
From: "Pequigney, Susan A. (CMS/CM)" <Susan.Pequigney@cms.hhs.gov>
Sent: 8/26/2022 1:58:51 PM +0000
To: "Labonte, Christiane (CMS/CM)" <Christiane.Labonte@cms.hhs.gov>
CC: "Farran, Patti A. (CMS/CM)" <Patti.Farran@cms.hhs.gov>; CMS CM-FFS_OIG-GAO <CMS_CM-FFS_OIG-GAO@cms.hhs.gov>
Subject: FW: FW: Due 8/29 Group and FO Sign Off - OIG Draft on ACP [A-06-20-04008]
Attachments: A-06-20-04008 DRAFT.docx; CMS Draft Response_ClearedRedline.docx; CMS Draft Response_ClearedRedline CM_PCG Edits 2.docx; A-06-20-04008 RvDraft 8-26-22 (clean).docx

Christiane, attached for Meena's review and approval is the response A-06-20-04008. Liz has reviewed and approved.

This audit has the following recommendations (*see proposed ownership below*):

- *Rec #1 – PCG (w/HAPG)*
- *Rec #2 – OFM (w/HAPG)*
- *Rec # 3 – OFM (w/HAPG)*
- *Rec #4 – HAPG*

HAPG Front Office's cleared w/out comment. PCG cleared with comments.

Please keep in mind that only substantive non-editorial comments are being requested.

OL is asking if this can be cleared today, Friday, 8/25/22 (preferably, by 2 PM if possible)

Thanks, Susan

From: Pequigney, Susan A. (CMS/CM) <>
Sent: Friday, August 26, 2022 9:36 AM
To: Richter, Elizabeth (CMS/CM) <elizabeth.richter@cms.hhs.gov>
Cc: Farran, Patti A. (CMS/CM) <Patti.Farran@cms.hhs.gov>; CMS CM-FFS_OIG-GAO <CMS_CM-FFS_OIG-GAO@cms.hhs.gov>
Subject: FW: Due 8/29 Group and FO Sign Off - OIG Draft on ACP [A-06-20-04008]

Good morning Liz, attached for your review and approval is the response A-06-20-04008.

This audit has the following recommendations (*see proposed ownership below*):

- *Rec #1 – PCG (w/HAPG)*
- *Rec #2 – OFM (w/HAPG)*
- *Rec # 3 – OFM (w/HAPG)*
- *Rec #4 – HAPG*

HAPG Front Office's cleared w/out comment. PCG cleared with comments.

Please keep in mind that only substantive non-editorial comments are being requested.

OL is asking if this can be cleared today, Friday, 8/25/22 (preferably, by 2 PM if possible)

Thanks, Susan

From: CMS CM-FFS_OIG-GAO <CMS_CM-FFS_OIG-GAO@cms.hhs.gov>
Sent: Friday, August 26, 2022 9:27 AM
To: Pequigney, Susan A. (CMS/CM) <Susan.Pequigney@cms.hhs.gov>
Cc: Farran, Patti A. (CMS/CM) <Patti.Farran@cms.hhs.gov>
Subject: Due 8/29 Group and FO Sign Off - OIG Draft on ACP [A-06-20-04008]

Greetings Susan –

This audit has the following recommendations (*see proposed ownership below*):

- *Rec #1 – PCG (w/HAPG)*
- *Rec #2 – OFM (w/HAPG)*
- *Rec # 3 – OFM (w/HAPG)*
- *Rec #4 – HAPG*

HAPG Front Office's cleared w/out comment.

However, PCG did have one edit (*see attached*).

For your review before submitting to both Liz & Meena (*see attached*).

Please keep in mind that only substantive non-editorial comments are being requested.

OL is asking if this can be cleared today, Friday, 8/25/22 (preferably, by 2 PM if possible)

Your help is greatly appreciated.

Respectfully,

George

From: Blackfield, Anne (CMS/CM) <Anne.Blackfield@cms.hhs.gov>
Sent: Wednesday, August 24, 2022 2:34 PM
To: Sabourin, Stephanie (CMS/OL) <Stephanie.Sabourin@cms.hhs.gov>
Cc: Bruton, Jessica N. (CMS/CM) <Jessica.Bruton@cms.hhs.gov>; Habit, Sandra C. (CMS/OL) <sandra.habit@cms.hhs.gov>; Hartinger, Alicia J. (CMS/OL) <alicia.hartinger@cms.hhs.gov>; Rauch, Julie (CMS/CM) <Julie.Rauch@cms.hhs.gov>; Brock, Tamika J. (CMS/CM) <Tamika.Brock@cms.hhs.gov>; CMS CM-FFS_OIG-GAO <CMS_CM-FFS_OIG-GAO@cms.hhs.gov>
Subject: FW: Due 8/29 Group and FO Sign Off - OIG Draft on ACP [A-06-20-04008]

Hello Stephanie – HAPG's FO signed off.

From: Sabourin, Stephanie (CMS/OL) <>
Sent: Thursday, August 4, 2022 10:07 AM
To: CMS CM-FFS_OIG-GAO <CMS_CM-FFS_OIG-GAO@cms.hhs.gov>
Cc: Hartinger, Alicia J. (CMS/OL) <alicia.hartinger@cms.hhs.gov>; Habit, Sandra C. (CMS/OL) <sandra.habit@cms.hhs.gov>; Danielson, Laura-Ashley (CMS/OL) <[CMS000070_0000006_0003](mailto:laura-</p></div><div data-bbox=)

ashley.danielson@cms.hhs.gov>

Subject: Comp Clearance: OIG Draft on Advance Care Planning [A-06-20-04008]

Good Morning,

Attached for group review and edit is the draft response to OIG's draft report on advance care planning. I have added in comment bubbles to notate the rec ownership, so please have components confirm or reach out to discuss. Clearance is due on Friday, August 12th. In addition, technical comments to the draft report are due Friday, August 26th. A full timeline is below:

Clearance Schedule

- Thurs, 8/4 – OL sends out draft response for clearance by component groups
- **Fri, 8/12 – Clearance due from component groups**
- Mon, 8/15 – OL sends out response for OL/OC/OGC clearance
- Thurs, 8/18 – OL/OC/OGC clearance due
- Fri, 8/19 – OL sends out response for final component group review and component front office/leadership sign off
- **Fri, 8/26 – Component Director sign off due; *Components send technical comments to OL***
- Mon, 8/29 – OL sends response to OA
- Thurs, 9/1 – OA clearance due; Response and technical comments sent to OIG

Best,

Stephanie

From: "Pequigney, Susan (CMS/CM)" <Susan.Pequigney@cms.hhs.gov>
Sent: 3/29/2024 10:05:20 AM +0000
To: "Labonte, Christiane (CMS/CM)" <Christiane.Labonte@cms.hhs.gov>
CC: "Ifill, George (CMS/CM)" <George.Ifill@cms.hhs.gov>; CMS CM-FFS_OIG-GAO <CMS_CM-FFS_OIG-GAO@cms.hhs.gov>
Subject: FW: FW: Medicare Program Safeguards for Inpatient Claims With Short Lengths of Stay (A-09-21-03022)
Attachments: A-09-21-03022 DRAFT.pdf; 24.03.22 Draft Response redline.docx; 24.03.22 Draft Response clean.docx

Christiane, attached for Meena's review and clearance is the draft response for OIG report A-09-21-03022.

This audit has 4 recommendations (*see proposed ownership below*):

- **R1 – CM; CPI, CCSQ to assist if needed**
- **R2 – CM; CPI, CCSQ to assist if needed**
- **R3 – CM or CPI depending on where edits would be implemented**
- **R4 – CPI, CCSQ**

HAPG, PBG & TCPG's Front Office's cleared w/o comment.

Please keep in mind that only substantive non-editorial comments are being requested.

OL is asking if this can be cleared at our earliest convenience, preferably by 3 PM today if possible.

