

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS'S SYSTEM EDITS SIGNIFICANTLY
REDUCED IMPROPER PAYMENTS TO
ACUTE-CARE HOSPITALS AFTER
MAY 2019 FOR OUTPATIENT SERVICES
PROVIDED TO BENEFICIARIES
WHO WERE INPATIENTS OF
OTHER FACILITIES**

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September 2022
A-09-22-03007

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: September 2022
Report No. A-09-22-03007

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



Why OIG Did This Audit

A prior OIG audit found that Medicare inappropriately paid acute-care hospitals \$51.6 million for outpatient services they provided from January 2013 through August 2016 to beneficiaries who were inpatients of long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and critical access hospitals (CAHs). The overpayments occurred because system edits were not working properly. Because of the large overpayment amount we identified, we conducted this followup audit to review payments to acute-care hospitals for outpatient services provided from September 2016 through December 2021 (audit period), including determining whether the Centers for Medicare & Medicaid Services (CMS) had corrected the system edits.

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 Audit

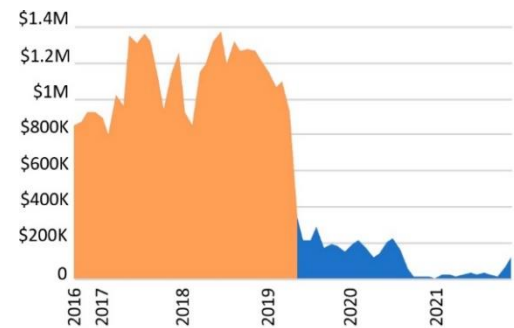
Our audit identified \$39.3 million in Medicare Part B payments to acute-care hospitals for outpatient services provided to beneficiaries who were inpatients of certain other facilities during our audit period. We identified inpatient claims from LTCHs, IRFs, IPFs, and CAHs and used the beneficiary information and service dates to identify outpatient claims from acute-care hospitals that overlapped with the identified inpatient claims.

CMS's System Edits Significantly Reduced Improper Payments to Acute-Care Hospitals After May 2019 for Outpatient Services Provided to Beneficiaries Who Were Inpatients of Other Facilities

What OIG Found

During our audit period, Medicare inappropriately paid acute-care hospitals \$39.3 million for outpatient services they provided to beneficiaries who were inpatients of other facilities (i.e., LTCHs, IRFs, IPFs, and CAHs). None of the \$39.3 million should have been paid because the inpatient facilities were responsible for payment. Each type of inpatient facility covered by our audit 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.

Before May 2019, the system edits were not working properly. However, after CMS modified the edits in May 2019, only \$3.4 million (less than 9 percent of the \$39.3 million in improper payments for the entire audit period) was inappropriately paid to acute-care hospitals from June 2019 through December 2021.



What OIG Recommends and CMS Comments

We recommend that CMS: (1) direct the Medicare contractors to recover the portion of the \$39.3 million in improper payments for our audit period that are within the 4-year reopening period, (2) instruct acute-care hospitals to refund beneficiaries up to \$9.8 million in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf, (3) direct the Medicare contractors to recover any improper payments after our audit period, and (4) continue to review the system edits to determine whether any refinements are necessary to prevent overpayments to acute-care hospitals for outpatient services provided to beneficiaries who are inpatients of other facilities. The report includes one other recommendation.

CMS concurred with four of our five recommendations and provided information on corrective actions it planned to take. For the remaining recommendation, CMS said that it will review data submitted for the audit period and consider how to best address any remaining improper payments made after the audit period.

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INTRODUCTION

WHY WE DID THIS AUDIT

A prior Office of Inspector General (OIG) audit found that Medicare inappropriately paid acute-care hospitals \$51.6 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).¹ The dates of service were from January 1, 2013, through August 31, 2016. Medicare overpaid the acute-care hospitals because the system edits that should have prevented or detected the overpayments were not working properly. We recommended that the Centers for Medicare & Medicaid Services (CMS), among other recommendations, instruct the Medicare contractors to recover the identified overpayments and correct the system edits to prevent overpayments. CMS concurred with all of our recommendations.

