

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**CONSECUTIVE MEDICARE  
INPATIENT STAYS**



Inspector General

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# *Office of Inspector General*

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## OBJECTIVE

To review services provided to beneficiaries with consecutive Medicare inpatient stays involving acute care hospitals, rehabilitation units, psychiatric units, and skilled nursing swing beds in acute care hospitals to determine: (1) whether there were problems with quality of patient care, (2) whether services were unnecessarily fragmented across consecutive inpatient stays, and (3) whether care was medically necessary and reasonable.

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## BACKGROUND

This inspection focuses on consecutive inpatient stays in fiscal year (FY) 2002 involving acute care hospitals and three types of inpatient facilities that may be found within acute care hospitals: rehabilitation units, psychiatric units, and skilled nursing swing beds. For purposes of this review, we define the term “consecutive inpatient stays” as a sequence of three or more individual inpatient facility stays for the same Medicare beneficiary, where the admission date for each successive stay occurs within 1 day of the discharge date for the preceding stay.

There were 63,345 sequences of consecutive inpatient stays (210,555 individual stays) involving one or more of these four facility types in FY 2002. Medicare payments for these stays totaled \$1.9 billion. These are payments from the Medicare Hospital Insurance Trust Fund and do not include any beneficiary payment amounts (i.e., deductibles and coinsurance).

Medicare fiscal intermediaries are responsible for ensuring that inpatient rehabilitation, inpatient psychiatric, and skilled nursing swing bed services are medically necessary and billed and paid appropriately. Medicare Quality Improvement Organizations (QIOs) are responsible for reviewing acute care hospital services for medical necessity and correct coding, and are required to review instances in which acute care hospitals may try to circumvent the prospective payment system through actions such as premature discharges, inappropriate transfers, and inappropriate or early readmissions. The QIOs are also responsible for reviewing services rendered by all types of Medicare providers to ensure that the quality of services met professionally recognized standards of health care.

Fiscal intermediaries ceased performing routine medical reviews of inpatient hospital services in 1982, when the Peer Review Organizations (now known as QIOs) were created. However, QIOs do not currently conduct routine case reviews of inpatient hospital services for the express purpose of identifying potential quality of care concerns or identifying activities that may suggest potential circumvention of the prospective payment system.

We reviewed FY 2002 Medicare inpatient facility services and identified sequences of consecutive inpatient stays that contained one or more of the four types of facilities included in our review. We selected a stratified-cluster sample of sequences of consecutive inpatient stays and collected beneficiaries' medical records for these stays from inpatient facilities. We forwarded the medical records for 120 sample sequences (407 individual stays) to an independent medical review contractor. Three physicians of internal medicine reviewed these medical records and answered questions about each individual stay. Then, to analyze the consecutive nature of these stays, physicians assessed each sequence of stays in its entirety as a single episode of care.

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## FINDINGS

**Twenty percent of consecutive inpatient stay sequences were associated with poor-quality care and/or unnecessary fragmentation of care.** The majority of sequences of consecutive inpatient stays reviewed were medically necessary and appropriate. However, 20 percent of sequences were associated with (1) quality of care problems that significantly contributed to the need for multiple inpatient stays, and/or (2) unnecessary fragmentation of health care services across multiple inpatient stays in a sequence. Medicare paid an estimated \$267 million for these sequences of stays in FY 2002.

Examples of quality of care problems included failure to treat patients in a timely manner, inadequate monitoring and treatment of patients, and inadequate care planning. Unnecessary fragmentation of services involved cases in which care provided across sequences of multiple inpatient stays may have been necessary and appropriate but should have been consolidated into fewer stays. In sequences containing swing bed stays, most instances of unnecessary fragmentation of care resulted from unwarranted transfers between acute care and swing bed stays.

**Poor-quality care was also a problem within individual stays.** As stated in the first finding, reviewers found quality of care problems associated with sequences of consecutive inpatient stays. Reviewers also found quality of care issues in their stay-specific reviews of the 407 individual inpatient stays within sample sequences. We estimate that 10 percent of individual inpatient stays in consecutive inpatient stay sequences involved problems with the quality of patient care. Medicare paid an estimated \$171 million in FY 2002 for these stays.

An additional 3 percent of individual stays were not associated with poor-quality care, but did involve medically unnecessary admission and treatment, medically inappropriate care setting, treatment that was not appropriate to the type of unit or hospital where it occurred, and/or premature discharge.

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## RECOMMENDATIONS

To address the Medicare program vulnerabilities discussed in this report, we recommend that CMS:

**(1) Direct QIOs to monitor the quality of inpatient services provided within sequences of consecutive Medicare inpatient stays involving acute care hospitals, skilled nursing swing beds, rehabilitation units, and psychiatric units; and (2) encourage QIOs and fiscal intermediaries, as appropriate, to monitor the medical necessity and appropriateness of inpatient services provided within these sequences of consecutive Medicare inpatient stays.**

This monitoring should consist of periodic reviews of a sample of inpatient services that were part of sequences of consecutive inpatient stays to target the types of problems found during this inspection, including poor quality of care and unnecessary fragmentation of care.

**(3) Reinforce efforts to educate providers about the appropriate uses of skilled nursing swing beds.**

CMS and its contractors should ensure that physicians and other acute care hospital staff understand and comply with Medicare rules regarding the appropriate uses of skilled nursing swing beds in acute care hospitals.

