

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE INAPPROPRIATELY PAID
ACUTE-CARE HOSPITALS FOR
OUTPATIENT SERVICES THEY PROVIDED
TO BENEFICIARIES WHO WERE
INPATIENTS OF OTHER FACILITIES**

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Office of Inspector General

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Report in Brief

Date: September 2017
Report No. A-09-16-02026

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



Why OIG Did This Review

Prior OIG reviews found that Medicare inappropriately paid for outpatient services provided to Medicare beneficiaries who were inpatients of acute-care hospitals. Those reviews did not cover outpatient services provided to beneficiaries who were inpatients of other types of facilities. From January 1, 2013, through August 31, 2016 (audit period), Medicare paid acute-care hospitals \$56 million for outpatient services they provided to beneficiaries who were inpatients of certain other facilities: long-term-care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and critical access hospitals (CAHs).

Our objective was to determine whether Medicare appropriately paid acute-care hospitals for outpatient services they provided to beneficiaries who were inpatients of other facilities.

How OIG Did This Review

We first identified inpatient claims from LTCHs, IRFs, IPFs, and CAHs with service dates during the audit period. We used the beneficiary information and service dates from the inpatient claims to identify outpatient claims (totaling \$51.6 million) from acute-care hospitals that overlapped with the identified inpatient claims from the inpatient facilities (i.e., outpatient claims that had service dates between, but not including, the admission and discharge dates on the inpatient claims).

Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities

What OIG Found

Medicare did not appropriately pay acute-care hospitals any of the \$51.6 million for outpatient services that we reviewed. In addition, beneficiaries were held responsible for unnecessary deductibles and coinsurance of \$14.4 million paid to the acute-care hospitals for outpatient services. Generally, Medicare should not pay an acute-care hospital for outpatient services provided to an inpatient of another facility, such as an LTCH. Instead, the services should be provided under arrangements between the two facilities, and Medicare should pay the inpatient facility for all services provided to a beneficiary (as part of the facility's inpatient payment rate).

Medicare overpaid the acute-care hospitals because the system edits that should have prevented or detected the overpayments were not working properly. If the system edits had been working properly since calendar year 2006, Medicare could have saved almost \$100 million, and beneficiaries could have saved \$28.9 million in deductibles and coinsurance that may have been incorrectly collected from them or someone on their behalf.

What OIG Recommends and CMS Comments

We recommend that the Centers for Medicare & Medicaid Services (CMS) direct the Medicare contractors to (1) recover the \$51.6 million in identified improper payments to acute-care hospitals in accordance with CMS's policies and procedures, (2) instruct the acute-care hospitals to refund beneficiaries up to \$14.4 million in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf, and (3) identify and recover any improper payments to acute-care hospitals after our audit period. We also recommend that CMS correct the system edits to prevent overpayments to acute-care hospitals and instruct the Medicare contractors to more effectively educate acute-care hospitals not to bill Medicare for outpatient services they provided to beneficiaries who were inpatients of other facilities, but rather to provide those services under arrangements and look to the inpatient facilities for payment.

CMS concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General reviews found that Medicare inappropriately paid for outpatient services provided to Medicare beneficiaries who were inpatients of short-term acute-care hospitals (acute-care hospitals).¹ Those reviews did not cover outpatient services provided to beneficiaries who were inpatients of other types of facilities. From January 1, 2013, through August 31, 2016 (audit period), Medicare paid acute-care hospitals \$56 million for outpatient services they provided to beneficiaries who were inpatients of certain other facilities: long-term-care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and critical access hospitals (CAHs).² Generally, Medicare should not pay an acute-care hospital for these services; instead, they should be provided under arrangements between the two facilities, and Medicare should pay the inpatient facility for all services provided to a beneficiary (as part of the facility's inpatient payment rate).

OBJECTIVE

Our objective was to determine whether Medicare appropriately paid acute-care hospitals for outpatient services they provided to beneficiaries who were inpatients of other facilities.

BACKGROUND

The Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. 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. Medicare beneficiaries are responsible for certain out-of-pocket costs, such as deductibles and coinsurance, for both Medicare Part A and Part B services.

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with Medicare administrative contractors (Medicare contractors) in each Medicare jurisdiction to, among other things, process and pay Medicare Part A and B claims submitted for hospital services.

¹ The most recent of these reports is *Medicare Paid New England Providers Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays* (A-01-15-00511), issued June 28, 2017. That report focused specifically on inpatient stays at acute-care hospitals.

² For our review, we considered acute-care hospitals to be both general acute-care hospitals and CAHs.

Short-Term Acute-Care Hospitals and Certain Inpatient Facilities

Acute-care hospitals provide inpatient acute care that is needed for a relatively short period of time and are paid through the Inpatient Prospective Payment System (IPPS) under Medicare Part A (42 CFR § 412.1). These hospitals also provide outpatient services, which are paid under Medicare Part B. Federal regulations specifically exclude the following types of hospitals from the IPPS: psychiatric, rehabilitation, children's, long-term-care, and cancer hospitals; hospitals outside the 50 States, the District of Columbia, and Puerto Rico; and hospitals reimbursed under special arrangements (42 CFR § 412.23). In addition, CAHs are not subject to the IPPS and are, instead, paid on a reasonable cost basis (Social Security Act § 1814(l)).