Because of the large overpayment amount identified in our prior audit, we conducted this followup audit to determine whether Medicare appropriately paid acute-care hospitals for outpatient services they provided to beneficiaries who were inpatients of other facilities (i.e., LTCHs, IRFs, IPFs, and CAHs) with dates of service from September 1, 2016, through December 31, 2021 (audit period), including determining whether CMS had corrected the system edits.²

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

Medicare Program

The Medicare program 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.

¹ *Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities* ([A-09-16-02026](#)), issued Sept. 18, 2017.

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

CMS administers Medicare. CMS contracts with Medicare administrative contractors (MACs) in each Medicare jurisdiction to, among other things, process and pay Medicare Part A and B claims submitted for hospital services.

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).³ These hospitals also provide outpatient services, which are paid under Medicare Part B. Our audit covered outpatient services that acute-care hospitals provided to beneficiaries who were inpatients of certain types of inpatient facilities excluded from the IPPS. Federal regulations specifically exclude the following types of hospitals from the IPPS: psychiatric, rehabilitation, children's, long-term care, and cancer hospitals; hospitals outside of 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; instead, they are paid on a reasonable-cost basis (Social Security Act (the Act) § 1814(l)).

The following describes the types of inpatient facilities covered in our audit:

- **LTCH:** a freestanding facility that 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 Under the IPPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment amount represents the total Medicare payment for the inpatient operating costs associated with a beneficiary's hospital stay. Inpatient operating costs include routine services, ancillary services (e.g., radiology and laboratory services), special care unit costs, malpractice insurance costs, and preadmission services.

(3) IPFs under a per diem PPS specific to IPFs.⁴ Under each PPS, payments made to the facilities are payment in full for all inpatient hospital services (42 CFR §§ 412.404, 412.509, and 412.604). Medicare pays CAHs on a reasonable-cost basis (the Act § 1814(l)(1)).

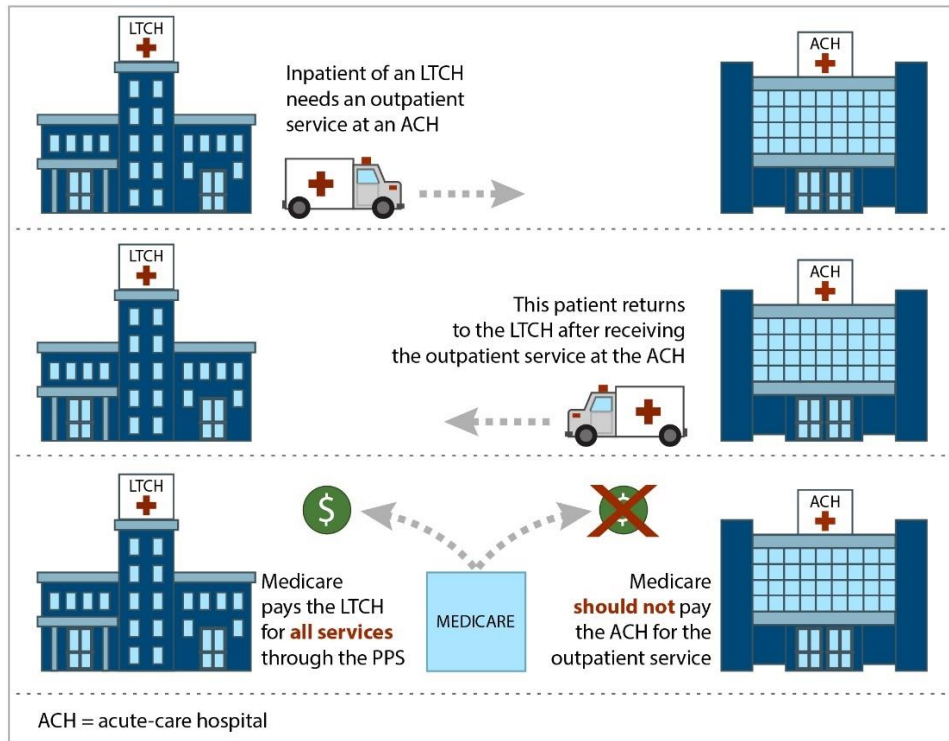
Each type of inpatient facility covered by our audit must: (1) provide directly all services furnished during an inpatient stay or (2) arrange for services to be provided on an outpatient basis by an acute-care hospital and include those outpatient services on its inpatient claims submitted to Medicare (42 CFR §§ 411.15(m), 412.404, 412.509, and 412.604). Except for services provided by physicians and certain other health care workers and for certain preventive services, Medicare should not pay an acute-care hospital for services furnished to a beneficiary when that beneficiary is still an inpatient of another facility (*Medicare Benefit Policy Manual* (Benefit Manual), chap. 15, § 250).

