Memorandum

Date APR 24 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of the Health Care Financing Administration Philadelphia Regional Office's Efforts to Identify and Recover Overpayments for 1-Day Inpatient Hospital Stays in Pennsylvania (A-03-00-00007)

To Michael McMullan
Acting Deputy Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of the Health Care Financing Administration Philadelphia Regional Office's Efforts to Identify and Recover Overpayments for 1-Day Inpatient Hospital Stays in Pennsylvania." The purpose of this report is to present the results of an Office of Inspector General review to assess the effectiveness of the Health Care Financing Administration (HCFA) Philadelphia regional office's (RO) efforts to identify and recover overpayments from its review of 1-day inpatient hospital stays in Pennsylvania for care provided during Calendar Year (CY) 1995. The purpose of the HCFA Philadelphia RO's review was to determine whether hospitals were correctly billing Medicare for 1-day inpatient hospital stays.

We found the HCFA Philadelphia RO's methodology for identifying claims for 1-day inpatient hospital stay reviews produced good results. With respect to the 1,514 claims subjected to medical review, 394 claims (26 percent) were found to be in error. Correspondingly, over $4.8 million (25 percent) of the Medicare payments associated with the claims were overpayments.

However, our review also found that about $1.65 million of the $4.8 million in identified overpayments were not collected by the fiscal intermediaries (FI) because in some cases a specific overpayment adjustment is not automatically recovered if it is processed after the related hospital cost report has been settled. Based on our recommendation, the FIs are in the process of collecting the $1.65 million, and we recommend that HCFA monitor their collection efforts to ensure the overpayments are recovered. We also recommend that HCFA direct the Pennsylvania FIs to implement procedures to ensure future overpayment adjustments made after cost report settlements are collected from providers. We believe the potential exists that similar overpayment adjustments by other FIs may have been made and not collected. We are, therefore, also recommending that HCFA direct all FIs to review the effectiveness of their procedures to ensure future overpayment adjustments made after cost report settlements are collected from providers. In addition, we recommend that HCFA identify and collect past overpayments not collected from providers where adjustments were made after the cost reports were settled.

During our review, we found that the HCFA Philadelphia RO initiated a project to review CY 1996 1-day inpatient hospital stays in Pennsylvania. If the same error rate identified in the HCFA Philadelphia RO's CY 1995 review occurred in CY 1996, we believe that Medicare may have overpaid Pennsylvania providers approximately $6.3 million. We were informed that the CY 1996 project was suspended indefinitely by HCFA due to other priorities. We recommend that HCFA Philadelphia RO resume and complete the CY 1996 review. Our review also found that HCFA contracted with four peer review organizations throughout the country, including Pennsylvania, to review additional 1-day inpatient hospital stays for selected periods of time subsequent to 1995. We recommend that HCFA ensure that overpayments identified in these reviews were collected by the FIs. Since HCFA's methodology for identifying 1-day inpatient hospital stays in Pennsylvania for review produced good results, we believe this initiative should be expanded on a nationwide basis.

In a response to our draft report, HCFA generally concurred with most of our recommendations. However, we believe HCFA officials need to take a more active role than indicated in their response to ensure FIs have adequate procedures in place to recover overpayment adjustments made after cost reports are settled. The HCFA response also expressed concerns about our recommendation to conduct the CY 1996 review of 1-day stays in Pennsylvania because of the age of the data. We believe HCFA officials need to reconsider their decision since overpayments may be as much as $6.3 million. The HCFA response is attached to this report as the Appendix.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-03-00-00007 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE HEALTH CARE FINANCING ADMINISTRATION PHILADELPHIA REGIONAL OFFICE'S EFFORTS TO IDENTIFY AND RECOVER OVERPAYMENTS FOR 1-DAY INPATIENT HOSPITAL STAYS IN PENNSYLVANIA

APRIL 2001
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Subject Review of the Health Care Financing Administration Philadelphia Regional Office's Efforts to Identify and Recover Overpayments for 1-Day Inpatient Hospital Stays in Pennsylvania (A-03-00-00007)

To Michael McMullan
Acting Deputy Administrator
Health Care Financing Administration

This final report provides the results of our review of the Health Care Financing Administration (HCFA) Philadelphia regional office's (RO) efforts to identify and recover overpayments for 1-day inpatient hospital stays in Pennsylvania.