Our review covered outpatient services that acute-care hospitals provided to beneficiaries who were inpatients of these certain types of inpatient facilities excluded from the IPPS:

- **LTCH:** a freestanding facility or a unit within an acute-care hospital. An LTCH focuses on patients with medically complex conditions or multiple conditions (comorbidities) that require, on average, an inpatient stay of greater than 25 days.
- **IRF:** a separate facility or a subunit of a hospital for which the primary purpose is to provide intensive rehabilitation services, such as physical, occupational, or speech therapy, to its inpatient population.
- **IPF:** a freestanding or specialized hospital-based unit that meets the urgent needs of those experiencing an acute mental health crisis.
- **CAH:** a hospital that is accessible to beneficiaries in rural communities and contains no more than 25 beds for inpatient care services.

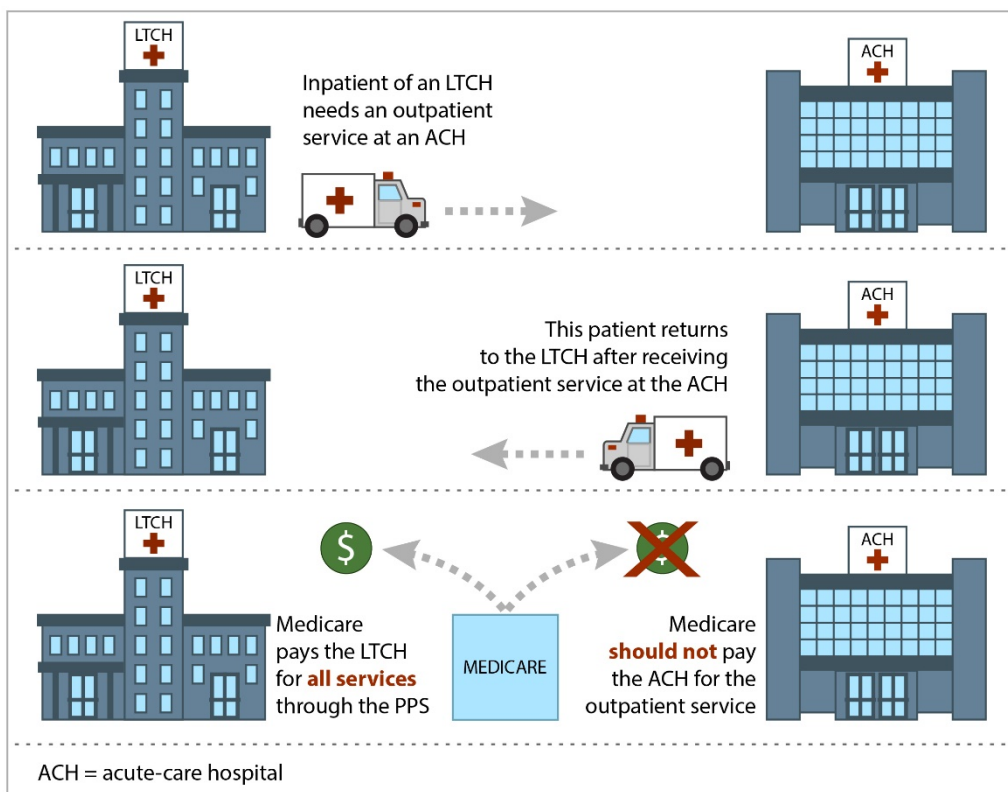
Medicare Payments to Certain Inpatient Facilities

Medicare pays for inpatient services under Part A. Specifically, Medicare pays (1) LTCHs under a prospective payment system (PPS) specific to LTCHs, (2) IRFs under a PPS specific to IRFs, and (3) IPFs under a per diem PPS specific to IPFs. Under each PPS, the payments made to the facilities are payment in full for all inpatient hospital services. Medicare pays CAHs on a reasonable-cost basis.

Each type of inpatient facility covered by our review must (1) provide directly all services furnished during an inpatient stay or (2) arrange for services to be provided on an outpatient basis by an acute-care hospital and include those outpatient services on its inpatient claims submitted to Medicare. Except for services provided by physicians and certain other health care workers and for certain preventive services, Medicare should not pay a facility (e.g., an acute-care hospital) for services furnished to a beneficiary at that facility (e.g., outpatient surgery or lab work) when the beneficiary is still an inpatient of another facility (i.e., has not been formally discharged).

Figure 1 illustrates a situation in which a Medicare beneficiary is an inpatient at an LTCH and needs a service that is not available at the LTCH but can be performed on an outpatient basis at an acute-care hospital. The LTCH transports the beneficiary to the acute-care hospital and makes arrangements for that hospital to furnish the outpatient service.³ (The beneficiary is not officially discharged from the inpatient facility.) Once the service has been furnished, the beneficiary returns to the LTCH to continue receiving care. Medicare pays the LTCH for all services, including the outpatient service, provided to the beneficiary as part of its PPS rate. Medicare should not make a separate payment to the acute-care hospital for that outpatient service. Instead, the acute-care hospital, under arrangements with the LTCH, can look to the LTCH for payment for the outpatient service it provided to the LTCH inpatient.