Thanks, Susan

From: Pequigney, Susan (CMS/CM)
Sent: Thursday, March 28, 2024 1:30 PM
To: Cheng (she/they), Ing-Jye (ing-jay) (CMS/CM) <IngJye.Cheng@cms.hhs.gov>
Cc: Ifill, George (CMS/CM) <George.Ifill@cms.hhs.gov>; CMS CM-FFS_OIG-GAO <CMS_CM-FFS_OIG-GAO@cms.hhs.gov>
Subject: FW: Medicare Program Safeguards for Inpatient Claims With Short Lengths of Stay (A-09-21-03022)

Ing-Jye, attached for your review and clearance is the draft response for OIG report A-09-21-03022.

This audit has 4 recommendations (*see proposed ownership below*):

- **R1 – CM; CPI, CCSQ to assist if needed**
- **R2 – CM; CPI, CCSQ to assist if needed**
- **R3 – CM or CPI depending on where edits would be implemented**
- **R4 – CPI, CCSQ**

HAPG, PBG & TCPG's Front Office's cleared w/o comment.

Please keep in mind that only substantive non-editorial comments are being requested.

OL is asking if this can be cleared at our earliest convenience, preferably by 3 PM today if possible.

Thanks, Susan

From: CMS CM-FFS_OIG-GAO <CMS_CM-FFS_OIG-GAO@cms.hhs.gov>
Sent: Thursday, March 28, 2024 12:49 PM
To: Pequigney, Susan (CMS/CM) <Susan.Pequigney@cms.hhs.gov>
Cc: Farran, Patti (CMS/CM) <Patti.Farran@cms.hhs.gov>
Subject: Medicare Program Safeguards for Inpatient Claims With Short Lengths of Stay (A-09-21-03022)

Greetings Susan –

This audit has 4 recommendations (*see proposed ownership below*):

- **R1 – CM; CPI, CCSQ to assist if needed**
- **R2 – CM; CPI, CCSQ to assist if needed**
- **R3 – CM or CPI depending on where edits would be implemented**
- **R4 – CPI, CCSQ**

HAPG, PBG & TCPG's Front Office's cleared w/o comment.

For your review before submitting to both Ing-Jye & Meena.

Please keep in mind that only substantive non-editorial comments are being requested.

OL is asking if this can be cleared at our earliest convenience, preferably by 3 PM today if possible.

Your help is greatly appreciated.

Respectfully,

George

From: Curry, Bridget (CMS/OL)
Sent: Monday, March 4, 2024 4:08 PM
To: CMS CM-FFS_OIG-GAO <CMS_CM-FFS_OIG-GAO@cms.hhs.gov>; Bruton, Jessica (CMS/CM) <Jessica.Bruton@cms.hhs.gov>; Janeczko, Susan (CMS/CM) <Susan.Janeczko@cms.hhs.gov>; Rice, David (CMS/CM) <David.Rice1@cms.hhs.gov>; Thompson, Donald (CMS/CM) <Donald.Thompson@cms.hhs.gov>; Hudson, Michele (CMS/CM) <Michele.Hudson@cms.hhs.gov>; Rivas, Yvette (CMS/CM) <Yvette.Rivas@cms.hhs.gov>; Zicha, Lorraine (CMS/CM) <Lorraine.Zicha@cms.hhs.gov>; Rooke, Fred (CMS/CM) <Fred.Rooke@cms.hhs.gov>; Mackey, Tracey (CMS/CM) <Tracey.Mackey@cms.hhs.gov>; Bernstein, Catherine (CMS/CM) <Catherine.Bernstein@cms.hhs.gov>; Keesecker, Deanna (CMS/CPI) <Deanna.Keesecker@cms.hhs.gov>; PERRY, ROBERT (CMS/CPI) <robert.perry@cms.hhs.gov>; Tabor, Jordan (CMS/CPI) <Jordan.Tabor@cms.hhs.gov>; Allen, Nakia (CMS/CPI) <nakia.allen-mcgee@cms.hhs.gov>; Barkai, Melissa (CMS/CPI) <Melissa.Barkai@cms.hhs.gov>; Graham, John (CMS/CPI) <John.Graham@cms.hhs.gov>; Johnson, Michael (CMS/CPI) <Michael.Johnson2@cms.hhs.gov>; Wilson-Coe, Tomiko (CMS/CPI) <Tomiko.Wilson-Coe@cms.hhs.gov>; Wood, Brandon (CMS/CPI) <Brandon.Wood@cms.hhs.gov>; CMS - CCSQ Exec SEC TEAM <CCSQEXECSECTeam@cms.hhs.gov>; Macer, Deonna (CMS/CCSQ) <Deonna.Macer@cms.hhs.gov>; Coleman, Laura (CMS/CCSQ) <Laura.Coleman@cms.hhs.gov>; Halim, Shaheen (CMS/CCSQ) <Shaheen.Halim@cms.hhs.gov>; Hegde, Sanjay (CMS/CCSQ) <Sanjay.Hegde@cms.hhs.gov>; Mondowney, Geri (CMS/CM) <Geri.Mondowney@cms.hhs.gov>; DuVerney, Jeanine (CMS/CM) <jeanine.duverney@cms.hhs.gov>; Hue, Marilu (CMS/CM) <Marilu.Hue@cms.hhs.gov>; Hazeley, Andrea (CMS/CM) <Andrea.Hazeley@cms.hhs.gov>; Watchorn, Marge (CMS/CM) <Marge.Watchorn@cms.hhs.gov>
Cc: Habit, Sandra (CMS/OL) <sandra.habit@cms.hhs.gov>; Andersen (he/him), Jerry (CMS/OFM) <Jerry.Andersen@cms.hhs.gov>; Bohannon, Nicole (CMS/OFM)

<Nicole.Thomas@cms.hhs.gov>; Pryor (she/her), Karla (CMS/OFM)
<Karla.Pryor@cms.hhs.gov>; del Pino, Cristopher (CMS/OFM)
<Cristopher.delPino@cms.hhs.gov>

Subject: Medicare Program Safeguards for Inpatient Claims With Short Lengths of Stay (A-09-21-03022)

Good Afternoon,

Attached is an initial draft of a response for the short stay report. Overall, the response stays pretty neutral. Based on the discussions that we have had it seems that most of things that OIG is recommending could potentially be feasible. However, it's a matter of whether the agency would want to pursue any of the recommendations. The recommendations are also pretty intertwined (ex. could add a condition code/modifier but how would it be utilized). We are also trying to be mindful of the public nature of the response. Please review and provide feedback as you see fit. We are available to discuss if you have concerns or would like to go in a different direction.

Thanks!

Bridget



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201



January 31, 2024

TO: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

FROM: Juliet T. Hodgkins
Principal Deputy Inspector General

**JULIET
HODGKINS**

Digitally signed by
JULIET HODGKINS
Date: 2024.01.31
14:46:07 -05'00'

SUBJECT: *OIG Draft Report: CMS Could Strengthen Program Safeguards To Prevent and Detect Improper Medicare Payments for Short Inpatient Stays, A-09-21-03022*

The attached draft report provides the results of our audit of program safeguards for ensuring that Medicare claims for short inpatient stays complied with Medicare requirements.

This draft report is subject to further review and revision. Please safeguard it against unauthorized use and disclosure. To properly consider your views concerning the facts and reasonableness of our recommendations, please provide written comments within 30 days from the date of this memo. Your comments should include a statement of concurrence or nonconcurrence with each recommendation:

- For each concurrence, please include a statement describing the nature of the corrective action taken or planned and provide a draft timeline for any actions, if available.
- For each nonconcurrence, please include specific reasons for the nonconcurrence and a statement of any alternative corrective action taken or planned.

Your comments will be summarized in the body of our final report and included as an appendix.

Section 8M of the Inspector General Act requires that the Office of Inspector General (OIG) post its publicly available reports on the [OIG website](#). Please send us a digitally signed electronic copy of your comments in PDF or Microsoft Word format.