The primary objective of our review was to assess the effectiveness of the HCFA Philadelphia RO's efforts to identify and recover overpayments from its review of 1-day inpatient hospital stays in Pennsylvania for care provided during Calendar Year (CY) 1995.

The HCFA Philadelphia RO's methodology for identifying claims for 1-day inpatient hospital stay reviews produced very good results. With respect to the 1,514 claims subjected to medical review, 394 claims (26 percent) were found to be in error. Correspondingly, over $4.8 million (25 percent) of the Medicare payments associated with the claims were overpayments.

Our review found that about $1.65 million of the identified overpayments were not collected by the fiscal intermediaries (FI) because in some cases a specific overpayment adjustment is not automatically recovered if it is processed after the related hospital cost report has been settled. We are recommending that HCFA monitor the Pennsylvania FIs' collection of the $1.65 million in overpayments and direct the FIs to implement procedures to identify and fully process overpayment adjustments made to providers after their cost reports are settled.

During our review, we found that the HCFA Philadelphia RO also initiated a project to review CY 1996 1-day inpatient hospital stays in Pennsylvania. We were informed that the CY 1996 project was suspended indefinitely by HCFA due to other priorities. If the same error rate identified in the HCFA Philadelphia RO's CY 1995 review occurred in CY 1996, we believe that Medicare may have overpaid Pennsylvania providers approximately $6.3 million. We believe that the HCFA Philadelphia RO should resume and complete this review of CY 1996 claims.

In addition, HCFA decided to contract with four peer review organizations (PRO) throughout the country, including KePRO (the Pennsylvania PRO), to review additional 1-day inpatient hospital stays for selected periods of time subsequent to CY 1995. The KePRO review found 37 percent of the 1-day inpatient hospital stay claims for 1997 reviewed in Pennsylvania were coded incorrectly or were not medically necessary and should be denied, resulting in overpayments of more than $3.8 million. We do not have the details of the other three PRO reviews. We recommend that HCFA ensure that overpayments identified in these reviews are collected by the FIs. Furthermore, since HCFA's methodology used in Pennsylvania to identify 1-day inpatient stays for review produced good results, we recommend that similar reviews be conducted on 1-day inpatient hospital stays on a nationwide basis but with greater emphasis placed on actually recovering the identified overpayments.

To correct the deficiencies identified in our review, we recommend that HCFA: (1) monitor the FIs' collection of $1.65 million in uncollected overpayments, (2) direct the Pennsylvania FIs to implement procedures to ensure that future overpayment adjustments made after cost report settlements are collected from providers, (3) work with all other FIs to ensure that future overpayment adjustments made after cost report settlements are collected from providers, (4) identify and collect past overpayments not collected from providers where adjustments were made after the cost reports were settled, (5) instruct the HCFA Philadelphia RO to conduct its CY 1996 review of 1-day inpatient hospital stays in Pennsylvania, (6) ensure that overpayments identified in the four PRO reviews were collected by the FIs, and (7) conduct similar 1-day inpatient hospital stay reviews on a nationwide basis.

In response to our draft report, HCFA generally concurred with most of our recommendations. However, we believe HCFA officials need to take a more active role than indicated in their response to ensure FIs have adequate procedures in place to recover overpayment adjustments made after cost reports are settled. The HCFA response also expressed concerns about our recommendation to conduct the CY 1996 review of 1-day stays in Pennsylvania because of the age of the data. We believe HCFA officials need to reconsider their decision since overpayments may be as much as $6.3 million. The HCFA response is attached to this report as the Appendix.

INTRODUCTION

Background

In 1983, the Congress enacted Public Law 98-21 which authorized a Medicare prospective payment system (PPS), effective October 1, 1983. Under PPS, acute care hospitals are reimbursed for each admission at the time of patient discharge, according to individual patient diagnoses which are categorized into diagnostic related group (DRG) codes. Since

the inception of PPS, there have been concerns over its financial impact on hospital operations. For instance, hospitals generally receive the full DRG payment for any inpatient admission. Therefore, it is beneficial for the hospital to increase the number of admissions, thus, increasing the potential for medically unnecessary admissions.