Figure 1: A Beneficiary Receives an Outpatient Service at an Acute-Care Hospital While Still an Inpatient of a Long-Term-Care Hospital



Postpayment and Prepayment Edits in the Medicare Claims Processing System

Before payment, all Medicare contractor claims are sent to CMS’s Common Working File (CWF) for verification, validation, and payment authorization. The CWF contains both postpayment and prepayment system edits that should prevent or detect overpayments for outpatient

³ Federal regulations define “arrangements” as those “which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services” (42 CFR § 409.3). CMS is silent on the specifics of the arrangements between the two parties.

services provided during inpatient stays. Once the CWF has processed a claim for payment, it electronically transmits information to the contractor about potential errors on the claim. The system edits should work as follows:

- **Postpayment Edit.** If the outpatient claim is processed for payment before the inpatient claim, once the inpatient claim is processed, a postpayment edit is designed to generate an “alert” to the Medicare contractor that processed the outpatient claim so that the payment can be recovered. The Medicare contractor is responsible for recovering the overpayment.
- **Prepayment Edit.** If the inpatient claim is processed for payment before the outpatient claim, once the outpatient claim is processed, a prepayment edit should deny the outpatient claim.

HOW WE CONDUCTED THIS REVIEW

Our review covered \$51,640,727 in Medicare Part B payments to acute-care hospitals for 129,792 claims that included outpatient services provided to beneficiaries who were inpatients of certain other facilities. To identify these services, we first identified inpatient claims from LTCHs, IRFs, IPFs, and CAHs with service dates from January 1, 2013, through August 31, 2016. We used the beneficiary information and service dates from the inpatient claims to identify outpatient claims from acute-care hospitals that overlapped with the identified inpatient claims from the inpatient facilities (i.e., outpatient claims that had service dates between, but not including, the admission and discharge dates on the inpatient claims). In addition, we identified claims for outpatient services billed during inpatient stays for the previous 7 years, back to calendar year (CY) 2006, to determine whether the postpayment and prepayment edits were working properly during that time period.

We focused only on the inappropriate Medicare Part B payments. We did not verify whether the inpatient facilities (1) paid the acute-care hospitals that provided the outpatient services or (2) included the outpatient services on their Medicare Part A claims. We did not use medical review to determine whether the services were medically necessary.

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 audit scope and methodology.

FINDINGS

For our audit period, Medicare inappropriately paid acute-care hospitals for outpatient services they provided to beneficiaries who were inpatients of other facilities (i.e., LTCHs, IRFs, IPFs, and CAHs). Specifically, none of the \$51,640,727 we reviewed, representing 129,792 claims, should have been paid because the inpatient facilities were responsible for payment. In addition, beneficiaries were held responsible for unnecessary deductibles and coinsurance of \$14,365,590 paid to the acute-care hospitals for those outpatient services.

Medicare overpaid the acute-care hospitals because the CWF edits that should have prevented or detected the overpayments were not working properly:

- In 94 percent of cases, the Medicare contractor processed for payment the acute-care hospital's outpatient claim before the inpatient facility's inpatient claim. The postpayment edit generated an alert to notify the Medicare contractor to recover the improper payment for the outpatient service, but the contractor did not act to recover it.⁴
- In 6 percent of cases, the Medicare contractor processed for payment the inpatient facility's inpatient claim before the acute-care hospital's outpatient claim. The prepayment edit should have denied the claim for the outpatient service but did not do so.

If the CWF edits had been working properly since CY 2006, Medicare could have saved \$99,149,320, and beneficiaries could have saved \$28,899,632 in deductibles and coinsurance that may have been incorrectly collected from them or someone on their behalf.

FEDERAL REQUIREMENTS

Section 1812 of the Social Security Act (the Act) states that inpatient hospital services provided to Medicare beneficiaries are paid under Medicare Part A. These include inpatient stays at LTCHs, IPFs, IRFs, and CAHs (the Act § 1861). All items and nonphysician services provided during a Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with another provider and billed to Medicare by the inpatient hospital through its Part A claim.⁵ This provision applies to *all* hospitals, regardless of whether they are subject

⁴ We consider the edit to be working properly when both the alert is generated and the Medicare contractor acts to recover the overpayment.

⁵ *Medicare Claims Processing Manual* (Claims Manual), Pub. No. 100-04, chapter 3, § 10.4. These services include all inpatient hospital services, which do not include certain physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified nurse midwife services, qualified psychologist services, and the services of an anesthetist (42 CFR §§ 409.10(a) and (b)).

to a PPS.⁶ Federal regulations state that Medicare does not pay any provider other than the inpatient hospital for services provided to the beneficiary while the beneficiary is an inpatient of the hospital (42 CFR §§ 412.404(d), 412.509(b), and 412.604(e)).

Beneficiaries generally share in the cost of Medicare Part B by paying deductibles and coinsurance (42 CFR § 489.30(b)). The deductible that beneficiaries pay for Part B coverage can change yearly.⁷ Once the deductible is met, beneficiaries generally pay a coinsurance amount equal to 20 percent of the amount allowed by Medicare in excess of the deductible (42 CFR § 489.30(b)). Medicare providers should refund to beneficiaries deductible and coinsurance amounts incorrectly collected from them or from someone on their behalf (Claims Manual, chapter 1, § 30.1.2).

