



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

FEB 27 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

Daniel R. Levinson

SUBJECT: Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2003 Through 2005 (A-04-07-03035)

The attached final report provides the results of our nationwide review of hospital compliance with Medicare's postacute care transfer policy. Consistent with the policy, Medicare pays full diagnosis-related group (DRG) payments to hospitals that discharge inpatients to their homes. In contrast, for specified DRGs, Medicare pays hospitals that transfer inpatients to certain postacute care settings, such as a skilled nursing facility or home health care, a per diem rate for each day of the stay, not to exceed the full DRG payment for a discharge.

Previous Office of Inspector General audits identified Medicare overpayments to transferring hospitals that did not comply with the postacute care transfer policy. In response to our recommendations, the Centers for Medicare & Medicaid Services (CMS) implemented an edit in the Common Working File (CWF) on January 1, 2004, to detect transfers improperly coded as discharges.

Our objectives were to determine whether (1) hospitals properly coded claims subject to Medicare's postacute care transfer policy during fiscal years 2003 through 2005 and (2) the new edit in the CWF detected all overpayments.

Hospitals did not always properly code claims subject to Medicare's postacute care transfer policy. Of the 150 claims in our sample, 92 claims totaling \$137,226 were improperly coded as discharges to home rather than transfers to postacute care. We did not identify any errors in the remaining 58 claims. Based on our sample results, we estimated that hospitals nationwide improperly coded 15,051 claims and that Medicare overpaid \$24,830,856 to these hospitals for the 3-year period that ended September 30, 2005.

Most of the overpayments occurred because CMS lacked adequate payment system controls before implementing the CWF edit. Although overpayments were significantly reduced after implementation of the edit, the edit did not detect 12 overpayments.

We recommend that CMS:

- instruct the fiscal intermediaries to:
 - recover the \$137,226 in overpayments identified in our sample and
 - review the remaining claims in our sampling frame and identify and recover additional overpayments estimated at \$24,693,630 and
- determine why the CWF edit did not detect 12 overpayments and amend the edit as appropriate.

In written comments on our draft report, CMS concurred with our recommendations.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-04-07-03035 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HOSPITAL COMPLIANCE WITH
MEDICARE'S POSTACUTE CARE
TRANSFER POLICY DURING
FISCAL YEARS 2003
THROUGH 2005**



Daniel R. Levinson
Inspector General

February 2009
A-04-07-03035

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Medicare's postacute care transfer policy distinguishes between discharges and transfers of beneficiaries from hospitals under the inpatient prospective payment system. Consistent with the policy, Medicare pays full diagnosis-related group (DRG) payments to hospitals that discharge inpatients to their homes. In contrast, for specified DRGs, Medicare pays hospitals that transfer inpatients to certain postacute care settings, such as a skilled nursing facility or home health care, a per diem rate for each day of the stay, not to exceed the full DRG payment for a discharge.

Previous Office of Inspector General audits identified Medicare overpayments to transferring hospitals that did not comply with the postacute care transfer policy. In response to our recommendations, the Centers for Medicare & Medicaid Services (CMS) implemented an edit in the Common Working File (CWF) on January 1, 2004, to detect transfers improperly coded as discharges.

OBJECTIVES

Our objectives were to determine whether (1) hospitals properly coded claims subject to Medicare's postacute care transfer policy during fiscal years 2003 through 2005 and (2) the new edit in the CWF detected all overpayments.

SUMMARY OF FINDINGS

Hospitals did not always properly code claims subject to Medicare's postacute care transfer policy. Of the 150 sampled claims, 92 claims totaling \$137,226 were improperly coded as discharges to home rather than transfers to postacute care. We did not identify any errors in the remaining 58 claims. Based on our sample results, we estimated that hospitals nationwide improperly coded 15,051 claims and that Medicare overpaid \$24,830,856 to these hospitals for the 3-year period that ended September 30, 2005.

Most of the overpayments occurred because CMS lacked adequate payment system controls before implementing the CWF edit. Although overpayments were significantly reduced after implementation of the edit, the edit did not detect 12 overpayments.

RECOMMENDATIONS

We recommend that CMS:

- instruct the fiscal intermediaries to:
 - recover the \$137,226 in overpayments identified in our sample and
 - review the remaining claims in our sampling frame and identify and recover additional overpayments estimated at \$24,693,630 and

- determine why the CWF edit did not detect 12 overpayments and amend the edit as appropriate.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our recommendations. CMS's comments, excluding a technical comment, are included as Appendix C.