The result of this incentive may be reflected in the increase in the number of 1-day inpatient hospital stays. As shown below, 1-day inpatient hospital discharges, as a percentage of total discharges, have increased from 6.8 percent in 1990 to 10.7 percent in 1997, an increase of 57 percent.

Year	Total Discharges	1-Day Discharges	Percent
1990	10,521,925	711,925	6.8
1991	10,800,000	747,000	6.9
1992	11,110,545	807,420	7.3
1993	11,157,860	868,355	7.8
1994	11,470,605	962,370	8.4
1995	11,680,885	1,069,520	9.2
1996	11,795,535	1,190,915	10.1
1997	11,952,088	1,276,334	10.7

One way in which hospitals could increase the number of admissions is by billing 1-day inpatient stays when the beneficiary actually received outpatient services, such as observational care. Effective August 2000, HCFA implemented a new payment system for outpatient services. Under this system, over 8,000 services are bundled into 451 groups known as ambulatory payment classifications. Each group receives a set Medicare Part B payment. In designing the new system, HCFA chose not to put observation care into its own payment group, citing concerns about abuse of these services and stating that payment for this care is spread across all groups.

Pennsylvania Review of 1995 Claims

An FI reported to the HCFA Philadelphia RO that it found large discrepancies between submitted charges and payments to hospitals for 1-day inpatient hospital stays. The FI suspected that hospitals were attempting to maximize reimbursement by billing 1-day inpatient hospital stays when the patient actually received outpatient services. As a result of

the FI's review, the HCFA Philadelphia RO initiated a review of 1-day inpatient hospital stays in the region. The HCFA Philadelphia RO subsequently limited its review to Pennsylvania providers. The purpose of the review was to determine whether hospitals in Pennsylvania were correctly billing Medicare for 1-day inpatient hospital stays occurring in CY 1995. The HCFA Philadelphia RO wanted to determine whether providers were attempting to maximize reimbursement by improperly billing 1-day inpatient hospital stays in cases where the patient actually received outpatient services.

Hospital Funding Options

Hospitals are reimbursed for inpatient stays in one of two ways:

- on the basis of actual claims submitted by hospitals to FIs, or
- on the basis of periodic interim payments (PIP).

Hospitals that are reimbursed based on actual claims receive a remittance advice showing the net difference between the amount of the payment requested and any adjustments.

Hospitals that are paid through PIP[1] receive predetermined biweekly payments and are not paid based on a remittance advice. As part of the cost report settlement process at the end of the provider's fiscal year, the FI compares actual claims against total PIP payments to determine whether the hospital was overpaid or underpaid. The FI uses the Provider Statistical and Reimbursement (PS&R) system to summarize the provider claims and overpayment adjustments for cost report settlement purposes. The PS&R system excludes from the settlement process those claims where an adjustment offsets the payment. Once the cost report is settled, the FI issues the Notice of Program Reimbursement (NPR) to the provider. We learned that in some cases a specific overpayment adjustment is not automatically recovered if it is processed after the related cost report has been settled.

Objective, Scope, and Methodology

The primary objective of our review was to assess the effectiveness of the HCFA Philadelphia RO's efforts to identify and recover overpayments from its review of 1-day inpatient hospital stays in Pennsylvania for care provided from January 1, 1995 to December 31, 1995. We also obtained data on whether similar reviews were performed by HCFA.

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[1]Although the number of hospitals receiving PIP payments has decreased in recent years, HCFA reported, that as of September 1998, 1,024 hospitals or almost 17 percent of participating hospitals received PIP payments nationwide.

To accomplish our objectives, we:

- Obtained an understanding of the methodology used by the HCFA Philadelphia RO to identify for review 1,514 1-day inpatient hospital stay claims in CY 1995.
- Obtained an understanding of the medical review process used by KePRO to review the 1,514 1-day inpatient hospital stays.
- Obtained an understanding of the adjustment and recovery process used to collect overpayments.
- Obtained a listing of overpayments identified by KePRO and determined whether the identified overpayments were recovered by the FIs.
- Discussed our results with the HCFA Philadelphia RO and the FIs.