MEDICARE INAPPROPRIATELY PAID ACUTE-CARE HOSPITALS FOR OUTPATIENT SERVICES THEY PROVIDED TO BENEFICIARIES WHO WERE INPATIENTS OF OTHER FACILITIES

Medicare inappropriately paid acute-care hospitals for outpatient services they provided to beneficiaries who were inpatients of other facilities, i.e., LTCHs, IRFs, IPFs, and CAHs. Specifically, none of the \$51,640,727 in payments we reviewed, representing 129,792 claims, should have been made because the inpatient facilities were responsible for payment.

As stated in Federal requirements, all items and nonphysician services provided during a Medicare Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with the inpatient hospital and another provider. The inpatient facilities in our review should have included those services on their inpatient claims to Medicare, and the acute-care hospitals could then have looked to the inpatient facilities for payment for the outpatient services provided.

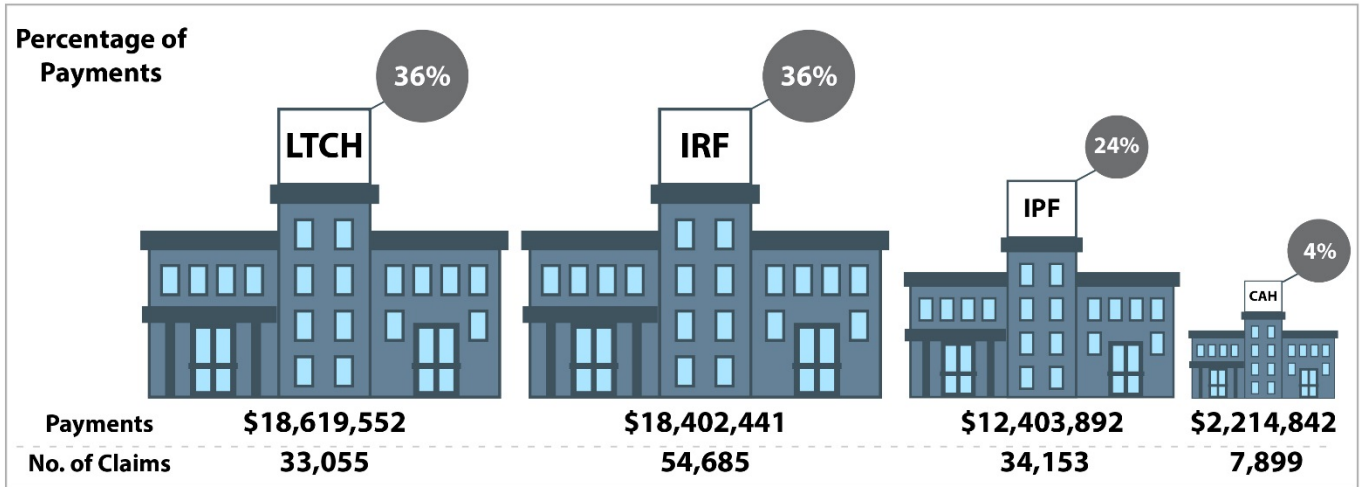
For \$48,454,486 (94 percent) of the total payments, the outpatient claims were processed for payment before the inpatient claims. For the remaining \$3,186,241 (6 percent), the inpatient claims were processed for payment before the outpatient claims. Because Medicare made inappropriate payments for outpatient services, beneficiaries were held responsible for unnecessary deductibles and coinsurance of \$14,365,590 paid to the acute-care hospitals for those services.

Figure 2 on the following page shows, according to type of inpatient facility, the percentage of total payments that Medicare made for outpatient services that should have been made by the inpatient facilities.

⁶ Claims Manual, chapter 3, § 10.4. There are some exceptions to this provision, including certain services payable only under Medicare Part B (*Medicare Benefit Policy Manual* (Benefit Manual), chapter 15, § 250) as well as some additional services that may be paid under Part B for beneficiaries who do not have Medicare Part A benefits or have exhausted their Part A benefits (Benefit Manual, chapter 6, § 10.2). We excluded from our review Part B-only claims and claims for beneficiaries who did not have Part A benefits or had exhausted their Part A benefits.

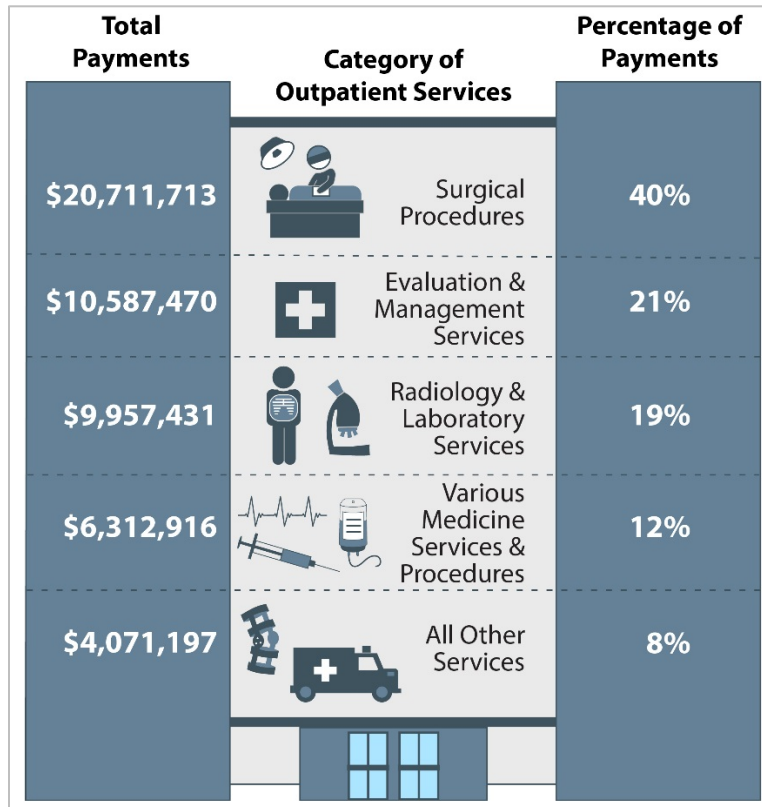
⁷ The Medicare Part B deductible for 2016 was \$166 (80 Fed. Reg. 70811 (Nov. 16, 2015)).

