMS directs its MACs to reopen and recover the identified overpayments. Providers may appeal the overpayment, which may result in an overpayment redetermination. The administrative appeals process is an independent review, and CMS communicates with the provider and the MAC regularly to obtain a status of open recommendations, including if appeals are filed. In addition, at the conclusion of the appeals process and in accordance with the 60-day rule per 42 CFR § 401.305, CMS also instructs the applicable MAC to issue a 60-day letter to the applicable provider requesting an attestation that the provider performed a self-assessment and determined that either no additional claims were submitted in error, or it has identified and returned or is working to return any identified additional applicable overpayment(s) to the MAC.

As part of the OIG audit recommendation resolution process, CMS receives updates from the MACs on collection amounts as well as other relevant collection documentation, and reports to OIG the status of collections on a regular basis. Some overpayment collections involve thousands of providers and claims, so CMS often collects high-level summary updates from its automated accounting system, while the source documentation supporting the summary reports are maintained by the MACs.

Additionally, CMS has created a new system for tracking OIG audit recommendations, known as the Audit Management System (AMS). CMS developed AMS in line with OMB Circular A-50, section 8(a)(4) and the Green Book to maintain accurate records on the status of audit recommendations. CMS solicited input from OIG during the development of the new system and is working with OIG to directly link CMS and OIG audit systems so audit reports, clearance documents, and audit appeals status updates flow between the two systems, reducing the need for manual updates. This process is ongoing, and both CMS and OIG are in regular communication to ensure that the new system serves both CMS and OIG needs.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should continue to follow up on the overpayment recovery recommendations contained in the 12 audits covered by this report.

CMS Response

CMS notes that this recommendation is duplicative of the recommendations regarding collections in OIG's 12 provider compliance audit reports, and CMS already takes administrative action to provide status updates on these recommendations to OIG regularly. CMS continues to recover any collectible portion of the findings, some of which is no longer collectable due to changes in the sustained amount, provider bankruptcy, and settlements, among other reasons. Since OIG ended their data collection in March 2021, CMS has continued collections, and to date has collected over 91 percent of currently sustained overpayments from OIG's selected audits. Therefore, CMS continues to request that the OIG remove this recommendation.

OIG Recommendation

CMS should improve tracking and responding on the status of claims identified in our reports as they proceed through the appeals process.

CMS Response

CMS concurs with this recommendation. CMS has consistently provided information about the status of claims as they proceed through the appeals process to the relevant OIG audit teams, and has worked with OIG to help them centrally store this information for other OIG users by partnering with them on a shared recommendation tracking system, known as the Audit Management System (AMS). One feature of the new system is the ability to upload documents, such as the results of appeals determinations, and CMS is now uploading these documents directly to the system.

OIG Recommendation

CMS should direct its MACs to follow up with eight of the 12 hospitals that have not responded to the recommendation to follow the 60-day rule or have not followed up at the conclusion of the appeals process (for those that are appealing the results of their audits).

CMS Response

CMS concurs with this recommendation. CMS will direct the MACs to follow up with the eight hospitals for a response to the 60-day rule notice, as appropriate. For those hospitals that are appealing the results of the audit and are therefore awaiting resolution of legal questions before proceeding with an investigation under the 60-day rule, CMS will follow up at the conclusion of the appeals process.

OIG Recommendation

CMS should revise its SOP to require MACs to follow up with providers at the conclusion of the appeals process and require the MACs to provide additional detail to CMS regarding specific follow-up actions taken.

CMS Response

CMS concurs with this recommendation. CMS will explore updating the SOP for external audits to require MACs to follow up with providers after the appeals process has completed.

OIG Recommendation

CMS should consider the results of this audit and future hospital compliance audits in its risk assessment process.

CMS Response

CMS currently instructs the MACs to consider the results of OIG and GAO work, among other factors, in determining where to focus their resources. CMS takes multiple factors into consideration when undertaking policy changes and new internal control activities. These factors already include results of OIG reports on individual providers as appropriate, as part of the larger picture of provider activity. However, OIG rollup reports and other reports that provide evidence of system-wide patterns most effectively complement our own internal risk assessment process, and provide the strongest support for policy changes and additional internal control activities. Therefore, CMS continues to request that the OIG remove this recommendation.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.