

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE INAPPROPRIATELY PAID  
HOSPITALS' INPATIENT CLAIMS  
SUBJECT TO THE POSTACUTE CARE  
TRANSFER POLICY**

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**Daniel R. Levinson  
Inspector General**

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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*Medicare inappropriately paid hospital inpatient claims subject to its postacute care transfer policy, resulting in overpayments totaling \$19.5 million over 4 years. The hospitals improperly coded claims as discharges to home or certain types of health care institutions rather than as transfers to postacute care.*

### WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews identified Medicare overpayments to hospitals that did not comply with Medicare's postacute care transfer policy. These hospitals transferred inpatients to certain postacute care settings but claimed the higher reimbursement associated with discharges to home. In those reports, we recommended that the Centers for Medicare & Medicaid Services (CMS) provide education to make hospitals aware of the transfer policy and require Medicare contractors to implement system edits to prevent and detect postacute care transfers that are miscoded as discharges. CMS generally concurred with our recommendations. However, more recent OIG reviews found that Medicare contractors made overpayments of approximately \$12.2 million to hospitals that did not comply with the policy.

The objective of this review was to determine whether Medicare appropriately paid hospitals' inpatient claims subject to the postacute care transfer policy.

### 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 makes full Medicare Severity Diagnosis-Related Group (MS-DRG) payments to hospitals that discharge inpatients to their homes or certain types of health care institutions, such as hospice settings. In contrast, for specified MS-DRGs, Medicare pays hospitals that transfer inpatients to certain postacute care settings, such as to homes for the provision of home health services and to skilled nursing facilities, a per diem rate for each day of the stay, not to exceed the full MS-DRG payment for a discharge. Therefore, the full MS-DRG payment is either higher than or equal to the per diem payment dependent on the patient's length of stay in the hospital. CMS requires hospitals to include a two-digit patient discharge status code on all inpatient claims to identify a beneficiary's status at the conclusion of an inpatient stay. Whether Medicare pays for a discharge or a transfer depends on the status code. In 2004, CMS implemented Common Working File (CWF) edits to identify transfers improperly coded as discharges.

Our review covered approximately \$84 million in Medicare Part A payments for 6,635 inpatient claims with specified MS-DRGs in which beneficiaries were transferred to postacute care and that had dates of service during the period January 2009 through September 2012. These claims were submitted by 1,672 short-term acute-care hospitals. This review did not include the claims identified in the recent OIG reviews of Medicare claims subject to the postacute care transfer policy.

## WHAT WE FOUND

Medicare inappropriately paid 6,635 Medicare claims subject to the postacute care transfer policy. The hospitals used incorrect patient discharge status codes on their claims, indicating that the patients were discharged to home or certain types of health care institutions rather than transferred to postacute care. Of these claims, 91 percent were followed by claims for home health services, and 9 percent were followed by claims for services in other postacute care settings. Medicare overpaid the hospitals by \$19,471,432.

Medicare overpaid the hospitals because the CWF edits related to postacute care transfers were not working properly. Specifically, some Medicare contractors did not always receive automatic adjustments, and the CWF edits erroneously calculated the number of days between the dates of service on the inpatient claim and the home health claim. Furthermore, according to CMS officials, the edits could not properly match inpatient claims with all home health claims because the range of provider numbers that identify home health agencies was not complete. As a result of our review, CMS officials indicated that they have taken actions to correct the CWF edits.

Medicare could have saved approximately \$31.7 million over 4 years if it had had controls to ensure that the CWF edits were working properly. This amount consisted of overpayments identified in this review and recent OIG reviews.

## WHAT WE RECOMMEND

We recommend that CMS:

- direct the Medicare contractors to recover the \$19,471,432 in identified overpayments in accordance with CMS's policies and procedures;
- direct the Medicare contractors to identify any transfer claims on which the patient discharge status was coded incorrectly and recover any overpayments after our audit period;
- correct the CWF edits and ensure that they are working properly; and
- educate hospitals on the importance of reporting the correct patient discharge status codes on transfer claims, especially when home health services have been ordered.

## CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS partially concurred with our first and second recommendations and concurred with our third and fourth recommendations. Regarding the first and second recommendations, CMS stated that some of the claims in our review had exceeded or would soon exceed the 4-year claim-reopening period and that CMS does not currently mandate areas for the Medicare contractors to review. Regarding the third and fourth recommendations, CMS provided information on actions that it had taken or planned to take to address the recommendations.

We encourage CMS to (1) recover the identified overpayments in accordance with its policies and procedures and (2) continue to identify any transfer claims on which the patient discharge status was coded incorrectly and recover any overpayments after the audit period.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews identified Medicare overpayments to hospitals that did not comply with Medicare's postacute care transfer policy. These hospitals transferred inpatients to certain postacute care settings but claimed the higher reimbursement associated with discharges to home. In those reports, we recommended that the Centers for Medicare & Medicaid Services (CMS) provide education to make hospitals aware of the transfer policy and require Medicare contractors to implement system edits to prevent and detect postacute care transfers that are miscoded as discharges. CMS generally concurred with our recommendations. However, in more recent OIG reviews of hospitals' compliance with Medicare billing requirements and reviews of certain Medicare claims subject to the postacute care transfer policy in Jurisdictions 1 and 2, we found that Medicare contractors made overpayments of approximately \$12.2 million to hospitals that did not comply with the policy. (Appendix A contains a list of the previously issued OIG reports on hospitals' submissions of Medicare claims subject to the postacute care transfer policy.)

### OBJECTIVE

Our objective was to determine whether Medicare appropriately paid hospitals' inpatient claims subject to the postacute care transfer policy.

### BACKGROUND

#### Medicare's Inpatient Prospective Payment System

The Social Security Act (the Act) established the inpatient prospective payment system (IPPS) for inpatient hospital services provided to Medicare beneficiaries (§§ 1886(d) and (g)). Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. A hospital inpatient is considered discharged from a hospital when the patient is formally released from or dies in the hospital.

CMS's payment rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which a beneficiary's stay is assigned. The MS-DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

#### Postacute Care Transfer Policy

Section 4407 of the Balanced Budget Act of 1997, P.L. No. 105-33, added section 1886(d)(5)(J) to the Act to establish the Medicare postacute care transfer policy. This provision and its implementing regulations (42 CFR § 412.4(c)) state that a postacute care transfer occurs when a beneficiary whose hospital stay was classified within specified MS-DRGs is discharged 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.

Medicare makes the full MS-DRG payment to a hospital that discharges an inpatient to home or certain types of health care institutions, such as hospice settings. 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 MS-DRG payment that would have been made if the inpatient had been discharged to home. Therefore, the full MS-DRG payment is either higher than or equal to the per diem payment dependent on the patient's length of stay in the hospital.

CMS requires hospitals to include a two-digit patient discharge status code on all inpatient claims to identify a beneficiary's status at the conclusion of an inpatient stay. Whether Medicare pays for a discharge or a transfer depends on the status code.

### **Medicare Contractors**

CMS contracts with Medicare contractors to, among other things, process and pay Medicare claims submitted for hospital services. The contractors' responsibilities include determining reimbursement amounts, conducting audits, and safeguarding against fraud and abuse. Each Medicare contractor processes Medicare claims for a defined geographic area, or "jurisdiction."

### **Medicare Claims Processing Systems**

Medicare contractors use the Fiscal Intermediary Standard System (FISS) to process inpatient claims submitted by hospitals in their designated jurisdictions. After being processed through the FISS but before payment, all Medicare contractor claims are sent to CMS's Common Working File (CWF) system for verification, validation, and payment authorization. Once the CWF has processed a claim, it electronically transmits information to the contractor regarding potential errors on the claim. Both the FISS and CWF contain edits to prevent and detect overpayments.