Figure 1 (on the next page) 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.⁵ 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 the LTCH's 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.

⁴ The per diem payment is based on the average routine operating, ancillary, and capital-related costs of 1 day of hospital inpatient services in an IPF (42 CFR § 412.402).

⁵ 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.

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 MACs pay outpatient claims, all 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 services provided during inpatient stays. Once the CWF has processed a claim for payment, it electronically transmits information to the MAC about potential errors on the claim. The CWF 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 automatically generate an “alert” to the MAC that processed the outpatient claim so that the payment can be recovered. The MAC 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 automatically.

Prior Office of Inspector General Audit

As a result of our prior audit (A-09-16-02026), CMS revised Medicare Learning Network (MLN) Matters Number SE17033, “Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities” (Dec. 13, 2017), which reminded hospitals of proper billing of services for beneficiaries in a covered Medicare Part A inpatient stay. CMS also implemented Change Request 9813 on April 3, 2017, which modified the CWF prepayment and postpayment edits to prevent overpayments to acute-care hospitals for outpatient services provided to Medicare beneficiaries who were inpatients of facilities other than acute-care hospitals.⁶

Medicare Requirements for Providers To Identify and Return Overpayments

OIG believes that this audit report constitutes 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.⁷

The 6-year lookback period is not limited by OIG’s 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.⁸

HOW WE CONDUCTED THIS AUDIT

For services provided from September 1, 2016, through December 31, 2021, Medicare Part B paid acute-care hospitals \$44.5 million for 105,651 claims that included outpatient services provided to beneficiaries who were inpatients of other facilities. To identify these outpatient services, we first identified inpatient claims from LTCHs, IRFs, IPFs, and CAHs with service dates during our audit period. We then 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). After excluding allowable services, such as claims for beneficiaries who did not have Medicare Part A benefits and preventive services (see Appendix A for claims and services we

⁶ CMS issues Change Requests to alert providers and MACs of a change in policy or procedures.

⁷ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

⁸ 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; 81 Fed. Reg. at 7670.

excluded), we identified \$39.3 million in Medicare Part B payments to acute-care hospitals for 91,509 claims that included outpatient services provided to beneficiaries who were inpatients of certain other facilities.

We focused on inappropriate Medicare Part B payments. We did not verify whether 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 outpatient 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.

Appendix A describes our audit scope and methodology.

FINDING

During our audit period, Medicare inappropriately paid acute-care hospitals \$39.3 million for outpatient services they provided to beneficiaries who were inpatients of other facilities (i.e., LTCHs, IRFs, IPFs, and CAHs). None of the \$39.3 million (representing 91,509 claims for the audit period) should have been paid because the inpatient facilities were responsible for payment.⁹ In addition, beneficiaries were held responsible for unnecessary deductibles and coinsurance of \$9.8 million paid to acute-care hospitals for those outpatient services.¹⁰

Before May 2019, the CWF edits were not working properly. However, after CMS modified the edits in May 2019, only \$3.4 million (less than 9 percent of the \$39.3 million in improper payments for the entire audit period) was inappropriately paid from June 2019 through December 2021 to acute-care hospitals for outpatient services they provided to beneficiaries who were inpatients of certain other facilities. Further review of the edits is needed to determine whether any refinements are necessary to identify and recover any improper payments made after our audit period.

FEDERAL REQUIREMENTS

Medicare Part A pays for inpatient hospital services provided to Medicare beneficiaries (the Act § 1812). These services include those provided during inpatient stays at LTCHs, IPFs, IRFs, and CAHs (the Act §§ 1861 and 1862(a)(14)). All items and nonphysician services provided during a Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements

⁹ The unrounded amount was \$39,310,499.

¹⁰ The unrounded amount was \$9,781,114.

with another provider and billed to Medicare by the inpatient hospital on its Part A claim.¹¹ This provision applies to all hospitals, regardless of whether they are subject to a PPS.¹² 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 §§ 411.15(m)(1), 412.404(d)(2), 412.509(b), and 412.604(e)(2)).

