Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OVERSIGHT OF MEDICARE PPS-EXEMPT HOSPITAL SERVICES

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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To examine the extent of routine review of Prospective Payment System (PPS)-exempt inpatient services for medical necessity and reasonableness.

BACKGROUND

Forty million beneficiaries have coverage for hospital services through Part A of Medicare. In addition to acute care hospitals, Part A covers inpatient care in psychiatric, rehabilitation, critical access, and long-term care hospitals. Each of these specialty hospitals is exempt from the PPS established for acute care hospitals in 1983.

During our annual work planning process, we determined that these providers were not being routinely reviewed. The Peer Review Organization (PRO) program, whose contractors have recently been renamed as Quality Improvement Organizations (QIOs), has eliminated routine medical review of PPS-exempt inpatient services from its contracts. Fiscal intermediaries, who reviewed claims prior to the PPS, ceased routine review with the establishment of the PRO program. Payment safeguard contractors, operating under the relatively new Medicare Integrity Program (MIP), have not received task orders dedicated to analysis and review of these providers either.

To determine the potential impact of this lapse in oversight, we reviewed data from the HCFA Customer Information System (HCIS) for the number of billing providers and an estimate of Medicare payments. We took information regarding improper payments attributed to PPS-exempt facilities from "Improper Fiscal Year 2000 Medicare Fee-for-Service Payments," report number A-17-00-02000. We reviewed requests for proposals for both the sixth and seventh PRO contract cycles, the Medicare Program Integrity Manual, Medicare regulations, and the Social Security Act. The PPS-exempt hospitals received approximately $8.7 billion from Medicare in the year 2000 and accounted for $800 million of the estimated year 2000 Medicare payment error rate.

FINDINGS

Medical Review of PPS-Exempt Hospitals and Units Has Not Been Routinely Performed

The QIOs, fiscal intermediaries, and MIP contractors could all potentially perform routine statistical analysis and medical review of PPS-exempt hospitals; however, for a variety of reasons, none were tasked to do so. On February 28, 2002, after our exit conference with CMS, fiscal intermediaries were notified that they may include PPS-exempt hospitals in their reviews; however, no additional funding was provided for this expansion of review responsibility.

Medicare Payments and Error Rate Estimates for PPS-Exempt Inpatient Services Are Significant

Medicare paid approximately $8.7 billion to PPS-exempt hospitals in 2000 for inpatient claims by over 3,700 different PPS-exempt hospitals and units. Our audit report "Improper Fiscal Year 2000 Medicare Fee-for-Service Payments," attributed $800 million of improper payments as being due to issues of medical necessity in PPS-exempt facilities.

RECOMMENDATION

The CMS should ensure that oversight of PPS-exempt hospital services is performed.

AGENCY COMMENTS

The CMS concurred with our recommendation, referencing Transmittal 21. Given the lack of funding for this additional work, it is not clear to what extent fiscal intermediaries will conduct systematic oversight, including medical review, nor is it clear to what extent this may hamper oversight of other Part A provider types by drawing off resources. The CMS should be able to assess the effects of this program memorandum as the results of its Comprehensive Error Rate Testing program become available. Appendix B contains the full text of CMS' comments.

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INTRODUCTION

PURPOSE

To examine the extent of routine review of Prospective Payment System (PPS)-exempt inpatient services for medical necessity and reasonableness.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for administrating the Medicare program, a health insurance program for certain Americans who are disabled, have end stage renal disease, or are over the age of 65. Part A of Medicare is hospital insurance, covering hospital care, skilled nursing, home health, and hospice for 40 million beneficiaries.

Section 1816 of the Social Security Act originally established fiscal intermediaries as the entities that pay claims to hospitals and other Part A providers. Among their duties, fiscal intermediaries were charged to "...make such audits of the records of providers as may be necessary to insure that proper payments are made..." [§ 1816(a)(2)(B)]. Until the mid 1980s, these were the sole CMS contractors who assured program integrity of hospital services.