In addition to these recommendations, we will forward information on cases that reflected poor quality of patient care, unnecessary fragmentation of services, medically unnecessary admission and treatment, and inappropriate treatment and setting of care to CMS for review and appropriate action.

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## AGENCY COMMENTS

CMS concurred with the OIG’s assessment of consecutive Medicare inpatient stays, but believes that existing mechanisms already largely address our recommendations. CMS stated that periodic reviews of sequences of consecutive inpatient stays are not warranted and contended that current QIO activities functionally cover the first and second of OIG’s recommendations. CMS agreed with OIG’s third recommendation and indicated that it will prepare a “Medlearn Matters” provider education article that will reference appropriate manual sections to remind providers of the appropriate uses of skilled nursing swing beds.

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## OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to believe that CMS should direct QIOs to monitor the quality of services provided within sequences of consecutive inpatient stays, and should encourage QIOs and fiscal intermediaries to monitor the medical necessity and appropriateness of inpatient services provided within these sequences of stays. We recognize that QIOs and fiscal intermediaries may examine selected individual inpatient stays for medical necessity, proper coding, and, in some cases, quality of care. However, current efforts do not focus on sequences of consecutive inpatient stays and could not detect the types of problems we found in our review.

CMS stated that QIOs conduct provider-wide quality improvement activities and review beneficiary complaints about the quality of care delivered in any setting. QIOs’ quality improvement projects, conducted as part of CMS’s Health Care Quality Improvement Program, are strictly voluntary collaborations between QIOs and providers to promote optimal care practices. These projects do not involve any routine or provider-specific case reviews to evaluate quality of care. We acknowledge that QIOs are required to conduct specific types of case reviews in response to beneficiary complaints. However, these are reactive, case-by-case reviews that do not reflect broad monitoring for quality that periodic reviews of a random sample of sequences of consecutive Medicare inpatient stays would afford.

CMS noted that QIOs conduct case reviews of inpatient hospital services as part of the Hospital Payment Monitoring Program. It is our understanding that the Clinical Data Abstraction Centers screen a large sample of individual inpatient services for medical necessity and proper coding of services. Sample services are not screened for potential

## E X E C U T I V E   S U M M A R Y

quality of care concerns. Only individual inpatient services that fail to pass the initial screening process undergo a QIO case review, where quality of care concerns may be detected. Since individual inpatient stays are sampled, the Clinical Data Abstraction Center's screening process could not detect problems within sequences of consecutive inpatient stays.

Additionally, CMS stated that fiscal intermediaries "will continue to actively pursue data analysis efforts regarding consecutive inpatient stays and perform medical review if aberrant billing patterns are defined." We are not aware that fiscal intermediaries have ever conducted or are currently conducting data analysis and/or medical review activities regarding the sequences of consecutive inpatient stays we included in our inspection. According to Chapter 1 of the "Medicare Program Integrity Manual," fiscal intermediaries alone could not conduct such reviews, as QIOs are the sole entities responsible for oversight of inpatient acute care hospital services.

We support CMS's planned effort to prepare and distribute a "Medlearn Matters" provider education article to remind providers of the appropriate uses of skilled nursing swing beds.

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## OBJECTIVE

To review services provided to beneficiaries with consecutive Medicare inpatient stays involving acute care hospitals, rehabilitation units, psychiatric units, and skilled nursing swing beds in acute care hospitals to determine: (1) whether there were problems with quality of patient care, (2) whether services were unnecessarily fragmented across consecutive inpatient stays, and (3) whether care was medically necessary and reasonable.

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## BACKGROUND

The Social Security Act of 1965 (the Act) established Medicare, which now provides health insurance coverage to Americans over the age of 65, certain people with disabilities, and people with end-stage renal disease. Medicare Part A provides insurance for inpatient care in acute care and other types of hospitals and in skilled nursing facilities. It also covers hospice care and some home health care.

### **Consecutive Medicare Inpatient Stays.**

This inspection focuses on consecutive inpatient stays in fiscal year (FY) 2002 involving acute care hospitals and three types of inpatient facilities that may be found within acute care hospitals: rehabilitation units, psychiatric units, and skilled nursing swing beds.

For purposes of this review, we define the term “consecutive inpatient stays” as a sequence of three or more individual inpatient facility stays for the same Medicare beneficiary, where the admission date for each successive stay occurs within 1 day of the discharge date of the preceding stay.

### **Medicare Payments for Consecutive Inpatient Stays.**

Medicare Part A payments for all inpatient facility stays in FY 2002 totaled \$101 billion. Payments to the four inpatient facility types included in this review accounted for \$84 billion of this total. As shown in Table 1, more than \$1.9 billion of these Medicare payments were for 63,345 sequences of consecutive inpatient stays (210,555 individual stays) involving one or more of the four facility types in our review. All Medicare payment amounts presented in this report reflect payments made from the Medicare Hospital Insurance Trust Fund and do not include any payments from beneficiaries. Medicare beneficiaries are responsible for payment of deductibles and coinsurance. Medicaid or private insurance policies may cover these costs.