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.¹³ 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 (the Act § 1866(a)(1)(C); 42 CFR §§ 489.40-42 and 489.20(b)).

EDITS SIGNIFICANTLY REDUCED IMPROPER PAYMENTS TO ACUTE-CARE HOSPITALS AFTER MAY 2019 FOR OUTPATIENT SERVICES PROVIDED TO BENEFICIARIES WHO WERE INPATIENTS OF OTHER FACILITIES, BUT FURTHER REVIEW OF THE EDITS IS NEEDED

The CWF contains both postpayment and prepayment edits that should prevent or detect overpayments for outpatient services provided during inpatient stays. For outpatient services that acute-care hospitals provided before May 2019 to beneficiaries who were inpatients of other facilities (i.e., LTCHs, IRFs, IPFs, and CAHs), the CWF edits were not working properly. However, after CMS modified the edits in May 2019, the edits significantly reduced improper payments to acute-care hospitals for outpatient services they provided to beneficiaries who were inpatients of other facilities, but further review of the edits is needed.

Improper Payments Made to Acute-Care Hospitals

For the entire audit period (September 2016 through December 2021), Medicare inappropriately paid acute-care hospitals \$39.3 million, representing 91,509 claims, for outpatient services provided to beneficiaries who were inpatients of other facilities. However, for services provided from June 2019 to the end of the audit period, improper payments were significantly reduced, to \$3.4 million (or less than 9 percent) of the \$39.3 million.

¹¹ *Medicare Claims Processing Manual* (Claims Manual), Pub. No. 100-04, chap. 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)).

¹² Claims Manual, chap. 3, § 10.4. There are some exceptions to this provision, including certain services payable only under Medicare Part B (Benefit Manual, chap. 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, chap. 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.

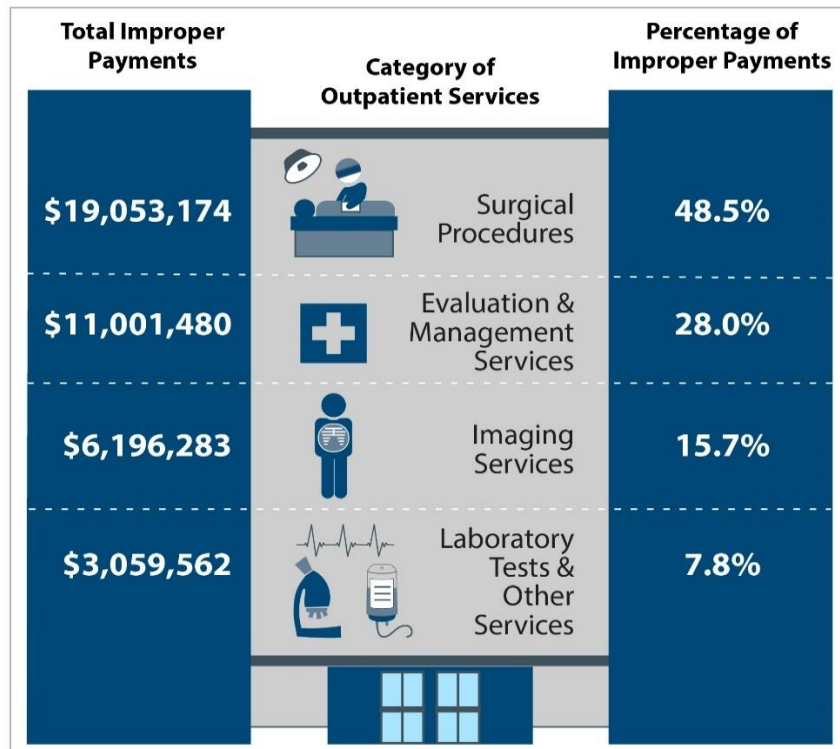
¹³ The Medicare Part B deductible for 2021 was \$203 (85 Fed. Reg. 71904 (Nov. 12, 2020)).

None of the outpatient services identified by our audit should have been paid because the inpatient facilities were responsible for payment. In addition, beneficiaries were held responsible for unnecessary deductibles and coinsurance of \$9.8 million paid to acute-care hospitals for those services. Each type of inpatient facility covered by our audit must: (1) provide directly all services furnished during an inpatient stay, subject to a few exceptions, 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.