On January 1, 2004, CMS implemented CWF edits<sup>1</sup> to identify improperly coded hospital claims and instructed the Medicare contractors to automatically cancel hospital claims that had incorrect patient discharge status codes. On March 15, 2004, CMS revised these edits and established new criteria for an automatic claim cancellation. Specifically, if a postacute care claim is processed and paid before a corresponding inpatient claim is processed, prepayment edits for inpatient claims are designed to reject the incoming inpatient claim. However, if an inpatient claim is

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<sup>1</sup> The CWF edits operate generally in the same way for all types of postacute care transfers depending on the postacute care setting as specified in 42 CFR § 412.4(c).

processed and paid before a corresponding postacute care claim is processed, postpayment edits are designed to (1) adjust the claim automatically by canceling the original inpatient claim and (2) identify the overpayment. In both instances, the hospital can submit an adjusted claim with the appropriate discharge status code to receive the per diem payment.

## **HOW WE CONDUCTED THIS REVIEW**

Our review covered \$83,921,870 in Medicare Part A payments for 6,635 inpatient claims with specified MS-DRGs in which beneficiaries were transferred to postacute care and that had dates of service during the period January 2009 through September 2012. These claims were submitted by 1,672 short-term acute-care hospitals. This review did not include the claims identified in the recent OIG reviews of Medicare claims subject to the postacute care transfer policy.

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. Through data analysis, we identified inpatient claims subject to the postacute care transfer policy that were improperly coded as discharges to home or certain types of health care institutions.

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

Appendix B contains the details of our audit scope and methodology.

## **FINDINGS**

Medicare inappropriately paid 6,635 Medicare claims subject to the postacute care transfer policy. The hospitals used incorrect patient discharge status codes on their claims, indicating that the patients were discharged to home or certain types of health care institutions rather than transferred to postacute care. Of these claims, 91 percent were followed by claims for home health services, and 9 percent were followed by claims for services in other postacute care settings. Medicare overpaid the hospitals by \$19,471,432. Medicare overpaid the hospitals because the CWF edits related to transfers to home health care, skilled nursing facilities, and non-IPPS hospitals were not working properly.

## **FEDERAL REQUIREMENTS**

Federal regulations state that for a beneficiary whose hospital stay is classified within one of the specified MS-DRGs, a discharge from an IPPS hospital to a qualifying postacute care setting is considered a transfer (42 CFR § 412.4(c)). The qualifying postacute care settings are

(1) hospitals or hospital units that are not reimbursed under the IPPS,<sup>2</sup> (2) skilled nursing facilities, and (3) home health care if services are provided within 3 days of the discharge.

CMS requires hospitals to include patient discharge status codes on all inpatient claims.<sup>3</sup> When a beneficiary is transferred to a setting subject to the postacute care transfer policy, a specific discharge status code should be used, depending on the type of postacute care setting. For example, discharge status code 03 should be used when the beneficiary is transferred to a skilled nursing facility, discharge status code 06 should be used when a beneficiary is transferred to home for home health services, and discharge status code 62 should be used when a beneficiary is transferred to an inpatient rehabilitation facility.<sup>4</sup> The Federal Register emphasizes that the hospital is responsible for coding the bill on the basis of its discharge plan for the patient. If the hospital subsequently determines that postacute care was provided, it is responsible for either coding the original bill as a transfer or submitting an adjusted claim.<sup>5</sup>

### **HOSPITALS IMPROPERLY CODED CLAIMS AS DISCHARGES TO HOME OR CERTAIN TYPES OF HEALTH CARE INSTITUTIONS RATHER THAN AS TRANSFERS TO POSTACUTE CARE**

Medicare inappropriately paid 6,635 Medicare claims subject to the postacute care transfer policy during the period January 2009 through September 2012. Hospitals improperly coded these claims as discharges to home (4,613 claims) or to certain types of health care institutions (2,022 claims) rather than as transfers to postacute care by using the incorrect patient discharge status codes. Of these claims:

- 6,053 claims were followed by claims for home health services provided within 3 days of the discharge date, resulting in \$17,513,197 of overpayments to the discharging hospitals;
- 507 claims were followed by claims for skilled nursing services provided on the same day as the discharge date, resulting in \$1,620,255 of overpayments to the discharging hospitals; and
- 75 claims were followed by claims for admissions to non-IPPS hospitals or hospital units on the same day as the discharge date, resulting in \$337,980 of overpayments to the discharging hospitals.