If you have any questions or comments about this report, please do not hesitate to contact me, or your staff may contact Brenda M. Tierney, Assistant Inspector General for Audit Services, at (917) 648-5649 or Brenda.Tierney@oig.hhs.gov. Please refer to report number A-09-21-03022 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS COULD STRENGTHEN PROGRAM SAFEGUARDS TO PREVENT AND DETECT IMPROPER MEDICARE PAYMENTS FOR SHORT INPATIENT STAYS

NOTICE – THIS DRAFT RESTRICTED TO OFFICIAL USE

This document is a draft report of the Office of Inspector General and is subject to revision; therefore, recipients of this draft should not disclose its contents for purposes other than for official review and comment under any circumstances. This draft and all copies thereof remain the property of, and must be returned on demand to, the Office of Inspector General.



Christi A. Grimm
Inspector General

January 2024
A-09-21-03022

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG) is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of the people they serve. Established by Public Law No. 95-452, as amended, OIG carries out its mission through audits, investigations, and evaluations conducted by the following operating components:

Office of Audit Services. OAS provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. The audits examine the performance of HHS programs, funding recipients, and contractors in carrying out their respective responsibilities and provide independent assessments of HHS programs and operations to reduce waste, abuse, and mismanagement.

Office of Evaluation and Inspections. OEI's national evaluations provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. To promote impact, OEI reports also provide practical recommendations for improving program operations.

Office of Investigations. OI's criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs and operations often lead to criminal convictions, administrative sanctions, and civil monetary penalties. OI's nationwide network of investigators collaborates with the Department of Justice and other Federal, State, and local law enforcement authorities. OI works with public health entities to minimize adverse patient impacts following enforcement operations. OI also provides security and protection for the Secretary and other senior HHS officials.

Office of Counsel to the Inspector General. OCIG provides legal advice to OIG on HHS programs and OIG's internal operations. The law office also imposes exclusions and civil monetary penalties, monitors Corporate Integrity Agreements, and represents HHS's interests in False Claims Act cases. In addition, OCIG publishes advisory opinions, compliance program guidance documents, fraud alerts, and other resources regarding compliance considerations, the anti-kickback statute, and other OIG enforcement authorities.

Report in Brief - DRAFT

Date: January 2024
Report No. A-09-21-03022

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Under CMS's two-midnight rule, implemented in fiscal year (FY) 2014, CMS generally considered it inappropriate for hospital stays not expected to span at least two midnights to be billed as inpatient. OIG issued a report about the effect of this rule on short inpatient stays (i.e., stays that lasted less than two midnights) for FY 2014. According to the report, hospitals were still billing for many short inpatient stays that were potentially inappropriate under the two-midnight rule, and Medicare paid almost \$2.9 billion for these stays. Given the high payment amount at risk for noncompliance identified in that report, we focused this audit on program safeguards for claims for short inpatient stays for calendar years 2016 through 2020 (audit period).

Our objective was to assess program safeguards for ensuring that Medicare claims for short inpatient stays complied with Medicare requirements.

How OIG Did This Audit

Our audit covered \$19.7 billion in Medicare Part A claims with dates of service during our audit period for 2.5 million short inpatient stays at 3,340 acute-care hospitals. We interviewed CMS officials to obtain an understanding of program safeguards for short inpatient stays. We also interviewed one of the Quality Improvement Organizations (QIOs) to obtain an understanding of its policies and procedures for reviewing claims for short inpatient stays.

CMS Could Strengthen Program Safeguards To Prevent and Detect Improper Medicare Payments for Short Inpatient Stays

What OIG Found

For our audit period, we identified three weaknesses in the established program safeguards for preventing and detecting improper payments for short inpatient stays and recovering overpayments. Specifically, CMS did not have: (1) adequate information to identify short inpatient stays at risk for noncompliance with the two-midnight rule, (2) prepayment edits for claims at risk for noncompliance with the two-midnight rule, and (3) adequate policies and procedures to review claims at risk for noncompliance with the two-midnight rule and to recover overpayments.

These weaknesses occurred because CMS relied primarily on postpayment reviews conducted by QIOs to ensure compliance with the two-midnight rule. Although QIOs reviewed thousands of claims for short inpatient stays and denied \$49.2 million in improper payments during our audit period, these reviews denied only 0.6 percent of the \$7.8 billion in improper payments estimated by CMS's Comprehensive Error Rate Testing reviews. In addition, QIOs did not refer any providers to Recovery Audit Contractors for additional reviews and overpayment recoveries. Without strengthening program safeguards, CMS and its contractors may not be able to prevent or detect improper payments for short inpatient stays and recover overpayments for claims that did not comply with Medicare requirements.

What OIG Recommends

We recommend that CMS: (1) add information to inpatient claims indicating any stay that did not span two or more midnights because of an unforeseen circumstance, (2) develop a list of inpatient procedure codes associated with the outpatient procedure codes on the inpatient-only procedures list, (3) implement prepayment edits for claims for short inpatient stays at risk for noncompliance with the two-midnight rule, and (4) update policies and procedures for postpayment reviews to focus on claims for short inpatient stays identified as at risk for noncompliance with the two-midnight rule and to focus on overpayment recoveries.

The final report will be available on the OIG website.

CMS000070_0000710_0004

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit	1
Objective	1
Background	2
Medicare Program	2
The Role of Medicare Contractors.....	2
Hospital Inpatient and Outpatient Prospective Payment Systems	3
Short Inpatient Stays and the Two-Midnight Rule	4
CMS Guidance for Medicare Contractors on Medical Reviews of Short Inpatient Stays.....	5
Medicare Program Safeguards for Compliance With the Two-Midnight Rule.....	6
CMS Estimated Improper Payments for Short Inpatient Stays	7
Prior Office of Inspector General Report on the Two-Midnight Rule	8
How We Conducted This Audit	9
FINDINGS.....	10
CMS Did Not Have Adequate Information To Identify Short Inpatient Stays at Risk for Noncompliance With the Two-Midnight Rule.....	10
CMS Did Not Have Claim Information To Identify Short Inpatient Stays for Which the Admitting Practitioner Expected a Longer Stay and the Longer Stay Did Not Occur Because of an Unforeseen Circumstance	11
CMS Had Inadequate Claim Information To Identify Short Inpatient Stays With Inpatient-Only Procedures	11
Medicare Paid Billions of Dollars for Short Inpatient Stays.....	11
CMS and Its Contractors Could Not Easily Identify Which Short Inpatient Stays Would Have Satisfied the Two-Midnight Benchmark or an Exception to the Benchmark.....	12
CMS Did Not Have Prepayment Edits for Claims at Risk for Noncompliance With the Two-Midnight Rule.....	12
There Were No Prepayment Edits for Claims for Short Inpatient Stays With Four Risk Factors	13
Medicare May Have Made Billions of Dollars in Potentially Improper Payments.....	15

CMS Did Not Have Adequate Policies and Procedures To Review Claims at Risk for Noncompliance With the Two-Midnight Rule and Recover Overpayments.....	15
Reviews by QIOs Were Not Adequate To Prevent Billions of Dollars in Improper Payments for Short Inpatient Stays	16
QIOs Did Not Refer Any Providers to RACs for Additional Reviews To Recover Overpayments.....	17
CMS and Its Contractors Did Not Recover Billions of Dollars in Estimated Improper Payments.....	18
CONCLUSION.....	18
RECOMMENDATIONS	19
APPENDICES	
A: Audit Scope and Methodology	20
B: The CMS Guideline for QIO Reviews of Claims for Short Inpatient Stays	22

INTRODUCTION

WHY WE DID THIS AUDIT

Prior Office of Inspector General (OIG) audits identified millions of dollars in Medicare overpayments for inpatient claims with short lengths of stay.¹ Instead of being billed as inpatient, the claims should have been billed as outpatient, which usually results in a lower Medicare payment. To improve clarity regarding admission decisions, the Centers for Medicare & Medicaid Services (CMS) implemented the two-midnight rule in fiscal year (FY) 2014. Under this rule, CMS generally considered it inappropriate for hospital stays not expected to span at least two midnights to be billed as inpatient. However, claims for procedures designated as “inpatient only” or procedures that CMS identified as rare and unusual exceptions (e.g., mechanical ventilation) were generally considered to be appropriate for inpatient billing even if the stay was less than two midnights. In calendar year (CY) 2016, the two-midnight rule was revised to allow stays expected to last less than two midnights to be billed as inpatient on a case-by-case basis, subject to medical review by a Medicare contractor.