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INTRODUCTION

BACKGROUND

Postacute Care Transfer Policy

With the implementation of the Medicare inpatient prospective payment system (IPPS) in 1983, a discharge was defined as a beneficiary's release from an IPPS hospital to any setting other than another IPPS hospital. A transfer was defined as a beneficiary's release from an IPPS hospital and admission to another IPPS hospital on the same day. Section 4407 of the Balanced Budget Act of 1997, P.L. No. 105-33, expanded the definition of a transfer by establishing the Medicare postacute care transfer policy. Pursuant to section 1886(d)(5)(J) of the Social Security Act (the Act), 42 U.S.C. § 1395ww(d)(5)(J), and implementing regulations (42 CFR § 412.4(c)), a postacute care transfer occurs when a beneficiary whose hospital stay was classified within specified diagnosis-related groups (DRG) is released from an IPPS hospital in one of the following situations:

- The beneficiary is admitted on the same day to a hospital or hospital unit that is not reimbursed under the IPPS.
- The beneficiary is admitted on the same day to a skilled nursing facility.
- The beneficiary receives home health services from a home health agency, the services are related to the condition or diagnosis for which the beneficiary received inpatient hospital services, and the services are provided within 3 days of the beneficiary's hospital discharge date.

Pursuant to 42 CFR §§ 412.4(e) and (f), Medicare pays the full DRG payment to a hospital that discharges an inpatient to home. In contrast, Medicare pays a hospital that transfers an inpatient to postacute care a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the inpatient had been discharged to home.

Nationally, hospitals billed Medicare for 10.2 million discharges for DRGs subject to the postacute care transfer policy during fiscal years (FY) 2003 through 2005.

Discharge Status Codes and Condition Codes

The Centers for Medicare & Medicaid Services (CMS) requires hospitals to include discharge status codes on all inpatient claims.¹ A discharge status code is a two-digit code that identifies a beneficiary's status at the conclusion of an inpatient stay. When a hospital discharges a beneficiary to home, discharge status code 01 (discharge to home) should be used. However, when a beneficiary is transferred to a setting subject to the postacute care transfer policy, a

¹In CMS's manuals, the discharge status code is also referred to as the "patient status code." For example, see chapter 25, § 60.2, of the 2005 version of the "Medicare Claims Processing Manual," Pub. No. 100-04.

different discharge status code should be used, depending on the type of postacute care setting.² For example, discharge status code 03 should be used when the beneficiary is transferred to a skilled nursing facility, and discharge status code 06 should be used when a beneficiary is transferred to home for home health services.

CMS also requires that specific condition codes be used on inpatient claims for beneficiaries transferred to home for home health services that are not subject to the postacute care transfer policy. If the services are not related to the hospitalization, the hospital should use condition code 42 with discharge status code 06. If the services are not provided within 3 days of the discharge date, the hospital should use condition code 43 with discharge status code 06 (65 Fed. Reg. 47054, 47081 (Aug. 1, 2000)).

In the preamble to the final postacute care transfer rule (63 Fed. Reg. 40954, 40979–80 (July 31, 1998)), CMS emphasized hospitals' responsibility to code discharge bills based on inpatient discharge plans. If a hospital subsequently learns that postacute care was provided, the hospital should submit an adjusted bill.

Prior Office of Inspector General Reports and Centers for Medicare & Medicaid Services Corrective Actions

Previous Office of Inspector General (OIG) audits identified Medicare overpayments that occurred because hospitals did not comply with the postacute care transfer policy.³ In those reports, we recommended that CMS provide education to make hospitals aware of the policy and require fiscal intermediaries to implement system edits to prevent and detect postacute care transfers that are miscoded as discharges. CMS generally concurred with our recommendations and initiated collection efforts on the overpayments that we identified. Effective January 1, 2004, CMS also implemented an edit in the Common Working File (CWF) to detect improperly coded claims and instructed its fiscal intermediaries to modify their claim-processing systems.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether (1) hospitals properly coded claims subject to Medicare's postacute care transfer policy during FYs 2003 through 2005 and (2) the new edit in the CWF detected all overpayments.

²See Program Memorandum (PM), Transmittal No. A-98-26, July 1, 1998; PM, Transmittal No. A-01-39, Mar. 22, 2001, Change Request 1565; Medicare Learning Network's Medlearn (MLN) Matters Number: SE0801; and MLN Matters Number: MM4046, Related Change Request 4046.

³Previous audits included "Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross Blue Shield of Georgia" (A-04-00-01210), "Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options" (A-04-00-02162), "Implementation of Medicare's Postacute Care Transfer Policy" (A-04-00-01220), "Compliance With Medicare's Postacute Care Transfer Policy for Fiscal Year 2000" (A-04-02-07005), and "Review of Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2001 and 2002" (A-04-04-03000). These reports are available at <http://oig.hhs.gov>.