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<sup>2</sup> The Act refers to hospitals and hospital units that are not reimbursed under the IPPS as “not subsection (d) hospitals” (§ 1886(d)(5)(J)). The Act also 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 (§ 1886(d)(1)(B)).

<sup>3</sup> *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 25, § 75.2.

<sup>4</sup> *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 3, § 40.2.4; Program Memorandum, Transmittal No. A-01-39, Mar. 22, 2001, Change Request 1565; Medicare Learning Network’s MLN Matters Number: SE0801; and MLN Matters Number: MM4046, Related Change Request 4046.

<sup>5</sup> 63 Fed. Reg. 40954, 40980 (July 31, 1998). See also MLN Matters Number: SE0408.

As a result, Medicare overpaid 1,672 hospitals by \$19,471,432. The overpayments represented the difference between the full MS-DRG payments and the per diem rates that should have been applied.

## **EDITS WERE NOT WORKING PROPERLY TO PREVENT OVERPAYMENTS TO HOSPITALS**

Medicare overpaid the hospitals because the CWF edits related to transfers to home health care, skilled nursing facilities, and non-IPPS hospitals were not working properly. Specifically, some Medicare contractors did not always receive the automatic adjustments that identify overpayments on inpatient claims. These contractors did not update their “Intermediary Name and Address” files. To automatically adjust a claim, CWF edits rely on updated Medicare contractor files to match an inpatient claim with the corresponding postacute care claim.

In addition, the CWF edits specifically related to transfers to home health care had the following issues:

- The edits erroneously calculated the number of days between the dates of service on the inpatient claim and the home health claim. Rather than calculating the number of days between the inpatient and home health claims as 3 days after the date of discharge from the inpatient hospital, the edits erroneously calculated the number of days as 2 days after the date of discharge.
- According to CMS officials, the edits could not properly match inpatient claims with all home health claims because the range of provider numbers that identify home health agencies was not complete.

As a result of our review, CMS notified the CWF maintenance contractors that Medicare contractors were not always receiving the automatic adjustments that identify overpayments on inpatient claims. In addition, CMS published Change Request 8139 (Transmittal 1167), effective July 1, 2013, to notify Medicare contractors that CMS had corrected the calculation of the number of days in the edits related to transfers to home health care. CMS also plans to correct the range of provider numbers in the edits that identify home health agencies.

Medicare could have saved approximately \$31.7 million over 4 years if it had had controls to ensure that the CWF edits were working properly.<sup>6</sup>

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<sup>6</sup> The \$31.7 million consisted of the \$19.5 million in overpayments identified in this report and the \$12.2 million in overpayments identified in recent OIG reviews covering calendar years 2009 through 2012.

## RECOMMENDATIONS

We recommend that CMS:

- direct the Medicare contractors to recover the \$19,471,432 in identified overpayments in accordance with CMS's policies and procedures;
- direct the Medicare contractors to identify any transfer claims on which the patient discharge status was coded incorrectly and recover any overpayments after our audit period;
- correct the CWF edits and ensure that they are working properly; and
- educate hospitals on the importance of reporting the correct patient discharge status codes on transfer claims, especially when home health services have been ordered.

### CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS partially concurred with our first and second recommendations and concurred with our third and fourth recommendations:

- Regarding the first recommendation, CMS stated that some of the claims in our review had exceeded or would soon exceed the 4-year claim-reopening period. CMS stated that upon receipt of the overpayment data from OIG, CMS would determine which claims could be collected consistent with its policies and procedures.
- Regarding the second recommendation, CMS stated that it had made updates to the CWF edits in 2013, resolving some of the vulnerabilities that we identified. CMS also stated that although it does not currently mandate areas for the Medicare contractors (specifically, the Recovery Auditors) to review, it would share our report with the Recovery Auditors.
- Regarding the third and fourth recommendations, CMS provided information on actions that it had taken or planned to take to address the recommendations.