After the two-midnight rule was implemented, OIG issued a report about the effect of this rule on short inpatient stays (i.e., stays that lasted less than two midnights) for FY 2014.² The report concluded that although short inpatient stays decreased overall, vulnerabilities to improper payments remained. According to the report, hospitals were still billing for many short inpatient stays that were potentially inappropriate under the two-midnight rule, and Medicare paid almost \$2.9 billion for these stays. CMS concurred with the report’s recommendations that CMS improve oversight of hospital billing under the two-midnight rule. Given the high payment amount at risk for noncompliance identified in that report, we focused this audit on program safeguards for claims for short inpatient stays for CYs 2016 through 2020 (audit period).

OBJECTIVE

Our objective was to assess program safeguards for ensuring that Medicare claims for short inpatient stays complied with Medicare requirements.

¹ *Medicare Could Save Millions by Strengthening Billing Requirements for Canceled Elective Surgeries* (A-01-12-00509), Aug. 5, 2013. *Medicare Did Not Pay Selected Inpatient Claims for Bone Marrow and Stem Cell Transplant Procedures in Accordance With Medicare Requirements* (A-09-14-02037), Feb. 1, 2016.

² *Vulnerabilities Remain Under Medicare’s 2-Midnight Hospital Policy* (OEI-02-15-00020), Dec. 19, 2016.

BACKGROUND

Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

To be paid by Medicare, a service or an item must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (Social Security Act (the Act) § 1862(a)(1)(A)). In addition, payment must not be made to any provider of services without information necessary to determine the amount due the provider (the Act § 1815(a)). The provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

CMS administers the Medicare program. CMS uses contractors to, among other things, process and pay claims submitted by hospitals.

The Role of Medicare Contractors

To administer Medicare, CMS contracted with the following entities during our audit period:

- *Beneficiary and Family Centered Care—Quality Improvement Organizations (QIOs)*: CMS contracted with QIOs to help Medicare enrollees with their concerns about the quality of care they receive from Medicare providers. Specifically, QIOs review complaints and quality of care and help to improve the effectiveness, efficiency, economy, and quality of services provided to Medicare enrollees. During our audit period, CMS contracted with two QIOs across five regions.
- *Medicare Administrative Contractors (MACs)*: CMS contracted with MACs to, among other things, process and pay Medicare Part A claims submitted by hospitals and conduct reviews and audits for defined geographic areas, or jurisdictions. A hospital must submit claims to the MAC that serves the State or territory in which the hospital is physically located.
- *Recovery Audit Contractors (RACs)*: CMS contracted with RACs to perform postpayment reviews of claims to identify improper payments. Specifically, RACs detect and collect overpayments and identify underpayments so that CMS and other Medicare contractors can implement actions to prevent future improper payments.

Hospital Inpatient and Outpatient Prospective Payment Systems

CMS pays for hospital inpatient services under the inpatient prospective payment system (IPPS) and pays for hospital outpatient services under the outpatient prospective payment system (OPPS). CMS designates certain services as “inpatient only.”

Inpatient Prospective Payment System

Under the IPPS, CMS pays hospital inpatient services at predetermined rates for patient discharges under the Medicare Part A benefit. The rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which an enrollee’s stay is assigned and the severity level of the enrollee’s diagnosis. Procedures performed during the stay are reported on the claim using International Classification of Diseases, 10th revision (ICD-10) procedure codes. Condition codes are also reported on the claim, which provide additional information related to the enrollee, the services provided, and billing parameters that affect the processing of the claim, including information about the inpatient admission.

An MS-DRG payment is, with certain exceptions, intended to be a payment in full to a hospital for all inpatient costs associated with an enrollee’s stay. CMS calculates and publishes annually the geometric mean length of stay (GMLOS) for each MS-DRG.³

Outpatient Prospective Payment System

Under the OPPS, Medicare pays for hospital outpatient services under Medicare Part B on a rate-per-service basis. Hospitals use Healthcare Common Procedure Coding System (HCPCS) codes to report the services provided.⁴

Under a policy known as the “3-day window” policy, certain outpatient services provided to an enrollee on the date of an inpatient admission or during the 3 calendar days before the date of admission are “bundled” (i.e., included) with the IPPS payment for the enrollee’s inpatient stay if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital. These services include all diagnostic and nondiagnostic services related to an inpatient admission.⁵

³ GMLOS is the national mean length of stay for each MS-DRG as determined and published by CMS. The geometric mean reduces the effect of very high or very low values (i.e., outliers), which might bias the mean if a straight average (arithmetic mean) were used.

⁴ The health care industry uses HCPCS codes to standardize coding for medical procedures, services, products, and supplies.

⁵ The Act § 1886(a)(4); 42 CFR § 412.2(c)(5).

Inpatient-Only Procedures List

CMS designates certain services as “inpatient only” and publishes an inpatient-only procedures (IPO) list annually.⁶ These procedures are generally surgical services that require inpatient care because of: (1) the nature of the procedure, (2) the underlying physical condition of the enrollee who requires the service, or (3) the need for at least 24 hours of postoperative recovery time or monitoring before the enrollee can be safely discharged. The 3-day window policy applies to inpatient admissions for procedures on the inpatient-only list.

Short Inpatient Stays and the Two-Midnight Rule

To improve clarity regarding admission decisions, CMS implemented the two-midnight rule in FY 2014. Under this rule, CMS generally considered it inappropriate for hospital stays not expected to span at least two midnights (i.e., short stays) to be billed as inpatient. However, claims for procedures on the IPO list or procedures that CMS identified as rare and unusual exceptions are generally considered to be appropriate for inpatient billing even if the stay was less than two midnights.⁷ After receiving extensive feedback from stakeholders, CMS revised the two-midnight rule in CY 2016 to allow a stay expected to last less than two midnights to be billed as inpatient on a case-by-case basis, subject to medical review by a Medicare contractor.⁸

During the implementation period (FYs 2014 and 2015), CMS limited enforcement of the two-midnight rule. RACs were prohibited from reviewing short inpatient stays, and MACs were limited to Targeted Probe and Educate (TPE) reviews.⁹ If the results of a TPE review indicated poor compliance with the two-midnight rule, the MAC provided education to the hospital staff and conducted further reviews. Beginning in FY 2016, QIOs assumed responsibility for conducting TPE reviews and educating hospitals. If the deficiencies that QIOs identify in their reviews continue, they may refer hospitals to RACs for further reviews.¹⁰

⁶ 42 CFR § 419.22(n). The IPO list is published annually on the CMS website as OPPS Final Rule Addendum E. In the CY 2021 Medicare OPPS and Ambulatory Surgical Center final rule (CMS-1736-FC), CMS finalized a policy to eliminate the IPO list over a 3-year period. However, CMS received many stakeholder comments that opposed elimination of the IPO list primarily because of patient safety concerns, stating that the IPO list serves as an important programmatic safeguard. As a result, CMS halted elimination of the IPO list in CY 2022 (CMS-1753-FC).

⁷ 78 Fed. Reg. 50496, 50944–50949 (Aug. 19, 2013).

⁸ 80 Fed. Reg. 70298, 70538–70545 (Nov. 13, 2015).

⁹ TPE reviews are postpayment reviews of short inpatient stays focused on educating doctors and hospitals about the Medicare Part A payment policy for inpatient admissions.

¹⁰ 80 Fed. Reg. 70298, 70540, 70545–70549 (Nov. 13, 2015).

CMS Guidance for Medicare Contractors on Medical Reviews of Short Inpatient Stays

In CY 2017, CMS issued clarifying guidance for Medicare contractors' medical reviews of short inpatient stays. The guidance discussed two distinct but related medical review policies: the two-midnight presumption and the two-midnight benchmark.¹¹

Two-Midnight Presumption

Under the two-midnight presumption, Medicare contractors will presume that hospital stays spanning more than two midnights after an enrollee is formally admitted as an inpatient are reasonable and necessary for Medicare Part A payment. Generally, Medicare contractors will not focus their medical review efforts on stays spanning two or more midnights after formal inpatient admission absent evidence of systemic gaming, abuse, or delays in the provision of care in an attempt to satisfy the two-midnight presumption.