Our review was conducted in accordance with the generally accepted government auditing standards. Our review of internal controls was limited to understanding the process used by the FIs to recover identified overpayments. We followed the process from the identification of an overpayment by KePRO through adjustment and collection by the FIs. We conducted our review from January 2000 to September 2000 at the HCFA Philadelphia RO; KePRO in Harrisburg, Pennsylvania; and at the two FIs[2] currently serving Pennsylvania hospitals--Veritus located in Pittsburgh, Pennsylvania, and Mutual of Omaha (Mutual) located in Omaha, Nebraska.

RESULTS OF REVIEW

Our review showed that:

- The HCFA Philadelphia RO's review methodology to identify 1-day inpatient hospital stays that should be subject to medical review produced good results.
- Veritus and Mutual did not collect about $1.65 million in identified overpayments.
- The HCFA Philadelphia RO's review of CY 1996 1-day inpatient hospital stays in Pennsylvania was suspended indefinitely.

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[2]Veritus and Mutual assumed responsibility for certain Pennsylvania providers in 1995/1996 when Aetna and Independence Blue Cross left the Medicare program.

- The HCFA central office contracted with PROs to conduct additional 1-day inpatient hospital stay reviews in four States.

1-Day Inpatient Hospital Stay Review Methodology

For the period January 1, 1995 to December 31, 1995, the HCFA Philadelphia RO identified 43,300 claims in the region where the Medicare reimbursement exceeded the provider's charges for a 1-day inpatient hospital stay. The HCFA Philadelphia RO refined the population by excluding deceased beneficiaries and beneficiaries transferred to another provider and included only provider claims where the difference between the Medicare reimbursement and the provider's charges was $5,000 or more. After these exclusions, the HCFA Philadelphia RO identified for medical review 1,514 claims totaling $19,174,832 in Pennsylvania.

The HCFA's methodology for identifying 1-day inpatient hospital stays produced very good results.

The HCFA's methodology for identifying claims for 1-day inpatient hospital stay reviews produced very good results. With respect to the 1,514 claims subjected to medical review, approximately 26 percent of the claims were found to be in error. Correspondingly, approximately 25 percent of the Medicare payments associated with the claims were overpaid.

In September 1996, the HCFA Philadelphia RO arranged for KePRO to review 1,514 1-day inpatient hospital stay claims for medical necessity, DRG coding, and correct billing. The KePRO's first level of review was conducted by nurse reviewers who identified 441 questionable 1-day inpatient hospital stays. The 441 claims were next reviewed by physician reviewers who determined that 396 of the questionable claims were coded incorrectly or were not medically necessary and should be denied. Some of KePRO's determinations were appealed to administrative law judges. After all due process procedures were exhausted, 394 claims totaling $4.8 million were declared overpayments. Of the 394 claims that were found to be in error, 348 were errors because the service should have been done in an outpatient setting rather than in an inpatient setting. The FIs were instructed to collect the overpayments associated with the 394 claims.

Overpayment Recovery

At the start of our review, we were informed by the HCFA Philadelphia RO and by personnel from the two FIs that they believed almost all of the $4.8 million in overpayments had been recovered. Our review, however,

showed that approximately $1.65 million or 34 percent of the $4.8 million had not been collected.

The following schedule shows the overpayments identified by KePRO and the amounts not collected by Veritus and Mutual.

FI	Claims	Overpayments	Claims Not Collected	Overpayments Not Collected
Veritus	**264**	**$3,141,725**	**31**	**$425,287**
Mutual	**130**	**$1,695,219**	**90**	**$1,224,124**
Totals	**394**	**$4,836,944**	**121**	**$1,649,411**

The $1.65 million in uncollected overpayments were mainly owed by hospitals which were paid through the PIP method. We found that the overpayment adjustments were made after the cost report for that year had been settled; therefore, the overpayments were not collected. Our audit at each of the two FIs illustrates the problem.