Types of Outpatient Services That Were Improperly Paid

Medicare paid acute-care hospitals for various types of outpatient services that should have been paid by the inpatient facilities. These outpatient services consisted of surgical procedures (e.g., cardiovascular, oncology, and endoscopy procedures); evaluation and management services (e.g., for emergency room and specialist visits); imaging services (e.g., computed tomography and magnetic resonance imaging scans); and laboratory tests (e.g., electrocardiograms and urinalysis) and other services. Figure 2 shows the percentage of total improper payments to acute-care hospitals by type of outpatient service during the entire audit period. The same types of outpatient services were provided to beneficiaries from June 2019 through December 2021 (after CMS modified the edits) and had similar percentages but at a smaller volume.

Figure 2: Percentage of Total Improper Payments to Acute-Care Hospitals by Type of Outpatient Service



Effects of Changes to CMS's Postpayment Edit

Our prior audit, A-09-16-02026 (which covered dates of service from January 2013 through August 2016), found that the CWF postpayment edit generated informational alerts about improper payments of claims, but the MACs did not act to recover overpayments because they did not understand that the alerts required them to take action.¹⁴ We recommended that CMS identify and recover improper payments after our audit period. In response, CMS stated that for outpatient claims with dates of service from September 2016 through March 2017, the original CWF postpayment edit (which generated informational alerts to the MAC that processed the outpatient claims) would have identified all improper payments of claims until April 1, 2017. In addition, CMS issued a Technical Direction Letter (TDL-180294) to the MACs instructing them to identify outpatient claims for services provided to beneficiaries who were inpatient of other facilities (i.e., overlapping outpatient claims) associated with the informational alert for claims from September 1, 2016, through April 1, 2017, and adjust the inappropriate outpatient claims.

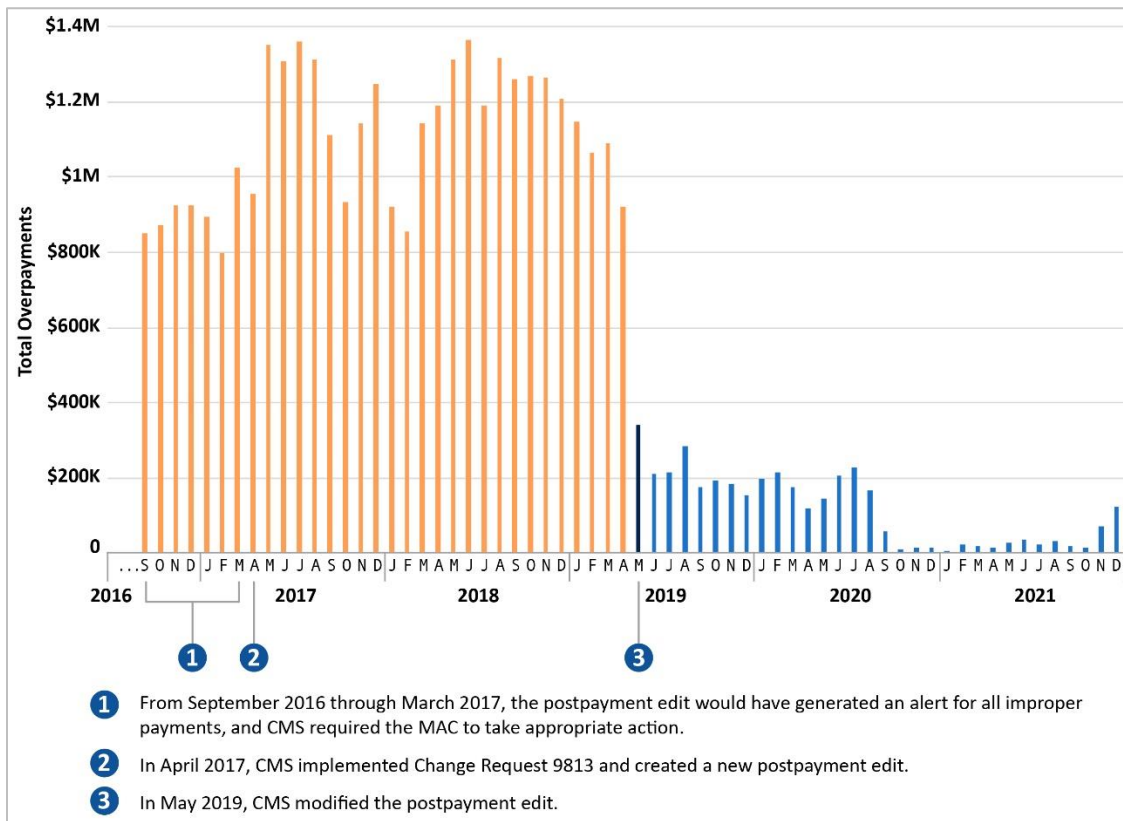
Beginning in April 2017, Change Request 9813 deactivated the informational alert and created a new postpayment edit that instructed the MACs to take action and recover overpayments for outpatient claims. However, improper payments to acute-care hospitals were still made after April 2017.