Two-Midnight Benchmark

Under the two-midnight benchmark, a hospital stay is generally payable under Medicare Part A if the admitting practitioner expects the enrollee to require medically necessary hospital care spanning two or more midnights and such reasonable expectation is supported by the medical record documentation.¹² Such a stay is payable regardless of whether the anticipated length of stay did not occur because of unforeseen circumstances, such as clinical improvement of the enrollee. An inpatient stay of less than two midnights that does not satisfy the two-midnight benchmark is nonetheless payable if:

- there is a procedure on the IPO list,
- there is a procedure that CMS identified as a rare and unusual exception to the two-midnight rule (e.g., mechanical ventilation), and
- the admission otherwise qualifies for a case-by-case exception because the medical record documentation supports the admitting practitioner's judgment that the enrollee required hospital care on an inpatient basis despite the lack of an expectation of a two-midnight stay. Medicare contractors will note CMS's expectation that stays under 24 hours would rarely qualify for an exception.

¹¹ CMS, *Clarifying Medical Review of Hospital Claims for Part A Payment*, Medicare Learning Network Matters Number: MM10080, effective June 13, 2017 (revised Jan. 9, 2019). Available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10080.pdf>. Accessed on Apr. 24, 2023.

¹² For purposes of determining whether the admitting practitioner had a reasonable expectation of hospital care spanning two or more midnights at the time of admission, the Medicare contractor takes into account the time that the enrollee spent receiving contiguous outpatient services within the hospital before inpatient admission.

See Appendix B for the guideline that CMS published for QIO reviews of claims for short inpatient stays.

Medicare Program Safeguards for Compliance With the Two-Midnight Rule

Addressing improper payments in the Medicare fee-for-service (FFS) program, including those for short inpatient stays under the two-midnight rule, and promoting compliance with Medicare coverage and coding rules are top priorities for CMS. In addition, preventing Medicare improper payments requires the active involvement of every component of CMS and effective coordination with CMS partners, including its contractors and providers.¹³

CMS and its contractors use a variety of program safeguards to prevent and detect improper payments and to promote provider compliance. These safeguards include measuring improper payment rates through the Comprehensive Error Rate Testing (CERT) program, implementing claims processing edits, and conducting postpayment reviews of claims.

Comprehensive Error Rate Testing Program

To measure payment compliance in the Medicare FFS program (including Part A), CMS reviews a stratified random sample of approximately 50,000 claims each fiscal year under the CERT program.¹⁴ This sample size allows CMS to calculate a national improper payment rate and contractor- and service-specific improper payment rates.¹⁵ The results of each CERT review are published annually on the CMS website and provide data on improper payments for short inpatient stays.

¹³ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 1, § 1.3.

¹⁴ Although the Federal fiscal year runs from October 1 through September 30, the Medicare FFS improper payment rate calculation includes claims submitted during the 12-month period from July 1 through June 30 before the start of the corresponding Federal fiscal year. For example, the FY 2020 Medicare FFS improper payment rate included claims submitted during the 12-month period from July 1, 2018, through June 30, 2019. The Medicare FFS sampling period does not correspond with the Federal fiscal year because of practical constraints with claims review and rate calculation methodologies.

¹⁵ The improper payment rate is not a “fraud rate” but a measurement of payments that did not meet Medicare requirements. Improper payments are payments that should not have been made or payments with incorrect amounts, and that consist of both overpayments and underpayments.

Claims Processing Edits

Medicare contractors implement CMS- or contractor-developed claims processing system edits to prevent and detect improper payments.¹⁶ Prepayment edits select claims for electronic review before the claims are paid; evaluate or compare information on the selected claims or other accessible sources; and, depending on the evaluation, take action on each claim. Such action could involve paying all or part of the claim, denying all or part of the claim, or suspending all or part of the claim for manual review. Postpayment edits select claims for electronic or manual review after the claims have been paid, and this review results in either no change to the initial payment determination or a revised determination indicating that an overpayment or underpayment occurred.

Postpayment Reviews of Claims

Beginning in CY 2016, QIOs began conducting TPE reviews for short inpatient stays under the revised two-midnight rule. These postpayment reviews are focused on educating doctors and hospitals about the Medicare Part A payment policy for inpatient admissions. QIOs may refer providers to RACs for additional postpayment reviews based on patterns of practice, such as high rates of claims denial after medical review or failure to improve after QIO assistance has been provided.

CMS Estimated Improper Payments for Short Inpatient Stays

Through its annual CERT review, CMS estimated that Medicare Part A improperly paid \$23.9 billion for all inpatient stays paid under the IPPS for FYs 2017 through 2021.¹⁷ The CERT reports provide a breakdown of the estimated improper payments by length of stay. Of the \$23.9 billion in estimated improper payments, \$7.8 billion was for short inpatient stays.¹⁸

¹⁶ CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, section 3.3.1.3.B, states that Medicare contractors shall ensure that automated prepayment and postpayment denials are based on a clear policy that serves as the basis for denial. When a clear policy exists, Medicare contractors have the discretion to automatically deny services without stopping a claim for manual review. The term "clear policy" means a statute, regulation, National Coverage Determination, coverage provision in an interpretive manual, coding guideline, Local Coverage Determination, or Local Coverage Article that specifies the circumstances under which a service will always be considered noncovered, incorrectly coded, or improperly billed.

¹⁷ CMS publishes annually on its website the results of each CERT review in a report called *Medicare Fee-for-Service Supplemental Improper Payment Data*. Table B7 of the report provides the projected improper payments by length of stay for Medicare Part A (Hospital IPPS) payments. Although improper payments may consist of overpayments and underpayments, 89.1 percent of the Medicare Part A (Hospital IPPS) improper payments for FYs 2017 through 2021 were overpayments.

¹⁸ CMS calculates the length of stay as the difference between the date of admission and the date of discharge on a claim. Short inpatient stays are listed under the line item for claims that had a length of stay of 0 or 1 day.

Table 1 shows the estimated improper payment amount by year for short inpatient stays and all inpatient stays.

Table 1: Estimated Improper Payment Amount by Year for Short Inpatient Stays and All Inpatient Stays

Length of Stay	Estimated Improper Payment Amount (in Billions)					
	2017	2018	2019	2020	2021	Total
Short Inpatient Stays	\$1.4	\$1.3	\$1.7	\$1.9	\$1.5	\$7.8
All Inpatient Stays	\$5.0	\$5.5	\$5.3	\$4.8	\$3.3	\$23.9

Compared with all inpatient stays, the estimated improper payment rate for short inpatient stays was higher. Table 2 shows the estimated improper payment rate by year for short inpatient stays and all inpatient stays.

Table 2: Estimated Improper Payment Rates by Year for Short Inpatient Stays and All Inpatient Stays

Length of Stay	Estimated Improper Payment Rate					
	2017	2018	2019	2020	2021	Average
Short Inpatient Stays	18.2%	17.0%	18.4%	19.9%	16.8%	18.1%
All Inpatient Stays	4.4%	4.8%	4.2%	4.0%	3.0%	4.1%

Prior Office of Inspector General Report on the Two-Midnight Rule

OIG issued a report about the effect of the two-midnight rule on inpatient and outpatient stays by comparing data for FY 2013 (before implementation of the rule) and FY 2014 (after the rule took effect).¹⁹ The report found that the number of short inpatient stays (i.e., stays that lasted less than two midnights) decreased but that vulnerabilities remained, including the following:

- Hospitals were still billing for many short inpatient stays that were potentially inappropriate under the two-midnight rule, and Medicare paid almost \$2.9 billion for these stays in FY 2014.
- Medicare paid more for some short inpatient stays than for short outpatient stays, although the stays were for similar reasons.

¹⁹ *Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy* (OEI-02-15-00020), Dec. 19, 2016.

- Hospitals continued to vary in how they billed inpatient and outpatient stays.