Scope

To identify transfers incorrectly coded as discharges, we focused on the 1.4 million Medicare claims with a discharge status code of 01 (discharge to home). By matching the 1.4 million claims for discharges to home to subsequent claims for postacute care, we identified a sampling frame of 17,278 claims for discharges within the DRGs subject to the postacute care transfer policy for the 3-year period that ended September 30, 2005. The sampling frame excluded discharges from Maryland hospitals because they were not reimbursed under the IPPS. The sampling frame also excluded all claims for which the beneficiary's length of stay at the hospital would have resulted in full payment to the hospital.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from Medicare payment files; we did not assess the completeness of the files. We also did not review the medical records of the IPPS hospitals from which the beneficiaries in our sample were discharged to determine whether there was a written plan of care for the provision of home health services.

We conducted our fieldwork at CMS headquarters in Baltimore, Maryland, from September 2007 to February 2008.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal laws, regulations, and guidance;
- selected a stratified random sample of 150 claims from the 17,278 claims in the sampling frame;
- reviewed the CWF for each of the 150 sampled claims to verify admission and discharge dates, the Medicare-paid amount, and whether the claim had been canceled;
- used CMS's "Pricer" program for the applicable FY to calculate what the correct payments to hospitals should have been for discharges that were followed by postacute care;
- subtracted the correct OIG-calculated payment from the original Medicare payment to the hospital to determine the hospital overpayment; and
- estimated, based on our sample results, the number and dollar value of overpayments to IPPS hospitals nationwide.

See Appendix A for details on our sampling methodology and Appendix B for the sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

Hospitals did not always properly code claims subject to Medicare's postacute care transfer policy. Of the 150 sampled claims, 92 claims totaling \$137,226 were improperly coded as discharges to home rather than transfers to postacute care. We did not identify any errors in the remaining 58 claims. Based on our sample results, we estimated that hospitals nationwide improperly coded 15,051 claims and that Medicare overpaid \$24,830,856 to these hospitals for the 3-year period that ended September 30, 2005.

Most of the overpayments occurred because CMS lacked adequate payment system controls before implementing the CWF edit on January 1, 2004. Although overpayments were significantly reduced after implementation of the edit, the edit did not detect 12 overpayments.

POSTACUTE CARE TRANSFER REQUIREMENTS

Pursuant to Medicare regulations (42 CFR § 412.4(e)), an inpatient hospital that discharges a beneficiary to home is paid the full DRG payment. In contrast, for specified DRGs, a hospital that transfers an inpatient to one of three specified postacute settings is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the inpatient had been discharged to home (42 CFR § 412.4(f)).

For a beneficiary whose hospital stay was classified within one of the specified DRGs, a discharge from an IPPS hospital to a qualifying postacute care setting is considered a transfer. The qualifying postacute care settings are (1) hospitals or hospital units that are not reimbursed under the IPPS,⁴ (2) skilled nursing facilities, and (3) home health care if services are provided within 3 days of the discharge.

In PM, Transmittal No. A-01-39, dated March 22, 2001, CMS advised hospitals that the use of discharge status code 01 (discharge to home) is appropriate only when the beneficiary is discharged from an inpatient facility and either (1) is not admitted on the same day to a non-IPPS facility or skilled nursing facility or (2) does not receive any home health services within 3 days of the date of discharge.

When a beneficiary is discharged to home for home health services, the discharge status code should be 06 regardless of whether the services are related to the hospital stay or whether the services are provided within the 3-day window. If the home health services are not subject to

⁴Section 1886(d)(5)(J) of the Act refers to hospitals and hospital units that are not reimbursed under the IPPS as "not subsection (d) hospitals." Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term "subsection (d) hospitals," such as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term-care hospitals, and cancer hospitals.

the postacute care transfer policy, hospitals should use discharge status code 06, together with the applicable condition code to indicate why the services are not subject to the policy.

CLAIMS IMPROPERLY CODED AS DISCHARGES RATHER THAN TRANSFERS

Of the 150 sampled claims, 92 claims totaling \$137,226 were improperly coded as discharges to home rather than transfers to postacute care.

- Sixty-two claims for discharges were followed by claims for home health services provided within 3 days of the discharge date. These improperly coded claims resulted in \$91,797 in excess payments to the discharging hospitals.
- Eighteen claims for discharges were followed by claims for skilled nursing services provided on the same day as the discharge date. These improperly coded claims resulted in \$32,431 in excess payments to the discharging hospitals.
- Twelve claims for discharges were followed by claims for admissions to non-IPPS hospitals or hospital units on the same day as the discharge date. These improperly coded claims resulted in \$12,997 in excess payments to the discharging hospitals.⁵

PAYMENT CONTROLS

The overpayments identified in our sample for the period before January 1, 2004, occurred because CMS lacked adequate payment system controls to detect miscoded claims.