The Peer Review Improvement Act of 1982 established PROs to review health care services provided to Medicare beneficiaries to determine: whether services were reasonable and medically necessary; whether they met professionally recognized standards of care; and, for inpatient services, whether they could have been more economically provided in an outpatient setting or an inpatient facility of a different type. PROs conducted a substantial number of random medical reviews of hospital claims, replacing fiscal intermediaries as the primary source of inpatient medical review.

The Health Insurance Portability and Accountability Act of 1996 created a third group of CMS contractors with the potential to conduct medical review of PPS-exempt inpatient services. In addition to QIOs and fiscal intermediaries, the Medicare Integrity Program currently uses 12 payment safeguard contractors to carry out specific task orders to conduct reviews, audit cost reports, make payment determinations, and educate providers and beneficiaries.

Methodology

Much of the data collection for this inspection occurred during routine work planning. The HCFA Customer Information System provided data on Medicare payments and the number of billing providers. Estimates of improper payments were taken from a current OIG report entitled "Improper Fiscal Year 2000 Medicare Fee-for-Service Payments," report number A-17-00-02000. The CMS documents were reviewed, including the requests for proposals for both the sixth and seventh (current) PRO contract cycles, the Medicare Program Integrity Manual, Medicare regulations, and the Social Security Act.

We conducted this study in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

The PPS-exempt hospital inpatient services have not been routinely reviewed for medical necessity since the PRO program eliminated routine medical review from its contracts in 1995. Fiscal intermediaries, who reviewed claims prior to the PPS, ceased routine review with the establishment of the PRO program. The PPS-exempt hospitals received approximately $8.7 billion from Medicare in the year 2000 and $800 million of the estimated year 2000 Medicare payment error rate was attributed to PPS-exempt facilities. The number of providers, the amount of Medicare reimbursement going to them, and the sizable payment error rate associated with PPS-exempt inpatient services makes it critical that systematic oversight occur. On February 28, 2002, CMS released a transmittal making fiscal intermediaries accountable for this oversight; however, no additional funding has been dedicated to PPS-exempt hospital medical review.

Medical Review of PPS-Exempt Hospitals Has Not Been Routinely Performed

While QIOs, fiscal intermediaries, and Medicare Integrity Program contractors all have authority to conduct medical review in hospitals, none were conducting routine review prior to February of 2002.

Quality Improvement Organizations. Through four contract cycles, CMS directed QIOs, then referred to as PROs, to carry out medical review of inpatient services. In the early 1990s, CMS began refocusing the PRO program on quality improvement. This involved voluntary collaborations between PROs and hospitals to improve the overall quality of care, rather than focusing on specific cases of substandard or unnecessary care. Random medical review by PROs was phased out in 1995, with few program integrity projects in the remainder of that contract or the subsequent 3-year contract cycle.

In response to hospital payment errors, CMS introduced the Payment Error Prevention Program into the sixth PRO contract, beginning in 1999. It's purpose was to reduce the occurrence of payment errors; however, the contract explicitly limited it to "inpatient PPS services." The CMS determined a state-specific error rate through medical review of inpatient PPS claims and PRO performance was evaluated based on reductions in that rate. A draft seventh cycle contract posted on the CMS Internet site on December 3, 2001 indicated that this limitation in PRO oversight would continue through the next 3-year contract cycle. Although medical reviews are still being conducted to measure state error rates, the Payment Error Prevention Program has been eliminated from the contract.

Medicare Integrity Program Contractors. Payment safeguard contractors have broad authority to conduct program integrity activities including data analysis and medical review. The Medicare Integrity Program offers the opportunity to create a single, specialized contractor to conduct hospital reviews, potentially improving review consistency and operational efficiency. To date, however, none of the task orders awarded specifically addresses oversight of PPS-exempt hospital claims.

Fiscal Intermediaries. Fiscal intermediaries have the authority to conduct reviews for reasonableness and medical necessity within their jurisdictions. Fiscal intermediaries did not conduct medical review of inpatient services on a routine basis once the PRO program began operations.

On February 5, 2002, a draft copy of this report was presented to CMS in an exit conference. On February 28, 2002, Transmittal 21 notified fiscal intermediaries that they may include PPS-exempt hospitals in their reviews; however, no additional funding was provided for this effort. The full text of the transmittal is in Appendix A.