<b>Table 1: Medicare Payments for Inpatient Stays, FY 2002</b>				
<b>Type of Inpatient Stay</b>	<b>All Inpatient Stays</b>		<b>Consecutive Inpatient Stays</b>	
	<b>Number of Stays</b>	<b>Medicare Payments</b>	<b>Number of Stays</b>	<b>Medicare Payments</b>
Acute Care Hospital	10,815,587	\$79,312,786,735	140,713	\$1,394,870,199
Rehabilitation Unit	271,517	\$2,838,128,268	38,719	\$372,537,620
Psychiatric Unit	331,098	\$2,123,306,086	18,830	\$110,004,471
Skilled Nursing Swing Beds	76,617	\$160,927,083	12,293	\$27,669,595
<b>Totals</b>	<b>11,494,819</b>	<b>\$84,435,148,172</b>	<b>210,555</b>	<b>\$1,905,081,885</b>

Source: Centers for Medicare & Medicaid Services, Medicare Provider Analysis and Review file, FY 2002

**Medicare Payment Systems.**

Acute care hospitals Section 1886(d) of the Act established the prospective payment system for Medicare acute care hospital services effective October 1, 1983. Under this system, the Centers for Medicare & Medicaid Services (CMS) pay a hospital a fixed, predetermined amount for each acute care stay, depending on the diagnosis related group code assigned to the stay.<sup>1</sup>

Inpatient units in acute care hospitals CMS also uses prospective payment systems to reimburse for care in inpatient rehabilitation units (beginning January 1, 2002) and skilled nursing swing beds (beginning July 1, 2002). Swing beds are located in hospitals that have special approval to use these beds, as needed, to provide either acute care or skilled nursing care.

In November 2003, CMS issued a proposed rule to implement a prospective payment system for inpatient psychiatric hospitals and units that would have become effective in April 2004. However, CMS has delayed issuing the final rule to implement the prospective payment system for inpatient psychiatric care due to the late publication of the proposed rule. At present, Medicare continues to pay for inpatient psychiatric care using a cost-based reimbursement system.

**Oversight of Inpatient Hospital Care.**

Fiscal intermediaries Pursuant to section 1816(a) of the Act and 42 CFR § 421.100, CMS contracts with fiscal intermediaries to pay claims for health care services provided to beneficiaries by hospitals and other inpatient facilities, and to ensure that the services rendered by these facilities are covered by the program. Fiscal intermediaries are

also responsible for ensuring that inpatient rehabilitation, inpatient psychiatric, and skilled nursing swing bed services are medically necessary and reasonable and are billed and paid appropriately, as required by 42 CFR § 421.100 and Chapter 1 of the “Medicare Program Integrity Manual.” Fiscal intermediaries ceased routine medical review of inpatient hospital services with the advent of CMS’s peer review program.

*Quality Improvement Organizations* Under the authority of the Peer Review Improvement Act of 1982, CMS contracted with groups of licensed physicians in each State to ensure the quality, effectiveness, efficiency, and economy of hospital care provided to Medicare beneficiaries. Section 1154(a) of the Act stipulates that Peer Review Organizations, now called Quality Improvement Organizations (QIOs), must review health care services rendered by all types of Medicare providers to ensure that the quality of services meets professionally recognized standards of health care. As part of the Hospital Payment Monitoring Program, the QIOs are also responsible for ensuring that acute care hospital services provided to Medicare beneficiaries are medically necessary and reasonable and are billed correctly.

Section 1886(f)(2) of the Act provides specific actions that the Secretary may take when QIOs determine that a Medicare provider took an action with the intent of circumventing the prospective payment system. The Act prohibits hospitals from admitting patients unnecessarily, admitting them unnecessarily multiple times, or engaging in other inappropriate practices designed to circumvent the prospective payment system. Section 4255(C) of the “Quality Improvement Organization Manual” specifies prohibited actions that are considered circumventions of the prospective payment system including premature discharges, inappropriate transfers, and inappropriate or early readmissions. If a QIO establishes that an acute care hospital has been taking actions with the intent of circumventing the prospective payment system, the QIO may deny admissions, initiate a sanction report and recommendation, or refer the cases to the Office of Inspector General (OIG) for potential termination of its Medicare provider agreement.

Originally, QIOs depended heavily upon medical case reviews of random samples of individual inpatient stays to determine medical necessity and quality of care. However, during the mid-1990s, individual case review activities were replaced with quality improvement projects conducted as part of CMS’s Health Care Quality Improvement Program.

Unlike case reviews, the quality improvement projects depend upon voluntary collaborations between QIOs, hospitals, and physicians to improve adherence to optimal care practices.

Currently, QIOs do not conduct routine case reviews of inpatient hospital services for the express purpose of identifying potential quality of care concerns or potential circumventions of the prospective payment system. However, QIOs are required to conduct specific types of case reviews to fulfill mandatory requirements including beneficiary complaints, alleged anti-dumping violations, gross and flagrant violations,<sup>2</sup> and Hospital Payment Monitoring Program cases. QIOs can refer cases to OIG for sanction as a result of case reviews. However, the numbers of monetary penalties and exclusions resulting from QIO referrals have declined significantly since the early 1990s.