In May 2019, CMS modified the postpayment edit because it was not working properly. CMS stated that this edit reviewed only the first outpatient claim, not the entire list of outpatient claims in the beneficiary's claim history. As a result, the edit did not reject the payment of every claim that an acute-care hospital submitted. After CMS fixed this issue in May 2019, there was a substantial decrease in improper payments.

Figure 3 (on the next page) shows the changes in improper payments to acute-care hospitals throughout our entire audit period (from September 2016 through December 2021) and the effect of CMS's actions to correct the CWF postpayment edit.

¹⁴ The informational alert allowed the inpatient claim to be paid and provided information to the MACs to enable them to investigate whether there was a duplicate payment and to adjust or cancel the outpatient claim.

Figure 3: Change in Improper Payments to Acute-Care Hospitals for Outpatient Services During Our Audit Period and the Substantial Decrease in Improper Payments After CMS Corrected the Postpayment Edit in May 2019



Although CMS’s modification of the CWF edits in May 2019 significantly reduced the amount of improper payments, some improper payments were still made from June 2019 through December 2021. Specifically, for this period, \$3.4 million (of the \$39.3 million in improper payments for the entire audit period), representing 7,276 claims, was paid to acute-care hospitals for outpatient services provided to beneficiaries of certain other inpatient facilities.¹⁵ These improperly paid claims were not associated with any specific issue related to the CWF edits. Further review of the edits is needed to determine whether any refinements are necessary to identify and recover any improper payments made after our audit period.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct the MACs to recover from acute-care hospitals the portion of the \$39,310,499 in identified improper payments for our audit period that are within the 4-year reopening period in accordance with CMS’s policies and procedures;

¹⁵ Seventy-five percent of the 7,276 improperly paid claims had payment amounts less than \$500.

- instruct acute-care hospitals to refund beneficiaries up to \$9,781,114 in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf;
- based upon the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can 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;
- identify any outpatient claims after our audit period for services provided to beneficiaries who were inpatients of other facilities and direct the MACs to recover any improper payments; and
- continue to review the CWF edits to determine whether any refinements are necessary to prevent improper payments to acute-care hospitals for outpatient services provided to beneficiaries who are inpatients of other facilities (i.e., LTCHs, IRFs, IPFs, and CAHs).

CMS COMMENTS

In written comments on our draft report, CMS concurred with our first, second, third, and fifth recommendations and provided information on actions that it planned to take to address these recommendations. For the fourth recommendation, CMS stated that, in coordination with other actions taken on the recommendations, it will review data submitted for the audit period and consider how to best address any remaining improper payments made after the audit period.

CMS's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For services provided from September 1, 2016, through December 31, 2021, Medicare Part B paid acute-care hospitals \$44,457,234 for 105,651 claims that included outpatient services provided to beneficiaries who were inpatients of other facilities. To identify these outpatient services, we first identified inpatient claims from LTCHs, IRFs, IPFs, and CAHs with service dates during our audit period. We then 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). After excluding allowable services, such as claims for beneficiaries who did not have Medicare Part A benefits and preventive services, we identified \$39,310,499 in Medicare Part B payments to acute-care hospitals for 91,509 claims that included outpatient services provided to beneficiaries who were inpatients of certain other facilities.

We focused on inappropriate Medicare Part B payments. We did not verify whether 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 outpatient services were medically necessary.