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

We provided to CMS the claim data containing the overpayment information that it requested. We encourage CMS to (1) recover the identified overpayments in accordance with its policies and procedures and (2) continue to identify any transfer claims on which the patient discharge status was coded incorrectly and recover any overpayments after the audit period.

**APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Noridian Healthcare Solutions, LLC, Inappropriately Paid Hospitals' Medicare Claims Subject to the Postacute Care Transfer Policy in Jurisdiction 2</i>	<a href="#">A-09-13-02035</a>	11/26/2013
<i>Medicare Compliance Review of Community Regional Medical Center<sup>7</sup></i>	<a href="#">A-09-12-02071</a>	6/11/2013
<i>Palmetto GBA, LLC, Inappropriately Paid Hospitals' Medicare Claims Subject to the Postacute Care Transfer Policy in Jurisdiction 1</i>	<a href="#">A-09-12-02038</a>	5/29/2013
<i>Medicare Compliance Review of Cedars-Sinai Medical Center for the Period January 1, 2008, Through June 30, 2011<sup>7</sup></i>	<a href="#">A-09-12-02048</a>	5/15/2013
<i>Medicare Compliance Review of California Pacific Medical Center, Pacific Campus, for Calendar Years 2009 and 2010<sup>7</sup></i>	<a href="#">A-09-12-02027</a>	1/10/2013
<i>Medicare Compliance Review of Hoag Memorial Hospital Presbyterian for Calendar Years 2008 Through 2011<sup>7</sup></i>	<a href="#">A-09-12-02012</a>	12/10/2012
<i>Medicare Overpaid Some Fiscal Year 2008 and 2009 Jurisdiction 4 Inpatient Rehabilitation Facility Claims That Did Not Comply With Transfer Regulations</i>	<a href="#">A-04-11-00078</a>	4/24/2012
<i>Medicare Compliance Review of John Muir Medical Center, Walnut Creek, for Calendar Years 2008 Through 2010<sup>7</sup></i>	<a href="#">A-09-11-02060</a>	2/23/2012
<i>Medicare Compliance Review of University of California, San Diego, Medical Center for Calendar Years 2008 and 2009<sup>7</sup></i>	<a href="#">A-09-11-02055</a>	2/23/2012
<i>Medicare Compliance Review of University of California, San Francisco, Medical Center for Calendar Years 2008 and 2009<sup>7</sup></i>	<a href="#">A-09-11-02034</a>	9/21/2011
<i>Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2003 Through 2005</i>	<a href="#">A-04-07-03035</a>	2/27/2009

<sup>7</sup> The postacute care transfer issue was only one of the findings in this report.

## **APPENDIX B: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our review covered \$83,921,870 in Medicare Part A payments for 6,635 inpatient claims with specified MS-DRGs in which beneficiaries were transferred to postacute care and that had dates of service during the period January 2009 through September 2012. These claims were submitted by 1,672 short-term acute-care hospitals. This review did not include the claims identified in the recent OIG reviews of hospitals' compliance with Medicare billing requirements and reviews of certain Medicare claims subject to the postacute care transfer policy in Jurisdictions 1 and 2.

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. Through data analysis, we identified inpatient claims subject to the postacute transfer policy that were improperly coded as discharges to home or certain types of health care institutions. We limited our review of CMS's internal controls to those applicable to implementation of Medicare's postacute care transfer policy. We did not evaluate the medical records of the IPPS hospitals from which the beneficiaries in our review were discharged to determine whether there was a written plan of care for the provision of home health services.