**Related Office of Inspector General Work.**

Since the implementation of the prospective payment system for acute care hospitals, OIG has conducted a number of audits to determine whether acute care hospitals are engaged in activities to maximize Medicare reimbursements by circumventing prospective payment system rules. These audits have focused on the implementation of Medicare's postacute care transfer policy and readmissions to the same acute care hospital on the same day. In a report issued in August 2002, "Review of Medicare Same-Day, Same-Provider Acute Care Readmissions in Pennsylvania During Calendar Year 1998" (A-03-01-00011), OIG examined a sample of medical records and found that 63 of 98 readmissions were billed incorrectly because beneficiaries were, in fact, admitted to a nonacute care unit within the hospital, or were never actually discharged from the initial admission.

In addition to identifying providers with high incidences of same-day readmissions, a February 2000 OIG report, "Analysis of Readmissions Under the Medicare Prospective Payment System for Calendar Years 1996 and 1997" (A-14-99-00401), also identified cases in which beneficiaries had three or more multiple, continuous readmissions to the same hospital. OIG made several recommendations, including a recommendation that CMS review the claims for these multiple, continuous readmissions. The report also pointed out that QIOs discontinued case review for random samples of acute care hospital readmission claims in 1993.

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## METHODOLOGY

The methodology for this inspection was composed of two parts: (1) an analysis of Medicare claims for all FY 2002 inpatient facility services, and (2) a medical record review of a sample of inpatient facility services.

### **Analysis of Medicare Claims.**

We accessed CMS's Medicare Provider Analysis and Review (MedPAR) file to analyze and manipulate data for all Medicare inpatient stays in FY 2002.<sup>3</sup> We used SAS programming to identify sequences of three or more consecutive inpatient stays, and then to identify those sequences that contained one or more of four facility types included in our review: acute care hospitals, inpatient rehabilitation units, inpatient psychiatric units, and skilled nursing swing beds in acute care hospitals. We chose to focus this inspection on consecutive inpatient stays involving these four types of facilities because rehabilitation units, psychiatric units, and skilled nursing swing beds are generally located within acute care hospitals. We excluded from review all other types of inpatient facilities that were involved in consecutive inpatient stays in FY 2002. For sequences involving the four facility types included in our review, we examined the data to determine the frequency of consecutive inpatient stay sequences and to assess the characteristics of these sequences.

### **Sample Design for Medical Review.**

The sample for this inspection consisted of sequences of three or more consecutive inpatient stays for the same beneficiary involving one or more of four inpatient facility types included in our review.

Analysis of FY 2002 MedPAR data indicated that Medicare payments for individual sequences of consecutive inpatient stays ranged from a low of \$150 to a high of \$1.3 million. Therefore, we stratified the population of consecutive stay sequences by Medicare payment amount. We designed three strata representing low, middle, and high Medicare payment amounts per sequence. For sampling purposes, each sequence was considered a cluster, or grouping, of individual inpatient stays. We selected a stratified-cluster sample of sequences of consecutive stays from the population of 63,345 sequences.

We intentionally oversampled due to concerns that open OIG investigations may have prevented us from contacting some inpatient facilities. As shown in Table 2 on the following page, the final sample for this inspection included 120 sequences (407 individual inpatient stays) for medical review.

**Table 2: Sample for Medical Review**

Stratum	Sequence Description	Total Medicare Payments	Sampling Frame	Sample Sequences for Review	Stays in Sample Sequences
1	Medicare payment per sequence < \$27,000	\$631,573,087	38,007	40	125
2	Medicare payment per sequence ≥ \$27,000 and < \$54,000	\$702,820,090	19,000	40	135
3	Medicare payment per sequence ≥ \$54,000	\$570,688,708	6,338	40	147
<b>Totals</b>		<b>\$1,905,081,885</b>	<b>63,345</b>	<b>120</b>	<b>407</b>

Source: FY 2002 MedPAR file and OIG data analyses

**Data Collection for Medical Review.**

Between October 2003 and March 2004, we collected medical records from inpatient facilities and an independent contractor performed medical reviews of these records.

Medical records We identified the names and addresses of the inpatient facilities that billed Medicare for all stays in each sample sequence. We prepared letters requesting copies of electronic and paper-based medical records in support of each stay in sample sequences, and mailed medical record requests to inpatient facilities.

Medical review We forwarded beneficiaries’ medical records for 120 sample sequences (407 individual stays) to an independent medical review contractor. This contractor employed three physicians of internal medicine to review the medical records for sample sequences. The physicians used a medical review instrument jointly developed by OIG and the contractor. The physicians answered specific questions pertaining to each individual stay in sample sequences. Then, to analyze the consecutive nature of these stays, the three physicians answered questions about each sequence of stays in its entirety as a single episode of care. The medical review instrument provided space for the physicians to explain their responses in narrative form.

## I N T R O D U C T I O N

Issues for medical review For each stay within a sequence, the physicians determined:

- The health care setting for the stay and the reason for admission,
- Whether the care setting was medically appropriate,<sup>4</sup>
- Whether the admission and treatment were reasonable and medically necessary,
- Whether the treatment provided during the stay was appropriate to the type of unit or hospital where it occurred,<sup>5</sup>
- Whether there were problems with the quality of patient care during the stay,
- Whether the patient was discharged prematurely, and
- Whether problems with the quality of patient care during the stay necessitated a subsequent stay in the sequence.