Figure 2: Percentage of Total Payments by Type of Inpatient Facility



Medicare paid acute-care hospitals for various outpatient services that should have been paid by the inpatient facilities. These services included surgical procedures, computed tomography scans, x-rays and other radiological services, laboratory services, emergency department visits, drug injections, echocardiography, infusion services, and ambulance services (Figure 3).

Figure 3: Percentage of Total Payments by Type of Outpatient Service



EDITS WERE NOT WORKING PROPERLY TO PREVENT OVERPAYMENTS

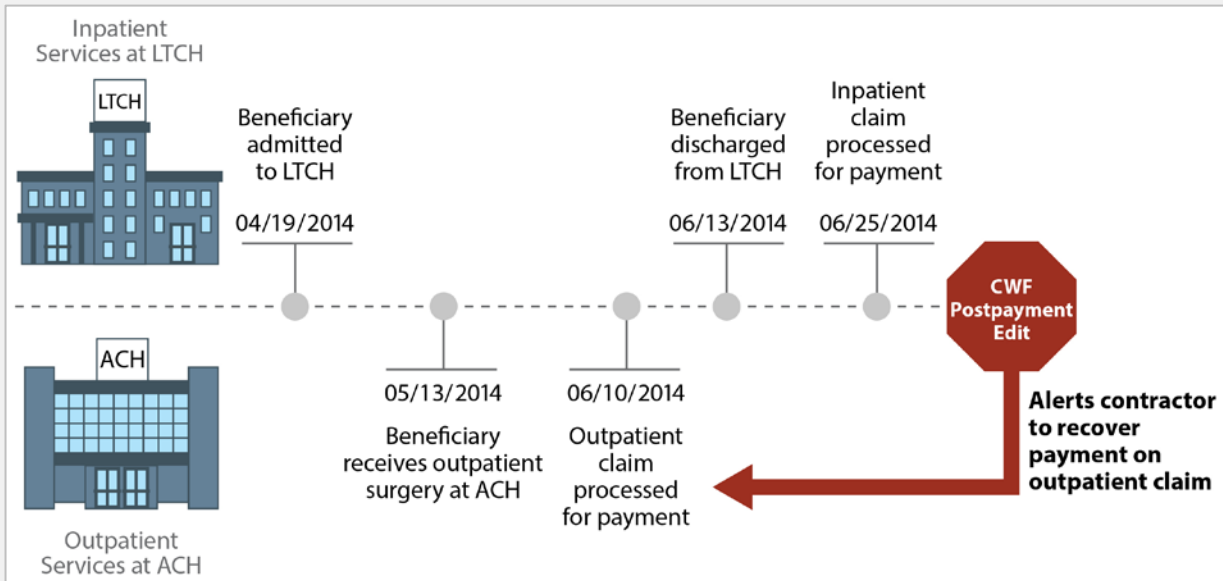
Medicare overpaid the acute-care hospitals because the CWF postpayment and prepayment edits that should have prevented or detected overpayments for outpatient services provided to beneficiaries who were inpatients of certain other facilities were not working properly:

- In 94 percent of cases, the postpayment edit alert was generated, but the Medicare contractor did not act to recover the overpayment. (See Example 1 on page 9.) According to CMS, the Medicare contractors did not take action on the postpayment alert because they did not understand that the alert required them to take action.
- In 6 percent of cases, the prepayment edit's automatic "reject" failed to deny the outpatient payment because either the edit was not designed to reject an outpatient claim that overlapped with a claim from a distinct-part unit of a hospital⁸ (e.g., an IRF or IPF) or the edit did not identify the full inpatient history of the beneficiary and thus missed the overlapping inpatient claim. (See Example 2 on page 10.)

CMS provided general instructions to the Medicare contractors regarding controls to prevent overpayments due to overlapping inpatient and outpatient claims. However, the Medicare contractors did not effectively educate inpatient facilities and acute-care hospitals about their responsibilities when outpatient services are provided to beneficiaries who are inpatients of other facilities.

⁸ A distinct-part unit of a hospital is a separate section of the hospital that provides a unique level of care (e.g., rehabilitative or psychiatric services) and operates independently of the rest of the hospital.