We conducted our audit from December 2012 to June 2013.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance;
- used CMS's National Claims History File to identify inpatient claims with specified MS-DRGs during our audit period for beneficiaries who received certain postacute care services after inpatient stays;
- used computer matching, data mining, and data analysis techniques to identify for review 6,635 claims coded as discharges to home or certain types of health care institutions;
- reviewed data from CMS's CWF to determine whether a selected number of claims were canceled or adjusted before our review;
- interviewed CMS officials and reviewed documentation provided by them to understand how the CWF edits work and to determine why Medicare made payments for the miscoded claims;
- used CMS's PC Pricer to reprice each improperly paid claim to determine the transfer payment amount, compared the repriced payment with the actual payment, and

determined the value of the overpayment;<sup>8</sup> and

- discussed the results of our review with CMS officials.

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

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<sup>8</sup> CMS's PC Pricer is software used to estimate Medicare payments. Because of timing differences in the data used to determine the payments, the estimated payments may not exactly match the actual claim payments.



## APPENDIX C: CMS COMMENTS



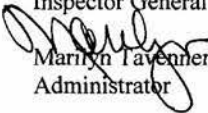
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** MAR 13 2014

**TO:** Daniel R. Levinson  
Inspector General

**FROM:**   
Marilyn Tavenner  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Inappropriately Paid Hospitals' Inpatient Claims Subject to the Postacute Care Transfer Policy (A-09-13-02036)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-mentioned OIG report. OIG's recommendations and the CMS response to those recommendations are discussed below.

### **OIG Recommendation**

The OIG recommends CMS to direct Medicare contractors to recover the \$19,471,432 in identified overpayments in accordance with CMS's policies and procedures.

### **CMS Response**

The CMS partially concurs with this recommendation. OIG reviewed claims that had dates of service during the period of January 2009 through September 2012. The calendar year (CY) 2009 claims identified in this audit have exceeded the 4-year claim reopening period as mandated by 42 CFR 405.980(b)(2). In addition, some of the CY 2010 claims have or will soon exceed the claim reopening period. Upon the receipt of the overpayment data from OIG, CMS will analyze each overpayment to determine which claims can be collected consistent with agency's policies and procedures. We request that OIG furnish CMS with the claims data that includes, at a minimum, the provider number, claim payment amount, overpayment amount, Medicare contractor number, claim paid date, health insurance claim number, and claim/document control number.

### **OIG Recommendation**

The OIG recommends CMS to direct the Medicare contractors to identify any transfer claims on which the patient discharge status was coded incorrectly and recover any overpayments after their audit period.

**CMS Response**

The CMS partially concurs with this recommendation. CMS made updates to the common working file (CWF) edits in 2013, resolving some of the vulnerabilities identified in this OIG report. The remaining claims would have to be manually researched and collected. Therefore, while CMS does not currently mandate areas for Recovery Auditor review, we will share this report with them.

**Recommendation**

The OIG recommends CMS correct the CWF edits and ensure that they are working properly.

**CMS Response**

The CMS concurs with the recommendation. CMS corrected the calculation of the number of days between the inpatient hospital claim discharge date and the home health care 'from' date with the implementation of change request (CR) 8139 on July 1, 2013. The expansion of the home health provider number range was corrected with the implementation of CR 8367 on January 6, 2014. Inpatient hospital claims previously processed with full Medicare Severity Diagnosis-Related Group payment have been adjusted to correct the patient discharge status code to pay the post-acute transfer payment.

On August 26, 2013 CMS issued Technical Direction Letter (TDL) 130513 – Review of Intermediary Name and Address File and Report 418 instructing Medicare Administrative Contractors (MACs) to correct their Intermediary Name and Address file which will allow CWF Informational Unsolicited Response (IUR) to process automatically. In addition we instructed MACs to routinely review Report 418 and process the IURs manually.

**Recommendation**

The OIG recommends CMS to educate hospitals on the importance of reporting the correct patient discharge status codes on transfer claims, especially when home health services have been ordered.

**CMS Response**

The CMS concurs with the recommendation and we will provide a Medicare Learning Network Matters® article educating hospitals and Medicare contractors on the correct patient discharge status codes to use when patients are discharged from the hospital.

The CMS thanks the OIG for the work done on this issue and look forward to working with the OIG in the future.