Veritus did not collect 31 overpayments totaling $425,287.

The HCFA Philadelphia RO instructed Veritus to collect overpayments totaling $3,141,725 for 264 claims. Veritus reviewed each claim to determine whether the provider had adjusted the claim, and if not, Veritus made the adjustment. The HCFA Philadelphia RO reviewed 20 remittance advices to ensure that the adjustments were made. Both the HCFA Philadelphia RO and Veritus concluded the overpayments were collected because adjustments were made in the claims processing system.

However, we determined that Veritus did not collect 31 overpayments totaling $425,287. We found 29 overpayments totaling $395,619 had not been collected because the adjustments were made after the PIP provider's cost report was settled. For example, the overpayments ranged from $16,463 for one claim at one provider to $118,125 for seven claims at a second provider. The NPR date to close out the cost reports for both providers was September 14, 1998. Because of the length of time it took to complete the review[3], the overpayment for the first provider was adjusted in the claims processing system on September 28, 1999, or more than a year after the cost report was settled. For the second provider, the seven overpayments were adjusted on June 25 and June 30, 1999, or about 9 months after the cost report was settled.

[3]The KePRO was directed to review the 1,514 claims as workload permitted. Thus, their review took about 29 months to complete.

Since the adjustments for the 29 claims did not offset the original claims during the cost report settlement process, providers were paid and overpayments totaling $395,619 were not collected. Veritus officials agreed with our findings.

We identified two claims totaling $29,668 where the adjustments were not made because the beneficiary's Health Insurance Claim (HIC) number was incomplete or the adjustment was not input into the claims processing system. We advised the HCFA Philadelphia RO, and they requested Veritus to make the adjustments.

Mutual did not collect 90 overpayments totaling $1.2 million.

The HCFA Philadelphia RO instructed Mutual to collect overpayments totaling $1,695,219 for 130 claims. Mutual reviewed each claim to determine if the provider had adjusted the claim, and if not, Mutual made the adjustment. Both the HCFA Philadelphia RO and Mutual concluded the overpayments were collected because adjustments were made in the claims processing system.

We determined that Mutual did not collect 90 overpayments totaling $1,224,124. We found that 87 overpayments totaling $1,181,203 had not been collected because the adjustments were made after the PIP provider's cost report was settled. For example, the overpayments ranged from $46,344 for 2 claims at 1 provider to $833,063 for 57 claims at a second provider. The NPR dates to close out the cost reports for the first provider were September 17, 1997 for the provider fiscal year ending (FYE) June 30, 1995 and September 22, 1998 for the provider FYE June 30, 1996[4]. Because of the length of time to complete the review, the overpayments were adjusted on March 18, 1998 and April 27, 1999 respectively, or more than 6 months after the cost reports were settled.

The NPR dates to close out the cost reports for the second provider were September 30, 1997 for the provider FYE June 30, 1995 and September 18, 1998 for the provider FYE June 30, 1996. The majority of the overpayments were adjusted between April 20, 1999 and May 6, 1999. As a result, the adjustments for FYE June 30, 1995 overpayments were entered more than 19 months after the cost report was settled, and the adjustments for FYE June 30, 1996 overpayments were entered more than 7 months after the cost report was settled.

Since the adjustments for the 87 claims did not remove the original claims from the cost report settlement process, the providers were paid and overpayments totaling $1,181,203 were not collected. Mutual officials agreed with our findings.

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[4]The HCFA Philadelphia RO review covered CY 1995 claims. Since the provider's FYE June 30, claims could either be on the provider's 1995 or 1996 cost report.

We also identified three claims totaling $42,921 where the adjustments were not made because of system problems related to the data transferred from an FI who left the program. Overpayments for the three claims totaling $42,921 were not collected. We advised the HCFA Philadelphia RO and they requested Mutual make the adjustments. In addition, we identified one claim where the adjustment had not been made because of an incorrect HIC number. During our review, we identified the correct HIC number for this claim and provided it to the HCFA Philadelphia RO. Mutual made the adjustment and collected $9,562.