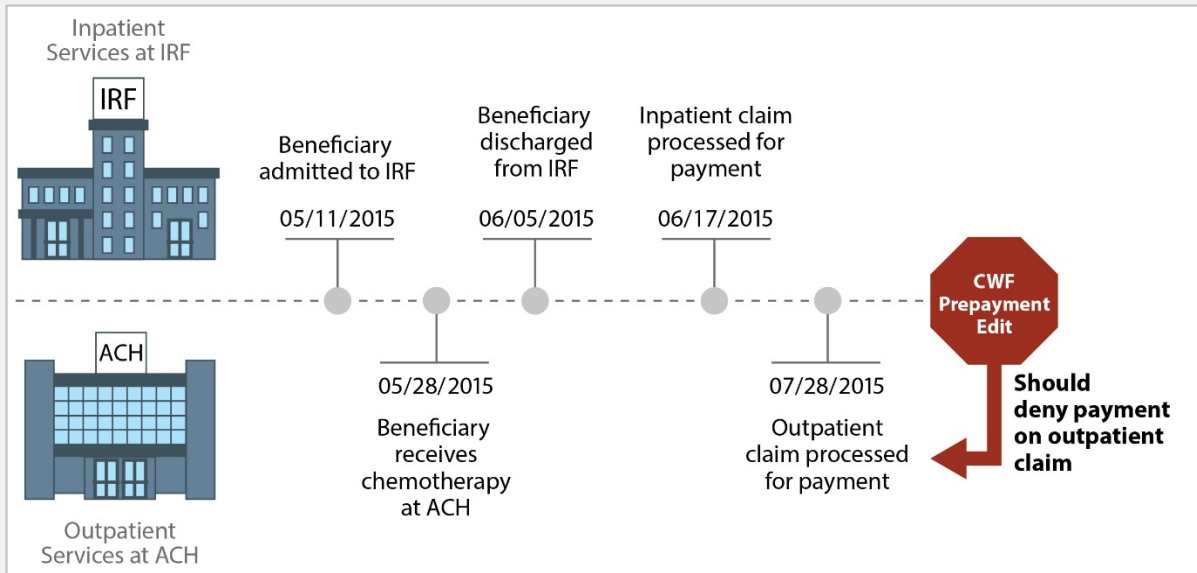
Example 1: Outpatient Claim Processed Before Inpatient Claim: Postpayment Edit



An LTCH admitted a Medicare beneficiary on April 19, 2014, for cholecystitis (inflammation of the gallbladder) and encephalopathy (a disease of the brain that alters brain function or structure). During the beneficiary’s inpatient stay, it was determined that the beneficiary needed surgery to insert a pulse generator and needed an electrocardiogram. On May 13, 2014, the beneficiary was transported to an acute-care hospital to receive those services on an outpatient basis. After the services were performed, the beneficiary returned to the LTCH on May 14, 2014, to receive additional inpatient services related to his condition. The LTCH discharged the beneficiary on June 13, 2014.

The acute-care hospital submitted a Part B claim to Medicare for the outpatient services before the LTCH discharged the beneficiary. The Medicare contractor processed the outpatient claim on June 10, 2014, and paid the acute-care hospital \$30,734. After discharging the beneficiary, the LTCH submitted a Part A claim to Medicare for the beneficiary’s inpatient stay. The Medicare contractor processed the inpatient claim on June 25, 2014, and paid the LTCH \$61,522. Because the CWF’s postpayment edit generated an alert to the Medicare contractor that a previously paid outpatient claim overlapped with a paid inpatient claim, the Medicare contractor should have recovered the outpatient payment to the acute-care hospital but did not do so.

Example 2: Inpatient Claim Processed Before Outpatient Claim: Prepayment Edit



A distinct-part unit IRF admitted a quadriplegic Medicare beneficiary on May 11, 2015, for rehabilitation after the beneficiary had spinal surgery at the related acute-care hospital to remove a malignant lesion. During his stay at the IRF, the beneficiary needed chemotherapy. On May 28, 2015, the beneficiary was taken to the related acute-care hospital for chemotherapy. On that same day, the beneficiary returned to the IRF to receive additional inpatient services related to his condition. The IRF discharged the beneficiary on June 5, 2015, and submitted a Part A claim to Medicare for the inpatient stay. The Medicare contractor processed the claim on June 17, 2015, and paid the IRF \$43,481. The related acute-care hospital submitted its Part B claim to Medicare more than a month after the chemotherapy was completed. On July 28, 2015, the Medicare contractor processed the outpatient claim and paid the acute-care hospital \$5,964. The CWF's prepayment edit should have denied the payment for the outpatient claim but did not do so.