To address these vulnerabilities, the report recommended that CMS: (1) conduct a routine analysis of hospital billing and target for review the hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the two-midnight rule and (2) identify and target for review the short inpatient stays that are potentially inappropriate under the two-midnight rule. CMS concurred with these recommendations and stated that it would instruct QIOs to conduct the recommended analysis and review short inpatient stays to determine the appropriateness of Medicare Part A payment.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$19.7 billion in Medicare Part A claims with dates of service from January 1, 2016, through December 31, 2020, for 2.5 million short inpatient stays at 3,340 acute-care hospitals.²⁰ These claims were paid under the IPPS on behalf of 2.2 million enrollees, each of whom a hospital indicated on each claim went home after an inpatient stay without additional care, such as home health or hospice care. We defined a short inpatient stay as one in which the claim showed that the enrollee was an inpatient for 1 or 2 days (i.e., a stay that lasted less than two midnights) based on the date of admission and date of discharge on the claim. For example:

- A claim with a date of admission on January 1 and a date of discharge on January 1 was considered a 1-day stay (i.e., zero midnights).
- A claim with a date of admission on January 1 and a date of discharge on January 2 was considered a 2-day stay (i.e., one midnight).

We interviewed CMS officials to obtain an understanding of program safeguards (such as claims processing edits and postpayment reviews) for short hospital stays paid under the IPPS. We also interviewed one QIO to obtain an understanding of its policies and procedures for reviewing claims for short inpatient stays.

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 A describes our audit scope and methodology.

²⁰ CMS defines an acute-care hospital as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

FINDINGS

CMS could strengthen program safeguards for ensuring that Medicare claims for short inpatient stays comply with Medicare requirements. For our audit period, we identified three weaknesses in the established program safeguards for preventing and detecting improper payments for short inpatient stays and recovering overpayments. Specifically, CMS did not have:

- adequate information to identify short inpatient stays at risk for noncompliance with the two-midnight rule,
- prepayment edits for claims at risk for noncompliance with the two-midnight rule, and
- adequate policies and procedures to review claims at risk for noncompliance with the two-midnight rule and to recover overpayments.

These weaknesses occurred because CMS relied primarily on postpayment reviews conducted by QIOs to ensure compliance with the two-midnight rule. Although QIOs reviewed thousands of claims for short inpatient stays and denied \$49.2 million in improper payments during our audit period, these reviews denied only 0.6 percent of the \$7.8 billion in improper payments estimated by CMS's CERT reviews. In addition, QIOs did not refer any providers to RACs for additional reviews and recovery of overpayments after furnishing the providers with assistance, and the QIO reviews did not significantly reduce the improper payment rate for short inpatient stays estimated by CMS's CERT reviews. Without strengthening program safeguards, CMS and its contractors may not be able to prevent or detect improper payments for short inpatient stays and recover overpayments for claims that did not comply with Medicare requirements.

CMS DID NOT HAVE ADEQUATE INFORMATION TO IDENTIFY SHORT INPATIENT STAYS AT RISK FOR NONCOMPLIANCE WITH THE TWO-MIDNIGHT RULE

CMS did not have claim information to identify short inpatient stays for which the admitting practitioner expected a longer stay and the longer stay did not occur because of an unforeseen circumstance. In addition, CMS had inadequate claim information to identify short inpatient stays with inpatient-only procedures. As a result, Medicare paid \$19.7 billion for 2.5 million short inpatient stays that were at risk for noncompliance with the two-midnight rule. Specifically, these claims did not satisfy the two-midnight presumption (i.e., each stay lasted less than two midnights), and CMS and its contractors could not easily identify which short inpatient stays would have satisfied the two-midnight benchmark or an exception to the benchmark.

CMS Did Not Have Claim Information To Identify Short Inpatient Stays for Which the Admitting Practitioner Expected a Longer Stay and the Longer Stay Did Not Occur Because of an Unforeseen Circumstance

Under the two-midnight benchmark, a hospital stay is generally payable under Medicare Part A if the admitting practitioner reasonably expects the enrollee to require hospital care spanning two or more midnights (i.e., a longer stay) and that expectation is supported by the medical record documentation. This is true regardless of whether the anticipated length of stay did not occur because of an unforeseen circumstance. However, there was no information, such as a condition code, on claims for short inpatient stays indicating that an unforeseen circumstance occurred that resulted in a shorter stay. Therefore, without conducting a medical review on a claim-by-claim basis, CMS and its contractors could not identify short inpatient stays in which a longer stay did not occur because of an unforeseen circumstance.

CMS Had Inadequate Claim Information To Identify Short Inpatient Stays With Inpatient-Only Procedures

Inpatient stays of less than two midnights that do not satisfy the two-midnight benchmark are nonetheless payable when there is a procedure on the IPO list. However, the IPO list has HCPCS codes that are used to report procedures on outpatient claims and does not include ICD-10 procedure codes, which are used to report procedures on inpatient claims.²¹ Therefore, CMS and its contractors did not have adequate information to identify short inpatient stays with inpatient-only procedures unless they manually reviewed the procedure codes listed on each claim. The prior OIG report on the two-midnight rule (OEI-02-15-00020) also identified as a concern the lack of an IPO list using ICD-10 procedure codes.

According to CMS officials, CMS does not have a list of ICD-10 procedure codes that correspond to the HCPCS codes on the IPO list. CMS stated that creating such a list would be technically challenging because of differences between the two classification systems. For example, an HCPCS code may map to zero, one, or more than one ICD-10 procedure code. However, the QIO we interviewed stated that it “developed an exclusion list [IPO list] and also utilized a credentialed coder with software crosswalk support to evaluate the actual procedure documented in the medical record as there is not a one-to-one correlation between the HCPCS codes and the ICD procedure codes.”

Medicare Paid Billions of Dollars for Short Inpatient Stays

Medicare paid \$19.7 billion for 2.5 million short inpatient stays that did not satisfy the two-midnight presumption (i.e., each stay lasted less than two midnights). Table 3 on the following page shows the number of and payment for short inpatient stays by year for our audit

²¹ Under the 3-day window policy, an inpatient-only procedure provided before inpatient admission by the admitting hospital, or an entity that is wholly owned or wholly operated by the admitting hospital, is generally included on an inpatient claim as an ICD-10 procedure code.

period. Because these claims did not satisfy the two-midnight presumption in the contractor guidance, these claims would have had to satisfy the two-midnight benchmark or an exception to the benchmark in order to qualify for IPPS payment. This includes the admitting practitioner's expectation that the enrollee requires medically necessary hospital care spanning two or more midnights or an assessment of the claim to determine whether an exception exists that would make a payment appropriate, such as the presence of an inpatient-only procedure.

Table 3: Number of and Payment for Short Inpatient Stays From CYs 2016 Through 2020

Year	1-Day Stays (Zero Midnights)		2-Day Stays (One Midnight)		All Short Inpatient Stays (Zero or One Midnight)	
	Number of Stays	Payment	Number of Stays	Payment	Number of Stays	Payment
2016	45,356	\$310,522,081	411,821	\$2,883,438,595	457,177	\$3,193,960,676
2017	55,250	395,328,425	513,592	3,710,602,102	568,842	4,105,930,527
2018	54,755	414,764,077	499,056	3,772,294,316	553,811	4,187,058,393
2019	57,659	472,477,739	528,338	4,356,053,778	585,997	4,828,531,517
2020	39,010	353,660,997	337,372	3,042,378,388	376,382	3,396,039,385
Total	252,030	\$1,946,753,319	2,290,179	\$17,764,767,179	2,542,209	\$19,711,520,498

CMS and Its Contractors Could Not Easily Identify Which Short Inpatient Stays Would Have Satisfied the Two-Midnight Benchmark or an Exception to the Benchmark

Without claim information indicating that a longer stay did not occur because of an unforeseen circumstance or an IPO list with ICD-10 procedure codes, CMS and its contractors could not easily identify which short inpatient stays would have satisfied the two-midnight benchmark or an exception to the benchmark. Not being able to make this identification could lead to an inefficient use of resources because CMS and its contractors may not focus postpayment reviews on claims at higher risk of improper payments.