We are recommending that HCFA direct the Pennsylvania FIs to implement procedures to ensure that future overpayment adjustments made after cost report settlements are collected from providers.

We also believe that HCFA should direct all FIs to review the effectiveness of their procedures to identify and collect overpayment adjustments made to PIP providers after their cost reports are settled. Since HCFA data identified 1,024 PIP providers nationwide as of September 1998, we believe the potential exists that similar overpayment actions by other FIs may have been made and not collected. We recommend that HCFA determine the extent to which past overpayments were not collected from PIP providers because adjustments were made after the cost reports were settled.

Additional 1-Day Inpatient Hospital Stay Reviews

During our review, we found that the HCFA Philadelphia RO also initiated a project to review CY 1996 1-day inpatient hospital stays in Pennsylvania. Using the same review technique used in its CY 1995 review, the HCFA Philadelphia RO identified, for medical review, 1,911 1-day inpatient hospital stays in Pennsylvania with Medicare payments of $24.8 million in CY 1996. We were informed that the CY 1996 project was suspended indefinitely by HCFA due to other priorities. If the same error rate identified in the HCFA Philadelphia RO's CY 1995 review occurred in CY 1996, we believe that Medicare may have overpaid Pennsylvania providers approximately $6.3 million. We believe that HCFA should reconsider its decision not to pursue the HCFA Philadelphia RO's CY 1996 review of 1-day inpatient hospital stays in Pennsylvania.

In addition, HCFA contracted with four PROs[5] throughout the country, including KePRO, to review additional 1-day inpatient hospital stays for selected periods of time subsequent to 1995. The KePRO review found 37 percent of the 1997 1-day inpatient hospital stay claims

[5]Pennsylvania (claims from December 1996 through November 1997), Indiana (claims from June 1998 through October 1999), Ohio (claims from October 1996 through September 1997), and Oregon (claims from January 1996 through December 1996).

reviewed in Pennsylvania were coded incorrectly or were not medically necessary and should be denied, resulting in overpayments of more than $3.8 million. We do not have the details of the other three PRO reviews. We recommend that HCFA ensure that overpayments identified in these reviews were collected by the FIs.

Since HCFA's methodology for identifying 1-day inpatient hospital stays for review produced good results, we believe this initiative should be expanded but with greater emphasis placed on actually recovering the identified overpayments. If the error rate identified in the Pennsylvania review is representative nationwide, the potential exists that a significant number of 1-day inpatient hospital stays were overpaid. We believe HCFA should use this methodology to identify potential claims for review on a nationwide basis. Depending on the results of this analysis, we believe HCFA should subject the claims to medical review to determine if they were appropriately reimbursed.

Conclusions and Recommendations

The HCFA Philadelphia RO developed an effective review technique for identifying 1-day inpatient hospital stays that should be subjected to medical review. The KePRO reviewed the 1,514 1-day inpatient hospital stay claims identified by the HCFA Philadelphia RO and found that approximately 26 percent of the claims were in error and providers were overpaid $4.8 million.

We determined that about $1.65 million of the overpayments were not collected by the FIs. The $1.65 million in uncollected overpayments were mainly owed by hospitals which were paid through the PIP method. We found the overpayments were not recovered because the cost report for that year had already been settled. The HCFA Philadelphia RO, Veritus, and Mutual officials concurred with our findings.

We believe the potential exists that similar overpayment actions by other FIs may have been made and not collected. Therefore, we believe that HCFA should direct all FIs to review the effectiveness of their procedures to ensure overpayment adjustments made to PIP providers after cost report settlements are collected. We are also recommending that HCFA identify and collect any past unrecovered overpayments where adjustments were made after the cost reports were settled.

Because of the effectiveness of the HCFA Philadelphia RO's review technique for identifying improper claims, we believe that HCFA should conduct similar reviews nationwide to determine whether 1-day inpatient hospital stays were appropriately reimbursed. Some observers have postulated that unscrupulous hospitals will attempt to circumvent the new hospital outpatient payment system, which does not reimburse separately for observational stays, by incorrectly coding observational stays as Part A inpatient stays. If this occurs, the number of 1-day inpatient hospital stays will

inappropriately increase. We believe that HCFA needs to monitor 1-day inpatient hospital stay claims to determine the existence and extent of such coding errors.