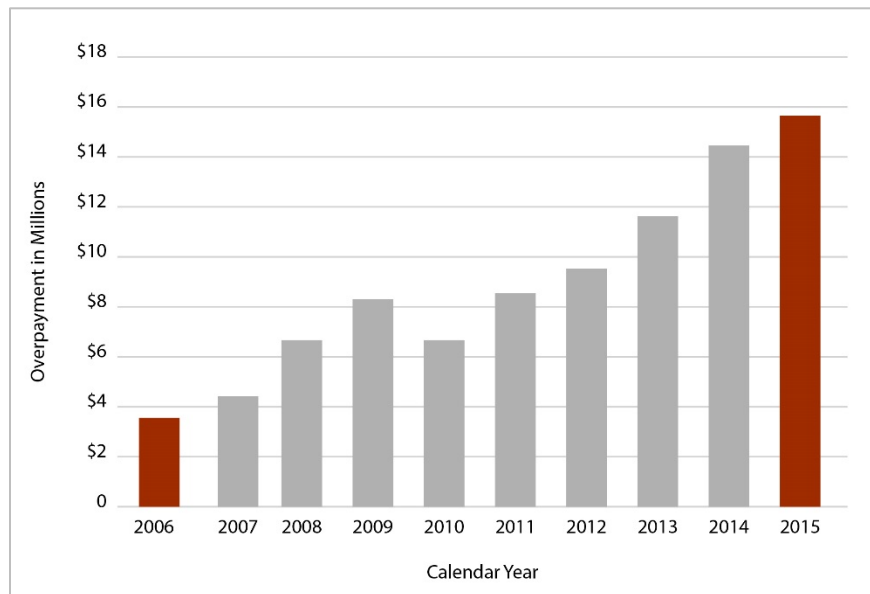
MEDICARE OVERPAID \$51.6 MILLION DURING OUR AUDIT PERIOD AND COULD HAVE SAVED ALMOST \$100 MILLION OVER THE LAST 10 YEARS

Medicare overpaid acute-care hospitals \$51,640,727 for outpatient services they provided to beneficiaries who were inpatients of certain other facilities. In addition, beneficiaries were held responsible for unnecessary deductibles and coinsurance of \$14,365,590 paid to the acute-care hospitals for those services.

In addition to identifying claims for outpatient services that overlapped with inpatient stays within our audit period, we identified overlapping claims for outpatient services for the previous 7 years, back to CY 2006, to determine whether the postpayment and prepayment edits were working properly during that period. We identified overpayments in each of the 10 years and found that from CYs 2006 through 2015, overpayments increased each year except for 2010. Overpayments due to overlapping claims for outpatient services more than

quadrupled during this period, from \$3.5 million in CY 2006 to \$15.6 million in CY 2015 (Figure 4). Total overpayments for CYs 2006 through August 31, 2016, were \$99,149,320.

Figure 4: Overpayments Quadrupled From Calendar Years 2006 Through 2015



If the CWF edits had been working properly since CY 2006, Medicare could have saved \$99,149,320, and beneficiaries could have saved \$28,899,632 in deductibles and coinsurance that may have been incorrectly collected from them or someone on their behalf.

RECOMMENDATIONS

We recommend that CMS direct the Medicare contractors to:

- recover the \$51,640,727 in identified improper payments to acute-care hospitals in accordance with CMS's policies and procedures,
- instruct the acute-care hospitals to refund beneficiaries up to \$14,365,590 in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf, and
- identify and recover any improper payments to acute-care hospitals after our audit period and instruct those hospitals to refund to beneficiaries any deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

We also recommend that CMS correct the CWF edits to prevent overpayments to acute-care hospitals for outpatient services provided to Medicare beneficiaries who were inpatients of

LTCHs, IRFs, IPFs, and CAHs. For example, CMS could revise the postpayment edit so that it implements an automatic recovery process rather than generating an alert to the Medicare contractor. In addition, CMS could revise the prepayment edit to identify outpatient claims that overlap with inpatient claims from a distinct-part unit of a hospital (e.g., an LTCH, IRF, or IPF) and ensure that it identifies full inpatient histories of beneficiaries. If the CWF edits had been working properly since CY 2006, Medicare could have saved \$99,149,320, and beneficiaries could have saved \$28,899,632 in deductibles and coinsurance that may have been incorrectly collected from them or someone on their behalf.

Finally, we recommend that CMS instruct the Medicare contractors to more effectively educate acute-care hospitals not to bill Medicare for outpatient services they provided to beneficiaries who were inpatients of other facilities, but rather to provide those services under arrangements and look to the inpatient facilities for payment.

CMS COMMENTS

In written comments on our draft report, CMS concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered \$51,640,727 in Medicare Part B payments to acute-care hospitals for 129,792 claims that included outpatient services provided to beneficiaries who were inpatients of certain other facilities. To identify these services, we first identified inpatient claims from LTCHs, IRFs, IPFs, and CAHs with service dates from January 1, 2013, through August 31, 2016. We used the beneficiary information and service dates from the inpatient claims to identify outpatient claims from acute-care hospitals that overlapped with the identified inpatient claims from the inpatient facilities, i.e., outpatient claims that had service dates between, but not including, the admission and discharge dates on the inpatient claims. In addition, we identified claims for outpatient services billed during inpatient stays for the previous 7 years, back to CY 2006, to determine whether the postpayment and prepayment edits were working properly during that time period.

We focused only on the inappropriate Medicare Part B payments. We did not verify whether the inpatient facilities (1) paid the hospitals that performed the outpatient services or (2) included the outpatient services on their Medicare Part A claims. We did not use medical review to determine whether the services were medically necessary.