For each sequence of stays, the physicians determined:

- Whether services were unnecessarily fragmented across multiple inpatient stays in the sequence,<sup>6</sup>
- Whether problems with quality of care significantly contributed to the need for multiple inpatient stays in the sequence,
- Whether premature discharge significantly contributed to the need for multiple inpatient stays in the sequence, and
- Whether it appeared that factors other than clinical considerations influenced the course of patient care in the sequence.

### **Data Analysis.**

Medical review data We aggregated the medical review results to identify the proportion of consecutive inpatient stays that physicians cited for poor quality of patient care, medically inappropriate care setting, medically unnecessary admission, premature discharge, medically unnecessary or unreasonable treatment, and treatment that was not appropriate to the type of unit or hospital where it occurred. We analyzed the proportion of stays cited for a particular problem by facility type. In addition, we identified the proportion of sequences that physician reviewers cited for unnecessary fragmentation of services across multiple stays, quality of care problems that significantly

## I N T R O D U C T I O N

contributed to the need for multiple stays, premature discharge(s) that contributed to the need for multiple stays, and nonclinical considerations that influenced the course of patient care. We estimated total Medicare payments associated with these stays and sequences.

We used SUDAAN software to produce weighted estimates of proportions and total payments. These estimates reflect the stratified-cluster sample design. Point estimates and confidence intervals for all statistics presented in the findings of this report are provided in Appendix A. We used qualitative data analysis software to aid in our analyses of narrative explanations that physicians recorded on the medical review instruments.

This study was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.



## ► FINDINGS

### **Twenty percent of consecutive inpatient stay sequences were associated with poor-quality care and/or unnecessary fragmentation of care**

The majority of sequences of consecutive inpatient stays reviewed were medically necessary and appropriate.

However, reviewers determined that 20 percent of consecutive inpatient stay sequences were associated with (1) quality of care problems that significantly contributed to the need for multiple inpatient stays, and/or (2) unnecessary fragmentation of health care services across multiple inpatient stays in a sequence. Quality of care problems were defined as medical errors, accidents, or patient care that did not meet professionally recognized standards. Unnecessary fragmentation of services involved cases where care provided across sequences of multiple inpatient stays may have been necessary and appropriate, but should have been consolidated to fewer stays.

Medicare paid an estimated \$267 million in FY 2002 for sequences of consecutive stays associated with poor-quality care and/or unnecessary fragmentation of care. This figure represents 14 percent of total Medicare payments in FY 2002 for consecutive inpatient stays involving one or more of the four facility types included in our review (\$1.9 billion).

Four of the sequences reviewed that were associated with poor-quality care and/or unnecessary fragmentation of care also involved one or more premature discharges that contributed to the need for multiple inpatient stays. For these sequences, reviewers noted that patients required additional evaluation or treatment that they did not receive prior to discharge. In one sequence, there may not have been a need for one or more of the subsequent stays had the patient received additional evaluation or treatment.

In another three sequences associated with poor-quality care and/or unnecessary fragmentation of care, reviewers were unable to identify clinical factors to justify the patient's course of care. Although there were multiple inpatient stays in these sequences, reviewers could not identify discernible breaks in the patient's treatment across stays or could not clearly determine the need for multiple inpatient admissions in two of these sequences.

## F I N D I N G S

### **Most quality of care problems and unnecessary fragmentation of care in these sequences of consecutive inpatient stays resulted from poor management of patient care.**

Reviewers described instances of poor management of patient care in almost all sequences that were cited for quality of care problems and unnecessary fragmentation of services.

For sequences associated with quality of care problems, we classified the following types of events as poor management of patient care: failure to treat patients in a timely manner, inadequate monitoring and treatment of patients, and inadequate care planning.

In one sequence, a patient was transferred from an acute care stay to a skilled nursing swing bed stay and then back to an acute care stay. During this sequence, the patient gained 20 pounds of fluid due to overhydration. Initially, this patient required intravenous fluid to treat dehydration. However, the patient had a history of heart failure. The reviewer noted that medical records did not indicate that an appropriate amount of monitoring took place for a patient with a history of congestive heart failure. Had medical staff monitored the patient better during the first acute care stay, congestive heart failure would have been detected and treated earlier, and these actions would have prevented the third stay in this sequence.

For sequences in which health care services were unnecessarily fragmented across stays, reviewers indicated that better management of patient care could have led to fewer inpatient stays. We classified the following types of events as poor management of patient care that resulted in unnecessary fragmentation of services across stays: unnecessary or inappropriate transfers and readmissions, inadequate assessment of patients, and inadequate care planning.

### **Most instances of unnecessary fragmentation of care in sequences including skilled nursing swing bed stays resulted from unwarranted transfers.**

Unnecessary fragmentation in sequences including swing bed stays occurred because there was no clinical need for a transfer to the swing bed. From the medical records, reviewers could not identify a change in the types of acute care services provided or a break in the continuity of patient care that would have justified new admissions to the skilled nursing swing bed stays. In one case, the reviewer wrote: "The record as sent to me was organized as one stay (e.g., all progress notes together, all labs together, etc.), and that indeed was what it was. I

separated the pages by dates and could find no clinical reason for dividing this patient’s course into four stays.” Reviewers noted that the change in patients’ status did not appear to be justified and thus resulted in additional inpatient admissions that were not needed.