CMS responded to recommendations in previous OIG reports by implementing an edit in the CWF effective January 1, 2004. This edit compares inpatient claims with postacute care claims to detect potential overpayments to discharging hospitals. Our audit identified significantly fewer overpayments following the implementation of the CWF edit. However, the edit did not detect 12 overpayments in our sample: 6 overpayments in FY 2004 (from April 1, 2004, to September 30, 2004) and 6 overpayments in FY 2005. We were unable to determine why the edit did not detect the 12 overpayments.

EXCESSIVE MEDICARE DIAGNOSIS-RELATED GROUP PAYMENTS

Based on our sample results for FYs 2003 through 2005, we estimated that IPPS hospitals nationwide improperly coded 15,051 claims and that Medicare made \$24,830,856 in excessive DRG payments to hospitals as a result of the erroneous coding. Of the estimated \$24,830,856 in overpayments, \$21,015,492 was attributable to FY 2003, when CMS did not have a CWF edit in place to prevent the overpayments. The table on the next page shows the reduction in both the number of potentially miscoded claims in the sampling frame and the estimated overpayments in FY 2004, during part of which the CWF edit was operational, and the significant reduction in FY 2005, during all of which the CWF edit was operational.

⁵The dollar amounts in the bullets do not total \$137,226 because of rounding.

Reduction in Estimated Overpayments

	Number of Potentially Miscoded Claims	Sample Size	Number of Miscoded Claims in Sample	Value of Overpayments in Sample	Estimated Overpayments
FY 2003 (stratum 1)	11,822	50	49	\$88,883	\$21,015,492
FY 2004 (stratum 2)	4,534	50	37	40,475	3,670,286
FY 2005 (stratum 3)	<u>922</u>	<u>50</u>	<u>6</u>	<u>7,868</u>	<u>145,078</u>
Total	17,278	150	92	\$137,226	\$24,830,856

RECOMMENDATIONS

We recommend that CMS:

- instruct the fiscal intermediaries to:
 - recover the \$137,226 in overpayments identified in our sample and
 - review the remaining claims in our sampling frame and identify and recover additional overpayments estimated at \$24,693,630 and
- determine why the CWF edit did not detect 12 overpayments and amend the edit as appropriate.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our recommendations. CMS stated that it would request the data necessary to recover each overpayment or potential overpayment. We will provide the requested data.

CMS's comments, excluding a technical comment, are included as Appendix C.

APPENDIXES

SAMPLING METHODOLOGY

IDENTIFICATION OF SAMPLING FRAME

We developed a database of paid claims for diagnosis-related groups subject to Medicare's postacute care transfer policy for the period October 1, 2002, through September 30, 2005. The database contained 10,169,124 final adjudicated claims totaling \$76,137,783,877. We excluded from the database:

- claims other than those having a discharge status code of 01 (discharge to home);
- claims from Maryland hospitals, which were not reimbursed under the inpatient prospective payment system (IPPS);
- claims for which full payment was due and no overpayment would have occurred because the claims met the provisions of the postacute care transfer policy;
- claims for discharges from hospitals that did not participate in the IPPS; and
- claims for which the Medicare payment amount equaled zero.

Using the above criteria, we created a database of claims with 1,439,817 unique Health Insurance Claim Numbers. We compared that database with the Centers for Medicare & Medicaid Services' Standard Analytical Files database of Medicare claims to determine whether any of the claims were "matched" by:

- an admission to a non-IPPS hospital or hospital unit on the discharge date,
- an admission to a skilled nursing facility on the discharge date, or
- treatment by a home health agency within 3 days after the discharge date.

The resulting matches identified a sampling frame of 17,278 claims totaling \$185,671,964 for the period October 1, 2002, through September 30, 2005, from which we drew our sample.

SAMPLE UNIT

The sample unit was a claim.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into three strata, with each stratum representing a fiscal year (FY).

Stratum	No. of Claims in Sampling Frame
1—FY 2003	11,822
2—FY 2004	4,534
3—FY 2005	<u>922</u>
Total	17,278

SAMPLE SIZE

We randomly selected 50 claims from each stratum for a total of 150 claims.

ESTIMATION METHODOLOGY

We used Office of Inspector General, Office of Audit Services, statistical software to estimate the number of improperly coded claims in the sampling frame and the dollar value of overpayments.

SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Sample Size	Value of Sample	Number of Improperly Coded Claims in Sample	Value of Overpayments in Sample
1—FY 2003	50	\$529,398	49	\$88,883
2—FY 2004	50	312,973	37	40,475
3—FY 2005	50	361,174	6	7,868
Total	150	\$1,203,545	92	\$137,226

ESTIMATES

Estimated Number of Improperly Coded Claims for FYs 2003–2005*Limits Calculated for a 90-Percent Confidence Interval*

Point estimate	15,051
Lower limit	14,442
Upper limit	15,661

Estimated Value of Overpayments for FYs 2003–2005*Limits Calculated for a 90-Percent Confidence Interval*

Point estimate	
Stratum 1	\$21,015,492
Stratum 2	3,670,286
Stratum 3	<u>145,078</u>
Total	\$24,830,856
Lower limit	\$16,215,710
Upper limit	\$33,446,001



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: NOV 31 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems *Kerry Weems*
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2003 Through 2005" (A-04-07-03035)

Thank you for the opportunity to review and comment on the above-referenced Office of Inspector General (OIG) draft report.

Under Medicare's post-acute care transfer policy, a discharge of a hospital inpatient to a post-acute care facility is considered a post-acute transfer. For qualifying Medicare Severity Diagnosis-Related Groups (MS-DRGs), payments for post-acute transfers are reduced when the patient's length of stay (LOS) is at least one day less than the geometric mean LOS for the MS-DRG and the patient is discharged to a post-acute setting. The following post-acute care settings are included in the transfer policy: Long-term care hospitals; rehabilitation facilities; psychiatric facilities; skilled nursing facilities; home health care when the hospital anticipates that the patient will receive clinically related care within three days after the hospital discharge; rehabilitation distinct part (DP) units located in an acute care hospital or a within a critical access hospital (CAH); psychiatric DP units located in an acute care hospital or within a CAH; cancer hospitals; and children's hospitals.

The purpose of the IPPS post-acute care transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in a patient's stay in order to minimize costs while still receiving the full MS-DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases. Claims for these patients that are transferred to one of these postacute facilities should be identified by using discharge status codes that reflect the type of postacute care the patient is to receive. This transfer status initiates a per diem payment for the transferring hospital instead of the regular diagnosis-related group payment. Because there is a strong financial incentive for hospitals to miscode these claims, the OIG has conducted several studies to ensure hospital compliance with the policy.

In this most recent study, the OIG reviewed a small sample of inpatient hospital claims for fiscal years 2003 through 2005 for compliance with the postacute care transfer policy. From a sample of 150 claims, the OIG found 92 claims were erroneously coded, resulting

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in more than \$137,000 in overpayments to hospitals. The OIG estimates that 15,051 such miscoded claims may have resulted in overpayments of \$24,830,856 to hospitals for the three-year period ended September 30, 2005. The OIG report recommends that the Centers for Medicare & Medicaid Services (CMS) instruct fiscal intermediaries (FIs) to recover the identified \$137,000 in overpayments, and to review the remaining claims identified as possible problem claims and recover any overpayments due to hospital errors in coding. Additionally, the OIG recommends that CMS determine why the Common Working File (CWF) edit did not detect 12 overpayments and amend the edit as appropriate.

OIG Recommendation

Instruct the FIs to recover the \$137,226 in overpayments identified in our sample.

CMS Response

We concur. The CMS shall direct the Medicare FIs or Medicare Administrative Contractors (MACs) to recover the \$137,226 in overpayments. CMS plans to recover the overpayments identified consistent with the agency's policies and procedures. The OIG will be asked to furnish for each overpayment or potential overpayment, the data necessary (provider numbers, claims information including the paid date, Health Insurance Claim (HIC) numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor specific data should be written to separate cd-roms in order to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation

Instruct the FIs or MACs to review the remaining claims in our sampling frame, and identify and recover additional overpayments estimated at \$24,693,630.

CMS Response

We concur that where the remainder of claims is indicative of overpayments, FIs and MACs shall be directed to recover these overpayments. The CMS plans to recover the overpayments identified consistent with the agency's policies and procedures. The OIG will be asked to furnish for each overpayment or potential overpayment, the data necessary (provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor specific data should be written to separate cd-roms in order to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation

Determine why the CWF edit did not detect 12 overpayments and amend the edit as appropriate.

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CMS Response

We appreciate the information and recently received the particular information about the overpayments. We intend to research the claims with the CWF maintainer and will determine additional appropriate action steps at the conclusion of that review.

We thank the OIG for conducting this audit and find their input to be very valuable.