Medicare Payments and Error Rate Estimates for PPS-Exempt Inpatient Services Are Significant

Medicare paid approximately $8.7 billion to PPS-exempt hospitals and units in 2000 for inpatient care

Table 1 summarizes Medicare payments to PPS-exempt hospitals and units in 2000. While psychiatric and rehabilitation care comprise the largest components of PPS-exempt payment, long-term care hospitals have experienced nearly a seven-fold increase in payment since 1992. Many long-term care hospitals are located on the campus of an acute PPS hospital, either as a hospital-within-a-hospital or as a satellite unit, facilitating discharges from the "host" hospital into a long-term care hospital without the patient being fully aware that discharge to a different provider has occurred.

Critical access hospitals, while accounting for a small portion of dollars ($128 million), consist of a significant number of hospitals, with many more still in the application process. The beneficiaries who depend on these facilities have few choices for urgent care. Medical review for medically unnecessary or unreasonable services in these settings is a beneficiary protection issue as much as it is program integrity.

Table 1
Medicare Payments to PPS-Exempt Hospitals and Units

Type of PPS-exempt unit or hospital	Number of billing facilities in 2000*	Payments in 2000*
Rehab Units in PPS Hospitals	968	$2.685 billion
Psychiatric Units in PPS Hospitals	1,468	$2.168 billion
Long-Term Care Acute Hospitals	258	$1.706 billion
Rehab Specialty Hospitals	204	$1.388 billion
Psychiatric Specialty Hospitals	505	$0.637 billion
Critical Access Hospitals	318	$0.128 billion
Totals	**3,721 hospitals and units**	**$8.712 billion**

* Data taken from HCIS, the HCFA Customer Information System. Run Date 01/28/2002.

An estimated $800 million was paid in error due to issues of medical necessity

For the past 5 years, the OIG has conducted annual reviews to estimate the extent of fee-for-service payments that do not comply with Medicare requirements. In Fiscal Year 1996, $23 billion of Medicare payments were estimated to be improper due to problems with documentation, coding, medical necessity, coverage, and other issues.

By the year 2000 review, payment errors due to medical necessity issues had declined to $5.1 billion (from $8.5 billion in the 1996 review). Medicare has been successful in lowering the overall payment error rate through a combination of education and enforcement activities. Errors in hospital inpatient services due to medical necessity issues were reduced to $1.8 billion for PPS hospitals, but an additional $800 million was attributed to PPS-exempt hospitals. Although not statistically significant, this is slightly higher than the $624 million paid in error in 1996.

A comparison of error rates for fiscal year measurements in 1996 and 2000 are listed below in Table 2. These data were previously published in our audit report “Improper Fiscal Year 2000 Medicare Fee-for-Service Payments," (A-17-00-02000).

Table 2
Improper Medicare Fee-For-Service Payments

Estimate of Improper Payments	**FY1996**	**FY2000**
Total Medicare Payments in Error	$23.2 billion	$11.9 billion
Portion of Error Attributed to Medical Necessity Issues	$8.5 billion	$5.1 billion
Portion of Error Attributed to Medical Necessity Issues in PPS Hospital Inpatient Services	$3.3 billion	$1.8 billion
Portion of Error Attributed to Medical Necessity Issues in PPS-Exempt Inpatient Services	$0.6 billion	$0.8 billion

CONCLUSION

Our review identified a gap in Medicare's program integrity controls and strategy. The PPS-exempt hospital inpatient services have not been routinely reviewed for medical necessity since the PRO program eliminated routine medical review from its contracts in 1995. Fiscal intermediaries, who reviewed claims prior to the PPS, ceased review with the establishment of the PRO program. The PPS-exempt hospitals received approximately $8.7 billion from Medicare in the year 2000 and $800 million of the projected year 2000 Medicare payment error rate was attributed to PPS-exempt facilities. The number of providers, the amount of Medicare reimbursement going to them, and the sizable payment error rate associated with PPS-exempt inpatient services makes it critical that systematic oversight occur. During the course of this inspection, CMS published Transmittal 21, directing fiscal intermediaries to include PPS-exempt inpatient services in their medical review functions, within their current operating budget. While we applaud CMS' action, we remain concerned since additional funds were not awarded in support of this additional responsibility.