CMS DID NOT HAVE PREPAYMENT EDITS FOR CLAIMS AT RISK FOR NONCOMPLIANCE WITH THE TWO-MIDNIGHT RULE

Although OIG and CMS, as well as the QIO we interviewed, identified risk factors for noncompliance with the two-midnight rule, CMS did not have prepayment edits to prevent potentially improper payments for short inpatient stays with these risk factors. Without prepayment edits for claims for short inpatient stays with known risk factors, CMS may have made billions of dollars in potentially improper payments.

There Were No Prepayment Edits for Claims for Short Inpatient Stays With Four Risk Factors

Prior OIG reports, CMS, and the QIO we interviewed identified short inpatient stays with the following four risk factors for noncompliance with the two-midnight rule: (1) stays for care generally spanning 1 week or longer, (2) stays with canceled procedures, (3) stays billed with MS-DRGs that CMS identified as at risk for noncompliance, and (4) stays billed with MS-DRGs identified by a QIO as at risk for noncompliance. Of the \$19.7 billion that Medicare paid for short inpatient stays during our audit period, up to \$11 billion was for claims with one or more of these risk factors. However, there were no prepayment edits for claims for short inpatient stays with these risk factors. Instead, CMS relied on postpayment edits and claim reviews to ensure compliance with the two-midnight rule. CMS stated that it has a Fraud Prevention System (FPS) model that identifies providers with anomalous inpatient admission patterns, including short inpatient stays.²² However, the FPS model flags claims for review after, not before, payment has been made.

Medicare Paid Millions of Dollars for Short Stays for Care Generally Spanning 1 Week or Longer

For our audit period, Medicare paid \$306.5 million for 10,512 short inpatient stays billed with MS-DRGs that had a GMLOS greater than or equal to 7 days. The average payment for these claims (\$29,162) was almost four times higher than the average for all short inpatient stays (\$7,754).

A prior OIG report (A-09-14-02037) identified a similar issue in which millions of dollars in overpayments for short inpatient stays were billed with MS-DRGs that had long average lengths of stay (i.e., a high GMLOS).²³ Specifically, the report identified \$6.3 million in overpayments from January 2010 through September 2013 for inpatient claims for bone marrow and stem-cell transplant procedures. The lengths of stay for these claims were 1 to 2 days, but the GMLOS for each of these claims was 10 to 21 days. Most of these stays were incorrectly billed as inpatient and should have been billed as outpatient.

Based on the findings in the prior OIG report, it is reasonable to maintain that for our audit period the claims for inpatient stays billed with MS-DRGs that had a long average length of stay may have been at risk for noncompliance with the two-midnight rule, and that the lack of prepayment edits may have allowed improper payments for claims with this risk factor.

²² The FPS is a state-of-the-art predictive analytics technology that analyzes all Medicare FFS claims nationwide before they are paid to identify these anomalous inpatient admission patterns.

²³ *Medicare Did Not Pay Selected Inpatient Claims for Bone Marrow and Stem Cell Transplant Procedures in Accordance With Medicare Requirements* (A-09-14-02037), Feb. 1, 2016.

Medicare Paid Millions of Dollars for Short Inpatient Stays With Canceled Procedures

For our audit period, Medicare paid \$156.3 million for 20,855 short inpatient stays with canceled procedures. These claims were billed with ICD-10 diagnosis codes that indicated specific procedures or treatments were not carried out.²⁴

Another prior OIG report (A-01-12-00509) identified millions of dollars in overpayments for short inpatient stays with canceled elective surgeries.²⁵ Specifically, the report identified \$38.2 million in estimated overpayments for CYs 2009 and 2010 for short inpatient stays (i.e., stays that lasted less than two midnights) that had a diagnosis code indicating that the surgical procedure on the claim was not carried out.

Based on our findings in the prior OIG report on canceled elective surgeries, it is reasonable to maintain that for our audit period the claims for short inpatient stays with canceled procedures may have been at risk for noncompliance with the two-midnight rule and that the lack of prepayment edits may have allowed improper payments for claims with this risk factor. Table 4 shows payments for short inpatient stays with canceled procedures by year for our audit period.

**Table 4: Payments for Short Inpatient Stays With Canceled Procedures by Year
From CYs 2016 Through 2020**

Year	Number of Claims	Payment
2016	3,531	\$23,684,597
2017	4,541	31,872,575
2018	4,467	33,271,084
2019	4,891	38,261,954
2020	3,425	29,229,134
Total	20,855	\$156,319,344

Medicare Paid Hundreds of Millions of Dollars for Short Inpatient Stays Billed With MS-DRGs That CMS Identified as High Risk

As part of its oversight of inpatient billing, CMS previously identified (i.e., before our audit) short inpatient stays billed with 45 MS-DRGs that were at risk for noncompliance with the two-midnight rule. According to CMS, these MS-DRGs were associated with 1-day inpatient stays (i.e., stays that did not span one midnight) that most likely were outpatient services rather than

²⁴ These diagnosis codes are in the Z53 series for “Persons encountering health services for specific procedures and treatments, not carried out.” We excluded diagnosis codes in subgroup Z53.3, “Procedure converted to open procedure,” because these codes indicate that a different type of procedure was performed than the type of procedure that was planned.

²⁵ *Medicare Could Save Millions by Strengthening Billing Requirements for Canceled Elective Surgeries* (A-01-12-00509), Aug. 5, 2013.

inpatient stays. Each of these MS-DRGs had a GMLOS ranging from 1.7 to 5.5 days. For our audit period, Medicare paid \$505.6 million for 91,804 one-day inpatient stays billed with these MS-DRGs.

Medicare Paid Billions of Dollars for Short Inpatient Stays Billed With MS-DRGs That a QIO Identified as High Risk

The QIO we interviewed previously identified (i.e., before our audit) short inpatient stays billed with 370 MS-DRGs that were considered at high risk for improper payments. Each of these MS-DRGs had a GMLOS ranging from 1.2 to 10.4 days, and many of them were on the list of MS-DRGs that CMS identified as at risk for noncompliance with the two-midnight rule. For our audit period, Medicare paid \$11 billion for 1,452,062 short inpatient stays billed with these MS-DRGs. Table 5 shows payments for 1-day and 2-day inpatient stays billed with MS-DRGs at high risk for improper payments.

Table 5: Payments for 1-Day and 2-Day Inpatient Stays Billed With MS-DRGs at High Risk for Improper Payments

Length of Stay	Number of Claims	Payment
1 Day (Zero Midnights)	152,843	\$1,135,518,224
2 Days (One Midnight)	1,299,219	9,852,299,591
Total	1,452,062	\$10,987,817,815

Medicare May Have Made Billions of Dollars in Potentially Improper Payments

Because CMS did not have prepayment edits for claims for short inpatient stays with four risk factors, Medicare may have made up to \$11 billion in potentially improper payments. Implementing claims processing edits—instead of conducting potential postpayment claim reviews such as those conducted by QIOs—may be able to prevent potentially improper payments before they are made. These edits would reduce the number of claims requiring postpayment reviews and allow QIOs to focus reviews on claims that most require them.

CMS DID NOT HAVE ADEQUATE POLICIES AND PROCEDURES TO REVIEW CLAIMS AT RISK FOR NONCOMPLIANCE WITH THE TWO-MIDNIGHT RULE AND RECOVER OVERPAYMENTS

CMS did not have adequate policies and procedures to ensure that: (1) QIO reviews were adequate to prevent billions of dollars in improper payments for short inpatient stays and (2) QIOs referred providers to RACs for additional reviews to recover overpayments. Without adequate policies and procedures to review claims at risk for noncompliance with the two-midnight rule, billions of dollars in estimated overpayments may not be recovered.

Reviews by QIOs Were Not Adequate To Prevent Billions of Dollars in Improper Payments for Short Inpatient Stays

Although QIOs reviewed thousands of claims for short inpatient stays and denied millions of dollars in improper payments during our audit period, these reviews were not adequate to prevent billions of dollars in estimated improper payments for short inpatient stays.