We did not review the overall internal control structure of CMS because our objective did not require us to do so. Rather, we limited our review of CMS's internal controls to those applicable to overlapping inpatient and outpatient claims. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our audit work from May through November 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's NCH file to identify Medicare Part A inpatient claims from LTCHs, IRFs, IPFs, and CAHs;
- excluded claims for beneficiaries who had exhausted their Medicare Part A benefits or did not have Part A benefits;
- used CMS's NCH file to identify Medicare Part B outpatient claims from acute-care hospitals that overlapped with the identified inpatient claims from the inpatient facilities;

- excluded from our review outpatient services when the dates of service overlapped with an occurrence span code 74 (identifying an interrupted stay) reported on the inpatient claim;⁹
- excluded from our review outpatient preventive services;¹⁰
- identified outpatient services on 129,792 acute-care-hospital outpatient claims that should have been included on the inpatient facilities' Medicare Part A inpatient claims;
- reviewed available data from CMS's CWF for the selected outpatient claims to determine whether the claims had been canceled or adjusted;
- identified beneficiary deductibles and coinsurance related to the acute-care-hospital outpatient services;
- interviewed CMS officials and reviewed documentation provided by them to understand how the CWF edits work and to determine why Medicare made payments for the outpatient claims that overlapped with the inpatient claims;
- provided to CMS our complete list of inappropriately paid outpatient services during our audit period;
- identified additional outpatient services on acute-care-hospital outpatient claims from CYs 2006 through 2012 that should have been included on the inpatient facilities' Medicare Part A inpatient claims, as well as the related payments for deductibles and coinsurance that were incorrectly collected from beneficiaries or from someone on their behalf; and
- discussed the results of our review 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.

⁹ An interrupted stay occurs when an inpatient is discharged from an inpatient facility and is readmitted to that facility within a certain number of days.

¹⁰ Examples include mammograms; Pap smears and pelvic exams; prostate, colorectal, and glaucoma screenings; influenza, pneumococcal pneumonia, and hepatitis B vaccines and their administration; and bone-mass measurements.

APPENDIX B: CMS COMMENTS




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: AUG 10 2017

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator 

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities (A-09-16-02026)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars by preventing improper payments.

Section 1812 of the Social Security Act states that inpatient hospital services provided to Medicare beneficiaries are paid under Medicare Part A. This includes inpatient stays at Long Term Care Hospitals, Inpatient Psychiatric Facilities, Inpatient Rehabilitation Facilities, and Critical Access Hospitals. Federal regulation states that Medicare does not pay any provider other than the inpatient hospital for services provided to a beneficiary while a beneficiary is an inpatient of the hospital. Therefore, all items and nonphysician services provided during a Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with another provider and billed to Medicare by the inpatient hospital through its Part A claim.

Generally, items and services furnished on an outpatient basis are paid under Medicare Part B. Beneficiaries generally share in the cost of Medicare Part B by paying deductibles and coinsurance. When a provider incorrectly bills for an item or service under Part B, the beneficiary or someone on their behalf may be subject to improper deductible or coinsurance charges. Medicare providers should refund any deductible or coinsurance amount that was incorrectly collected from a beneficiary or someone on their behalf.

CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. CMS has taken actions to prevent Medicare overpayments by educating providers on proper billing. CMS educates providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. Additionally, CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and postpayment reviews.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS recover the \$51,640,727 in identified improper payments to acute-care hospitals in accordance with CMS's policies and procedures.

CMS Response

CMS concurs with this recommendation. CMS will conduct an analysis to determine how to address the identified improper payments to acute-care hospitals in accordance with CMS' policies and procedures.

OIG Recommendation

The OIG recommends that CMS instruct the acute-care hospitals to refund beneficiaries up to \$14,365,590 in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

CMS Response

CMS concurs with this recommendation. Based on the outcome of the analysis regarding how to address the identified improper payments to acute-care hospitals, CMS will determine how to address any deductible or coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

OIG Recommendation

The OIG recommends that CMS identify and recover any improper payments to acute-care hospitals after the audit period and instruct those hospitals to refund to beneficiaries any deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

CMS Response

CMS concurs with this recommendation. Based on the outcome of the analysis regarding how to address the identified improper payments to acute-care hospitals, CMS will determine how to address any improper payments to acute-care hospitals and subsequent deductible or coinsurance amounts made by beneficiaries or individuals on their behalf made after the audit period.

OIG Recommendation

The OIG recommends that CMS correct the CWF edit to prevent overpayments to acute-care hospitals for outpatient services provided to Medicare beneficiaries who were inpatients of Long Term Care Hospitals, Inpatient Psychiatric Facilities, Inpatient Rehabilitation Facilities, and Critical Access Hospitals.

CMS Response

CMS concurs with this recommendation. As the OIG reported, the CWF postpayment edit alert was generated but the contractor did not act on it. CMS modified the CWF prepayment edit to systematically prevent overpayments to acute-care hospitals for outpatient services provided to Medicare beneficiaries who were inpatients of Long Term Care Hospitals, Inpatient Psychiatric Facilities, Inpatient Rehabilitation Facilities, and Critical Access Hospitals in April 2017.

OIG Recommendation

The OIG recommends that CMS instruct the Medicare contractors to more effectively educate acute-care hospitals not to bill Medicare for outpatient services provided to beneficiaries who were inpatients of other facilities, but rather to provide those services under arrangements and look to the inpatient facilities for payment.

CMS Response

CMS concurs with this recommendation. CMS provided general instructions to the Medicare contractors regarding controls to prevent overpayments due to overlapping inpatient and outpatient claims. CMS will instruct the Medicare contractors to more effectively educate acute-care hospitals not to bill Medicare for outpatient services provided to beneficiaries who were inpatients of other facilities, but rather to provide those services under arrangements and look to the inpatient facilities for payment.