**Poor-quality care was also a common problem within individual stays**

As stated in the first finding, reviewers found quality of care problems associated with

sequences of consecutive inpatient stays. Reviewers also found quality of care issues in their stay-specific reviews of the 407 individual inpatient stays within these sequences. Reviewers found that 10 percent of individual inpatient stays were associated with poor quality of patient care. An additional 3 percent of inpatient stays reflected other problems including medically unnecessary admission and treatment, inappropriate treatment and setting of care, and premature discharge.

**Ten percent of individual stays in consecutive inpatient stay sequences involved poor quality of patient care.**

Physicians were asked to determine whether the medical records for each individual stay in the sequences under review indicated problems with the quality of patient care in the stay. Quality of care problems were defined as medical errors, accidents, or patient care that did not meet professionally recognized standards. Based on our analysis of medical review data, we estimate that 10 percent of individual inpatient stays involved problems with the quality of patient care. Medicare paid an estimated \$171 million in FY 2002 for these stays, or 9 percent of total Medicare payments in that year for consecutive inpatient stays involving one or more of the four facility types included in our review (\$1.9 billion).

Reviewers determined that poor quality of patient care was the only problem associated with 8 percent of individual inpatient stays reviewed. Two percent of stays were associated with poor quality of patient care as well as other problems, including medically unnecessary admission, medically inappropriate care setting, treatment that was not appropriate to the unit or hospital where it occurred, and premature discharge.

**Most quality of care problems in these individual stays resulted from poor management of patient care and medical errors.**

Most of the quality of care problems that reviewers identified among individual inpatient stays were categorized as poor management of

## F I N D I N G S

patient care and medical errors. Similar to our findings regarding sequences associated with quality of care problems, poor management of patient care in these individual stays involved medical staff failing to treat patients in a timely manner; exhibiting poor clinical knowledge; performing inadequate planning; and failing to properly evaluate, diagnose, and treat their patients.

Reviewers also described specific medical errors that resulted in poor quality of patient care. Examples of these medical errors included drug overdoses, inadequate prevention of blood clots, misplaced pacemaker wires, improper administration of intravenous fluids, and administration of inappropriate or ineffective drugs. The quality of care problems that reviewers found in the individual inpatient stays often contributed to the need for multiple inpatient stays in related sequences.

**An additional 3 percent of individual stays in consecutive inpatient stay sequences were not associated with poor-quality care, but involved medically unnecessary admission and treatment, inappropriate treatment and setting of care, and premature discharge.**

Poor quality of care was the most common problem associated with the individual inpatient stays reviewed; however, reviewers found other problems with individual inpatient stays. An additional 3 percent of stays reflected problems such as medically unnecessary admission, medically inappropriate care setting, treatment that was not appropriate to the type of unit or hospital where it occurred, medically unnecessary treatment, and premature discharge.

## ► R E C O M M E N D A T I O N S

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Medical review of sequences of consecutive Medicare inpatient stays revealed instances of poor quality of patient care and unnecessary fragmentation of health care services across multiple stays. Physician reviewers' examination of medical records for sequences of consecutive inpatient stays provided context that would not have been available using a random sample of individual inpatient stays. This approach enabled reviewers to analyze the consecutive nature of these stays and identify the broader impacts of poor-quality care and unnecessary fragmentation of care beyond the level of an individual inpatient stay.

QIOs are responsible for ensuring that the quality of health care services provided to Medicare beneficiaries meets appropriate standards. Both QIOs and fiscal intermediaries share responsibilities for ensuring that services provided in the four types of inpatient facilities included in our review are medically reasonable and necessary and are billed correctly. Therefore, to address the Medicare program vulnerabilities discussed in this report, we recommend that CMS:

**(1) Direct QIOs to monitor the quality of inpatient services provided within sequences of consecutive Medicare inpatient stays involving acute care hospitals, skilled nursing swing beds, rehabilitation units, and psychiatric units; and (2) encourage QIOs and fiscal intermediaries, as appropriate, to monitor the medical necessity and appropriateness of inpatient services provided within these sequences of consecutive Medicare inpatient stays.** This monitoring should be conducted through periodic reviews of a sample of inpatient services that were part of sequences of consecutive inpatient stays to target the types of problems found during this inspection, including poor quality of care and unnecessary fragmentation of care.

**(3) Reinforce efforts to educate providers about the appropriate uses of skilled nursing swing beds.**

CMS and its contractors should ensure that physicians and other acute care hospital staff understand and comply with Medicare rules regarding the appropriate uses of skilled nursing swing beds in acute care hospitals.

In addition to these recommendations, we will forward information on cases that reflected poor quality of patient care, unnecessary fragmentation of services, medically unnecessary admission and treatment, and inappropriate treatment and setting of care to CMS for review and appropriate action.

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## AGENCY COMMENTS

CMS concurred with OIG's assessment of consecutive Medicare inpatient stays, but believes that existing mechanisms already largely address our recommendations. CMS stated that periodic reviews of sequences of consecutive inpatient stays are not warranted and contended that current QIO activities functionally cover the first and second of OIG's recommendations. CMS agreed with OIG's third recommendation and indicated that it will prepare a "Medlearn Matters" provider education article that will reference appropriate manual sections to remind providers of the appropriate uses of skilled nursing swing beds.