We, therefore, recommend that HCFA:

1. Monitor the FIs' collection of $1,649,411 in overpayments identified in the HCFA Philadelphia RO's CY 1995 1-day inpatient hospital stay review which our review found had not been collected.

2. Direct the Pennsylvania FIs to implement procedures to ensure that future overpayment adjustments made cost report settlements are collected from PIP providers.

3. Work with all other FIs to ensure that future overpayment adjustments made after cost report settlements are collected from PIP providers.

4. Identify and collect past overpayments not recovered from PIP providers where adjustments were made after the cost reports were settled.

5. Instruct the HCFA Philadelphia RO to conduct its CY 1996 review of 1-day inpatient hospital stays in Pennsylvania and collect identified overpayments.

6 Ensure that overpayments identified in the four PRO reviews were collected by the FIs.

7. Conduct similar 1-day inpatient hospital stay reviews on a nationwide basis.

HCFA Comments and OIG Response

In response to our draft report, HCFA generally concurred with most of our audit recommendations. However, based on HCFA's written response, we wish to elaborate on several of the recommendations.

In our recommendations 2 and 3, we recommended that HCFA direct the Pennsylvania FIs, as well as all other FIs, to implement procedures to ensure future overpayment adjustments made after cost report settlements are recovered from PIP providers. In response, HCFA officials stated they would remind the FIs of their responsibility to reopen cost reports to collect overpayments identified after PIP provider cost reports are settled. We believe more action than merely reminding FIs is warranted. We believe HCFA needs to work with the FIs to ensure there are appropriate systems and processes in place to recover overpayments identified after a PIP provider's cost report is settled.

Although HCFA officials stated they concurred with our recommendation 5 to instruct the Philadelphia RO to conduct the CY 1996 review of 1-day inpatient hospital stays in Pennsylvania, the text to the response implies they do not agree due to the age of the data. We believe HCFA officials need to reconsider their decision. As indicated in this report, CY 1996 overpayments may be as much as $6.3 million.

With regard to HCFA's comments on our recommendation 6, we are unable to furnish provider-specific data to the FIs to collect overpayments identified by the four PROs. Our review was limited to determining whether the four PROs identified overpayments associated with 1-day inpatient hospital stays. Information on the overpayments should be available at the PROs and, therefore, HCFA should instruct the four PROs to provide the FIs with the data needed to collect the overpayments. Also, in response to this recommendation, HCFA requested the OIG to furnish provider-specific reports to FIs and ROs. As appropriate, prior to the issuance of our provider-specific reports, our findings are shared with the FI and/or RO. However, when our recommendations involve multiple FIs or are determined to warrant the attention of the HCFA Administrator, as in this report, our reports are addressed to the HCFA Administrator. We send these reports to the HCFA Administrator since we do not want to be viewed as usurping the Administrator's authority in implementing remedies to the problems identified in our reports.

The complete text of HCFA's comments is included as the Appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES

DATE: FEB 2 8 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report "Review of the Health Care Financing Administration Philadelphia Regional Office's Efforts to Identify and Recover Overpayments for 1-Day Inpatient Hospital Stays in Pennsylvania," (A-03-00-00007)

Thank you for the opportunity to comment on the above-mentioned report. This report is the result of the OIG's review assessing the effectiveness of the Health Care Financing Administration (HCFA) Philadelphia Regional Office's (RO) efforts to identify and recover overpayments from its review of 1-day inpatient hospital stays in Pennsylvania for care provided during Calendar Year (CY) 95.

The OIG recognizes the effectiveness of the HCFA Philadelphia RO's methodology for identifying claims for 1-day inpatient hospital stays. The OIG notes that with respect to the 1,514 claims subjected to medical review, 394 claims (26 percent) were found to be in error. This resulted in overpayments totaling $4.8 million of the Medicare payments associated with these claims. However, the OIG notes that in some cases the fiscal intermediary (FI) did not automatically recover overpayment adjustments if they were processed after the related hospital cost report had been settled. The FIs are currently collecting these overpayments and HCFA concurs with the OIG recommendation that we monitor their collection efforts. In addition, we will direct all FIs to implement procedures to ensure that future overpayment adjustments are made after the providers' cost reports are settled and collected from providers. Our specific comments to your recommendations are as follows:

OIG Recommendation No. 1:
HCFA should monitor the FI's collection of $1,649,411 in overpayments identified in the HCFA Philadelphia RO's CY 1995 1-day inpatient stay review which their review found had not been collected.