RECOMMENDATION

CMS should ensure that oversight of PPS-exempt hospital services is performed

Over 3,700 acute and post-acute providers have been free from any systematic review since 1995. While the potential for review now exists, there is still no dedicated funding, nor is there an explicit level of effort or performance goal for PPS-exempt inpatient review. To the extent that fiscal intermediaries elect to conduct review of PPS-exempt hospitals, the resources must be taken from review of other Part A providers, such as skilled nursing facilities and home health agencies.

Agency comments

The CMS agreed with our recommendation, referencing Transmittal 21. Given the lack of funding for this additional work, it is not clear to what extent fiscal intermediaries will conduct systematic oversight, including medical review, nor is it clear to what extent this may hamper oversight of other Part A provider types by drawing off resources. The CMS should be able to assess the effects of this program memorandum as the results of its

Comprehensive Error Rate Testing program become available. Appendix B contains the full text of CMS' comments.

APPENDIX A

Medicare Program Integrity Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 21

Date: FEBRUARY 28, 2002

CHANGE REQUEST 1969

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
1	1.2		

NEW/REVISED MATERIAL--EFFECTIVE DATE: April 1, 2002
IMPLEMENTATION DATE: April 1, 2002

CLARIFICATION/MANUALIZATION--EFFECTIVE/IMPLEMENTATION DATE: n/a

Chapter 1, §1.2 - Types of Claims for Which Contractors Are Responsible - is revised to clarify the types of inpatient hospital claims for which contractors are responsible for performing MR functions.

These instructions should be implemented within your current operating budget.

NOTE: Red italicized font identifies new material.

CMS-Pub. 83

1.2 - Types of Claims for which Contractors are Responsible - (Rev. 21, 02-28-02)

Contractors *may perform* MR functions for the following types of claims:

- All claims appropriately submitted to a carrier, DMERC, or Regional Home Health Intermediary (RHHI) and;
- All claims appropriately submitted to an intermediary *including but not limited to:*
  - *Acute Care Inpatient PPS Hospital Swing Beds*
  - *Ambulatory surgical centers (free standing and hospital based)*
  - *Inpatient rehabilitation freestanding hospitals or excluded rehabilitation units of PPS hospitals*
  - *Inpatient critical access hospitals including swing beds*
  - *Inpatient psychiatric freestanding hospitals or excluded psychiatric units of PPS hospitals*
  - *Inpatient long term care hospitals*
  - *All ESRD facilities (freestanding and hospital based).*

Prior to implementing medical review in the above settings, contractors shall notify providers they may be subject to review. Contractors shall apply Progressive Corrective Action (Transmittal AB-00-72) in review of these claims.

Contractors shall include claims from the above settings in doing data analysis to plan their medical review strategy using the same criteria employed in other settings. Customer service and education plans should also be considered. Amendments to plans and strategies should be made as needed if analysis indicates adjustment of priorities.

As part of your annual review of LMRP in conformance with PIM Ch. 1, Sec. 2.3.1, consider the need to modify your policies to apply to these settings. As in any setting, contractors shall provide educational opportunities to assure knowledge of applicable policies and appropriate billing procedures.

APPENDIX B

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Service

Administrator
Washington, DC 20201

DATE: JUN 26 2002

TO: Janet Rehnquist
Inspector General

FROM: Thomas A. Scully
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: *Oversight of Medicare PPS-Exempt Hospital Services* (OEI-12-02-00170)

Thank you for the opportunity to comment on the above-referenced report.

We concur with the recommendation that the Centers for Medicare & Medicaid Services ensure oversight of Prospective Payment System (PPS)-exempt hospital services. On February 28, we released Transmittal 21, a change to the Program Integrity Manual that instructs fiscal intermediaries to perform medical review functions on all claims submitted to them including the PPS-exempt hospital services highlighted in this report, with the exception of acute care inpatient (DRG) claims.

ACKNOWLEDGMENTS

This report was prepared under the direction of Stuart Wright, Director, Medicare and Medicaid Branch. Other principal Office of Evaluation and Inspections staff who contributed include:

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