We did not perform an overall assessment of the internal control structures 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 the CWF system edits that identify 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 from November 2021 to August 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and CMS guidance;
- used CMS's NCH file to identify Medicare Part A inpatient claims from certain types of inpatient facilities (i.e., 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 (i.e., LTCHs, IRFs, IPFs, and CAHs);
- excluded from our audit outpatient services when the dates of service overlapped with an occurrence span code 74 (which identified an interrupted stay) reported on the inpatient claim;¹⁶
- excluded from our audit outpatient preventive services;¹⁷
- identified outpatient services on 91,509 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 deductible and coinsurance amounts related to the outpatient services provided by the acute-care hospitals;
- interviewed CMS and MAC officials and reviewed documentation they provided to understand how CWF edits work and to determine why Medicare made payments for outpatient claims that overlapped with inpatient claims;
- provided to CMS our complete list of inappropriately paid outpatient claims during our audit period; 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.

¹⁶ An interrupted stay occurs when an inpatient is discharged from an inpatient facility and is readmitted to the facility within a certain number of days.

¹⁷ Examples of outpatient preventive services include the following: mammograms; Pap smears and pelvic exams; prostate, colorectal, and glaucoma screenings; influenza, pneumococcal pneumonia, hepatitis B, and COVID-19 vaccines, as well as administration of these vaccines; and bone-mass measurements.

APPENDIX B: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: September 14, 2022

TO: Amy Frontz
Deputy Inspector General for Audit Services
Office of Inspector General

FROM: Chiquita Brooks-LaSure *Chiq B LaS*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS's System Edits Significantly Reduced Improper Payments to Acute-Care Hospitals After May 2019 for Outpatient Services Provided to Beneficiaries Who Were Inpatients of Other Facilities (A-09-22-03007)

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 serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes. One of the ways in which we do this is by protecting our programs' sustainability for future generations by serving as a responsible steward of public funds.

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 (LTCH), Inpatient Psychiatric Facilities (IPF), Inpatient Rehabilitation Facilities (IRF), and Critical Access Hospitals (CAH). 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. For example, 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. Since the OIG's previous audit, CMS has enhanced the system edits for outpatient services provided to beneficiaries who were inpatients of other facilities, including by ensuring the edit reviews every claim in a beneficiary's claim history. CMS is pleased that OIG noted these modifications significantly reduced the amount of improper payments. Additionally, 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 (MLN), weekly electronic newsletters, and quarterly compliance newsletters. Since the OIG's previous audit, CMS published an MLN matters article titled Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities.¹

The OIG's recommendations and CMS's responses are below.

OIG Recommendation

The OIG recommends that CMS direct the MACs to recover from acute-care hospitals the portion of the \$39,310,499 in identified improper payments for our audit period that are within the 4-year reopening period in accordance with CMS's policies and procedures.

CMS Response

CMS concurs with this recommendation. CMS will instruct the MACs to recover the identified overpayments consistent with relevant law and the agency's policies and procedures.

OIG Recommendation

The OIG recommends that CMS instruct acute-care hospitals to refund beneficiaries up to \$9,781,114 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. As part of the overpayment recovery process, the MACs will notify the providers so that they can refund any deductible or coinsurance amounts that may have been incorrectly collected from beneficiaries or from someone on their behalf.

OIG Recommendation

The OIG recommends that CMS, based upon the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can 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.

CMS Response

CMS concurs with this recommendation. CMS will analyze OIG's data to identify appropriate providers to notify of potential overpayments. CMS will then instruct its Medicare contractors to notify the identified providers of OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

¹ Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay (December 2017). Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE17033.pdf>

OIG Recommendation

The OIG recommends that CMS identify any outpatient claims after our audit period for services provided to beneficiaries who were inpatients of other facilities and direct the MACs to recover any improper payments.

CMS Response

CMS will review the data submitted for the audit period, and informed by this analysis and in coordination with the actions taken for the above recommendations, CMS will consider how to best address any remaining improper payments that occurred after the audit period.

OIG Recommendation

The OIG recommends that CMS continue to review the CWF edits to determine whether any refinements are necessary to prevent improper payments to acute-care hospitals for outpatient services provided to beneficiaries who are inpatients of other facilities (i.e., LTCHs, IRFs, IPFs, and CAHs).

CMS Response

CMS concurs with this recommendation. CMS will continue to explore opportunities to further enhance the Common Working File (CWF) edits to prevent improper payments to acute-care hospitals for outpatient services provided to beneficiaries who are inpatients of other facilities.