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## OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to believe that CMS should direct QIOs to monitor the quality of services provided within sequences of consecutive inpatient stays, and should encourage QIOs and fiscal intermediaries to monitor the medical necessity and appropriateness of inpatient services provided within these sequences of stays. We recognize that QIOs and fiscal intermediaries may examine selected individual inpatient stays for medical necessity, proper coding, and, in some cases, quality of care. However, current efforts do not focus on sequences of consecutive inpatient stays and could not detect the types of problems we found in our review.

CMS stated that QIOs conduct provider-wide quality improvement activities and review beneficiary complaints about the quality of care delivered in any setting. QIOs' quality improvement projects, conducted as part of CMS's Health Care Quality Improvement Program, are strictly voluntary collaborations between QIOs and providers to promote optimal care practices. These projects do not involve any routine or provider-specific case reviews to evaluate quality of care. We acknowledge that QIOs are required to conduct specific types of case reviews in response to beneficiary complaints. However, these are reactive, case-by-case reviews that do not reflect broad monitoring for quality that periodic reviews of a random sample of sequences of consecutive Medicare inpatient stays would afford.

CMS noted that QIOs conduct case reviews of inpatient hospital services as part of the Hospital Payment Monitoring Program. It is our understanding that the Clinical Data Abstraction Centers screen a large sample of individual inpatient services for medical necessity and proper

## R E C O M M E N D A T I O N S

coding of services. Sample services are not screened for potential quality of care concerns. Only individual inpatient services that fail to pass the initial screening process undergo a QIO case review, where quality of care concerns may be detected. Since individual inpatient stays are sampled, the Clinical Data Abstraction Center's screening process could not detect problems within sequences of consecutive inpatient stays.

Additionally, CMS stated that fiscal intermediaries "will continue to actively pursue data analysis efforts regarding consecutive inpatient stays and perform medical review if aberrant billing patterns are defined." We are not aware that fiscal intermediaries have ever conducted or are currently conducting data analysis and/or medical review activities regarding the sequences of consecutive inpatient stays we included in our inspection. According to Chapter 1 of the "Medicare Program Integrity Manual," fiscal intermediaries alone could not conduct such reviews, as QIOs are the sole entities responsible for oversight of inpatient acute care hospital services.

We support CMS's planned effort to prepare and distribute a "Medlearn Matters" provider education article to remind providers of the appropriate uses of skilled nursing swing beds.

▶ **A P P E N D I X ~ A**

Estimates and Confidence Intervals

**Table 1: Sequence Counts, Point Estimates, and Confidence Intervals (n=120 Sequences)**

	Sequence Count	Point Estimate	95% Confidence Interval
Sequences Associated With Poor Quality of Care and Unnecessary Fragmentation of Health Care Services	18	20.14%	11.30% - 28.98%
Estimated Medicare Payments for Sequences of Consecutive Inpatient Stays Associated With Poor Quality of Care and Unnecessary Fragmentation of Health Care Services		\$266,711,464	\$154,692,649 - \$378,730,279

Source: Independent medical review contractor, OIG analysis of medical review results

**Table 2: Stay Counts, Point Estimates, and Confidence Intervals (n=407 Inpatient Stays)**

	Stay Count	Point Estimate	95% Confidence Interval
Inpatient Stays Associated With Poor Quality of Care	33	9.51%	5.45% - 13.57%
Inpatient Stays Associated With Poor Quality of Care Only	29	7.91%	4.68% - 11.14%
Inpatient Stays Associated With Poor Quality of Care in Addition to Other Problems	4	1.60%	0.03% - 3.17%
Inpatient Stays Associated With Medically Unnecessary Admissions, Medically Unnecessary Treatment, Inappropriate Setting, Premature Discharge, and Treatment That Was Not Appropriate to the Facility Where It Occurred	9	3.21%	0.84% - 5.58%
Estimated Medicare Payments for Consecutive Inpatient Stays Associated With Poor Quality of Care		\$171,457,370	\$96,778,160 - \$246,136,580

Source: Independent medical review contractor, OIG analysis of medical review results



Centers for Medicare & Medicaid Services' Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

MAR 29 2005

Administrator  
Washington, DC 20201

**TO:** Daniel R. Levinson  
Acting Inspector General  
Office of Inspector General

**FROM:** Mark B. McClellan, M.D., Ph.D.  
Administrator *MM*

**SUBJECT:** Office of Inspector General (OIG) Draft Report, "Consecutive Medicare Inpatient Stays" (OEI-03-01-00430)

Thank you for the opportunity to review and comment on the above OIG draft report.

Medicare beneficiaries accessing medical services often have consecutive stays at providers offering differing levels of medical services. Medicare's Quality Improvement Organizations (QIOs) actively seek to improve the quality of care beneficiaries receive in many of these provider settings, including inpatient acute care hospitals and nursing homes as well as services received through home health agencies and physician's offices. In addition to these provider-wide quality improvement activities, QIOs review complaints about the quality of care delivered to Medicare beneficiaries in any setting. These complaints are used as a source of quality improvement, often resulting in quality improvement plans from the involved provider and may involve care from consecutive stays, as identified in the OIG report.