Response:
We concur. The FIs are in the process of collecting these overpayments and HCFA will monitor the FIs' collection efforts.

OIG Recommendation No. 2:
HCFA should direct the Pennsylvania FIs to implement procedures to ensure that future overpayment adjustments made after periodic interim payments (PIP) provider reports are settled and collected from providers.

Response:
We concur. We will remind the Pennsylvania FIs of their responsibility to reopen cost reports to recover overpayments resulting from overpayment adjustments made after PIP providers' cost reports are settled.

OIG Recommendation No. 3:
HCFA should work with all other FIs to ensure that future overpayment adjustments made after PIP provider reports are settled and collected from providers.

Response:
We concur. We will remind all FIs of their responsibility to reopen cost reports to recover overpayments resulting from adjustments made after PIP providers' cost reports are settled.

OIG Recommendation No. 4:
HCFA should identify and collect past overpayments not recovered from PIP providers where adjustments were made after the cost reports were settled.

Response:
We concur. We will reopen the providers' cost reports once we are notified by the Peer Review Organization (PRO) of the claims to be adjusted. We will then run the claims through the system, adjust the Provider Statistical and Reimbursement Report, make appropriate adjustments to the providers' cost reports, and collect any overpayments resulting from the PRO reviews.

OIG Recommendation No. 5
HCFA should instruct the Philadelphia RO to conduct the CY 1996 review of 1-day inpatient hospital stays in Pennsylvania and collect identified overpayments.

Response:
We concur. The PROs are currently operating under a performance-based contract

that requires them to identify potential sources of erroneous payments (through analysis and review of administrative data sets) and engage in educational activities that will correct these payments thereby reducing the overall payment error rate. As a result, the resources of the PROs are fully engaged in analyzing this data. We do not agree that the PROs should expend efforts to identify overpayments on 5-year-old data. However, we do agree that 1-day inpatient stays may represent a current problem and prove a valuable area for the PROs to investigate as a potential source of payment errors. We will provide the PROs a copy of the final version of this report and instruct them to include a review of 1-day inpatient stays in their analysis.

OIG Recommendation No. 6:
HCFA should ensure that the FIs collected overpayments identified in the four PRO reviews.

Response:
We concur that additional overpayments related to this issue and identified by the PROs should be recouped by the FIs. Since this report is a draft, it will not be sent to the RO at this time. After issuance of the final report, the OIG will have to furnish the data necessary (provider numbers, claims information, health insurance claim numbers, etc.) for the FIs to complete their recovery action. At that time, we will forward the final report and the information needed by the FI to effectuate recovery of the overpayments to the RO for appropriate action along with the identity of the OIG person to be contacted if any questions arise.

In the past the OIG has agreed to furnish provider-specific home health agency reports to the regional home health intermediaries to eliminate delays in commenting on their reports. We believe that similar arrangements for advising FIs and ROs should be considered for other OIG reports, when appropriate, since this is part of the RO's function.

OIG Recommendation No. 7:

HCFA should conduct similar 1-day inpatient hospital stay reviews on a nationwide basis.

Response:

We concur. As stated in the response to recommendation five, the PROs are currently operating under a performance-based contract that requires them to identify potential sources of erroneous payments (through analysis and review of administrative data sets) and engage in educational activities that will correct these payments thereby reducing the overall payment error rate. As a result, the

resources of the PROs are fully engaged in analyzing this data. We do agree that 1-day inpatient stays may represent a current problem and prove a valuable area for the PROs to investigate as a potential source of payment errors. We will provide the PROs a copy of the final version of this report and instruct them to include a review of 1-day inpatient stays in their analysis.