The OIG has identified concerns about the quality of care and the medical necessity of services within consecutive stays for Medicare beneficiaries, specifically for consecutive stays at acute care hospitals, rehabilitation units, psychiatric units and skilled nursing swing beds in acute care facilities. While we would concur with the OIG's assessment, we believe existing mechanisms already largely address the recommendations provided by the OIG. We appreciate the OIG report, however, and will use it to further refine our efforts to ensure the quality and medical necessity of services provided to Medicare beneficiaries.

**Recommendations 1 and 2**

The CMS should (1) direct QIOs to monitor the quality of inpatient services provided within sequences of consecutive Medicare inpatient stays involving acute care hospitals, skilled nursing swing beds, rehabilitation units, and psychiatric units; and (2) encourage QIOs and fiscal intermediaries, as appropriate, to monitor the medical necessity and appropriateness of inpatient services provided within these sequences of stays.

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**Response**

While not focusing on consecutive stays, QIOs already perform the above functions.

The QIOs monitor quality of care concerns in the above settings. Further, quality of care concerns for a Medicare beneficiary are not setting-specific or stay-specific, but are beneficiary-specific and will include all settings necessary for a concern review.

Under the Hospital Payment Monitoring Program (HPMP), 38,448 Medicare randomly selected inpatient records are screened for medical necessity and appropriateness of inpatient services concerns annually in generation of the inpatient portion of the fee-for-service error rate. When possible medical necessity concerns are found, these records are referred to QIO case review. In this process, when quality of care concerns are found, these cases are also referred to the appropriate QIO for review. The case rate for medically unnecessary services and inappropriateness of inpatient services is on par with that found through the HPMP.

Fiscal Intermediaries (FIs) are responsible for ensuring medical necessity and appropriateness of services in the other named settings.

Thus, additional work through periodic reviews of a sample of inpatient stays that were part of sequences of consecutive inpatient stays is not warranted as the recommendations are functionally covered by current QIO activities.

The FIs will continue to actively pursue data analysis efforts regarding consecutive inpatient stays and perform medical review if aberrant billing patterns are defined.

**Recommendation 3**

The CMS should reinforce efforts to educate providers about the appropriate uses of skilled nursing swing beds.

**Response**

We agree. The CMS will prepare a Medlearn Matters provider education article that will reference appropriate manual sections to serve as a reminder to providers concerning the appropriate uses of skilled nursing swing beds.

## ▶ E N D N O T E S

<sup>1</sup> For purposes of payment, an acute care hospital stay is assigned to one of approximately 500 categories called diagnosis related groups (DRG) based on the patient's diagnoses, demographic information, and medical procedures performed during the stay. As some patients require more intensive services and procedures than others, Medicare reimbursement amounts vary depending on the DRG assigned to a stay. CMS pays for hospital inpatient care at a predetermined rate per discharge, not based on length of stay. For particular cases that are unusually costly, known as outlier cases, the payment is increased. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases.

<sup>2</sup> As specified in 42 CFR § 1004.1,

gross and flagrant violation means a violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety, or well-being of a program patient or places the program patient unnecessarily in high-risk situations.

Health care provider obligations under the Social Security Act (the Act) are specified at section 1156(a):

It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act — (1) will be provided economically and only when, and to the extent, medically necessary; (2) will be of a quality which meets professionally recognized standards of health care; and (3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

<sup>3</sup> The MedPAR file is made up of final action records for all Medicare beneficiaries using inpatient facility services. Each record summarizes all services provided to a beneficiary during an inpatient facility stay from the time of admission to the time of discharge. The file is created quarterly from CMS's National Claims History 100 Percent Nearline File.

## E N D N O T E S

- <sup>4</sup> Physician reviewers were asked, “In your professional opinion, was the setting a medically appropriate care setting for this stay?” To answer this question, reviewers considered the overall condition and treatment needs of the patient upon admission to the care setting.
- <sup>5</sup> Physician reviewers were asked, “In your professional opinion, does it appear that the treatment provided during this stay was appropriate to the type of unit or hospital where it occurred?” To answer this question, reviewers considered the specific treatments rendered to the patient during the stay to determine whether these treatments were appropriately provided in the unit/hospital where they occurred.
- <sup>6</sup> Physician reviewers were asked, “Does it appear that services were unnecessarily fragmented across the multiple inpatient stays in this sequence?” We provided reviewers with the following examples to define the concept of unnecessary fragmentation. Example A: A patient is discharged to a rehabilitation unit after hip replacement. After several days in the rehabilitation unit, the patient is transferred to a swing bed, where the same course of rehabilitation and general care continues. Example B: A patient is admitted to acute care with pneumonia. Initial laboratory findings include a glucose level of 350 milligrams per deciliter, although the patient has not been previously diagnosed with diabetes. Treatment during the initial acute stay focuses solely on the pneumonia. The patient is discharged to a swing bed, where a urinalysis is positive for sugar. On day 5 of the swing bed stay, blood tests again show abnormal glucose levels and the patient is readmitted to acute care for uncontrolled diabetes. Example C: A patient is admitted to acute care with symptoms of psychosis. Laboratory studies rule out any organic cause and a diagnosis of schizophrenia is made. Treatment with medication is initiated, and on day 3 the patient is admitted to the psychiatric unit. Medical treatment continues in the psychiatric unit until day 14, when the patient is transferred back to acute care without explanation. On day 20, the patient is released on oral antipsychotics.



## A C K N O W L E D G M E N T S

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