In accordance with CMS's policies and procedures, QIOs began conducting TPE reviews of claims for short inpatient stays in FY 2016. The first statement of work (SOW 11) covered claims with hospital discharge dates from April 1, 2015, through December 31, 2018, and the TPE reviews were conducted in six probe cycles (i.e., rounds) by two QIOs. Each probe cycle covered a 6- to 9-month period of claims, and the QIOs reviewed 4,313 to 19,184 claims in each cycle. The QIOs initially selected claims based on hospital size; however, the methodology was later refined to focus on the top 175 providers with high or increasing numbers of short inpatient stays. In total, the QIOs reviewed 65,539 claims for short inpatient stays and denied payment for 8,904 claims totaling \$49.2 million for SOW 11. See Table 6 for results of the QIO reviews of short inpatient stays by probe cycle for SOW 11.

Table 6: Results of the QIO Reviews of Short Inpatient Stays by Probe Cycle

Probe Cycle	Number of Claims Reviewed	Number of Claims Denied	Payment Denied
1	18,053	298	\$1,937,081
2	19,184	3,539	22,782,748
3	9,820	1,497	7,770,049
4	5,538	1,068	6,044,108
5	8,631	1,649	1,636,648
6	4,313	853	8,995,452
Total	65,539	8,904	\$49,166,086

The second statement of work (SOW 12) covered claims with hospital discharge dates starting August 1, 2021. As a result, QIOs have not reviewed claims for short inpatient stays with discharge dates from January 1, 2019, through July 31, 2021.

Although QIOs denied \$49.2 million in improper payments for short inpatient stays during our audit period, these reviews were focused on educating doctors and hospital staff about inpatient admission requirements after implementation of the two-midnight rule rather than on recovering overpayments. However, the two-midnight rule is now an established policy, and these reviews were not adequate to significantly reduce improper payments for short inpatient stays, which were estimated by CMS's CERT reviews to total \$7.8 billion during our audit

period.²⁶ If CMS does not update its policies and procedures for postpayment reviews to focus on claims for short inpatient stays identified as at risk for noncompliance with the two-midnight rule, billions of dollars in estimated overpayments may not be recovered.

QIOs Did Not Refer Any Providers to RACs for Additional Reviews To Recover Overpayments

Although QIOs identified and provided education to hundreds of providers for which there were major concerns over compliance with the two-midnight rule, the QIOs did not refer these providers to RACs for additional reviews and recovery of overpayments.

According to CMS policies and procedures, RACs were prohibited from reviewing claims for short inpatient stays without a referral from a QIO. According to the policy, a QIO should have referred a provider to an RAC for additional review based on a pattern of improper billing, such as a high rate of claims denial after a medical review or failure to improve after QIO assistance has been provided. For SOW 11, QIOs identified 860 providers for which they had “major concerns” over compliance with the two-midnight rule.²⁷ However, QIOs did not refer any providers to RACs for additional review because the providers did not continue to meet the criteria (i.e., patterns of improper billing) for referral after QIO assistance (i.e., education) had been provided. Table 7 shows the number of providers that QIOs identified with major compliance concerns by probe cycle.

Table 7: Providers for Which the QIOs Identified Major Concerns Over Compliance With the Two-Midnight Rule by Probe Cycle

Probe Cycle	Number of Providers Reviewed	Number of Providers With Major Compliance Concerns
1	1,661	28
2	1,704	502
3	443	99
4	222	68
5	346	111
6	173	52
Total	4,549	860

²⁶ The dates of service for the QIO recoveries and the CERT estimate do not align. The QIO recoveries were for claims with dates of service from Apr. 1, 2015, through Dec. 31, 2018. (There were no additional recoveries until SOW 12 began in 2021.) The CERT estimate was for claims with dates of service from July 1, 2015, through June 30, 2020.

²⁷ A QIO identified a “major concern” with a provider’s compliance if the provider’s denial rate was 20.01 percent or greater of the reviewed claims for the provider-specific sample. A QIO may have identified major concerns with the same provider in more than one probe cycle.

Although QIOs assisted providers with compliance concerns as part of their reviews, these reviews did not significantly reduce the improper payment rates for short inpatient stays, which were estimated by CMS's CERT reviews to average 18.1 percent during our audit period. In addition, there were no RAC reviews over our 5-year audit period under the QIO referral policy. If CMS does not update its policies and procedures for postpayment reviews to allow for additional reviews (whether by RACs or other contractors), billions of dollars in estimated overpayments may not be recovered.

CMS and Its Contractors Did Not Recover Billions of Dollars in Estimated Improper Payments

Although QIOs denied \$49.2 million in improper payments for short inpatient stays during our audit period, this amount was only 0.6 percent of the \$7.8 billion in improper payments estimated by CMS's CERT reviews. Despite identifying providers with compliance concerns, QIOs did not refer any of these providers to RACs for additional reviews and recovery of overpayments after furnishing the providers with assistance. If CMS does not update its policies and procedures for postpayment reviews to focus on claims for short inpatient stays at risk for noncompliance with the two-midnight rule and recovery of overpayments (whether by RACs or other contractors), billions of dollars in estimated improper payments may not be recovered.

CONCLUSION

We identified three weaknesses in the established program safeguards for preventing and detecting improper payments for short inpatient stays and recovering overpayments. Specifically: (1) CMS did not have claim information to identify short inpatient stays for which the admitting practitioner expected a longer stay and the longer stay did not occur because of an unforeseen circumstance, and CMS had inadequate claim information to identify short inpatient stays with inpatient-only procedures; (2) CMS did not have prepayment edits for claims at risk for noncompliance with the two-midnight rule; and (3) CMS did not have adequate policies and procedures to review claims at risk for noncompliance with the two-midnight rule and recover overpayments.

Medicare paid \$19.7 billion for 2.5 million short inpatient stays that did not satisfy the two-midnight presumption (i.e., each stay lasted less than two midnights). Of the \$19.7 billion, up to \$11 billion was for claims at higher risk for improper payments. Specifically, we identified \$306.5 million for short inpatient stays for care generally spanning 1 week or longer, \$156.3 million for short inpatient stays with canceled procedures, \$505.6 million for short inpatient stays billed with MS-DRGs that CMS identified as at risk, and \$11 billion for short inpatient stays billed with MS-DRGs that one QIO identified as at risk.

These weaknesses occurred because CMS relied primarily on postpayment reviews conducted by QIOs to ensure compliance with the two-midnight rule. Although QIOs reviewed thousands of claims for short inpatient stays and denied \$49.2 million in improper payments during our audit period, these reviews denied only 0.6 percent of the \$7.8 billion in improper payments

estimated by CMS's CERT reviews. In addition, QIOs did not refer any providers to RACs for additional reviews and recovery of overpayments after furnishing the providers with assistance, and the QIO reviews did not significantly reduce the improper payment rate for short inpatient stays estimated by CMS's CERT reviews. Without strengthening program safeguards, CMS and its contractors may not be able to prevent and detect improper payments for short inpatient stays and recover overpayments for claims that did not comply with Medicare requirements.

RECOMMENDATIONS

To strengthen program safeguards for preventing and detecting improper payments for short inpatient stays and recovering overpayments for claims that do not comply with Medicare requirements, we recommend that the Centers for Medicare & Medicaid Services work with its contractors to:

- add information to inpatient claims indicating any stay that did not span two or more midnights because of an unforeseen circumstance (e.g., a condition code);
- develop a list of ICD-10 procedure codes associated with the HCPCS codes on the inpatient-only procedures list;
- implement prepayment edits for claims for short inpatient stays at risk for noncompliance with the two-midnight rule (i.e., short inpatient stays with risk factors, such as canceled procedures or certain MS-DRGs); and
- update policies and procedures for postpayment reviews to focus on:
 - claims for short inpatient stays identified as at risk for noncompliance with the two-midnight rule and
 - recovery of overpayments (e.g., through additional reviews by RACs or other contractors).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$19,711,520,498 in Medicare Part A claims with dates of service from January 1, 2016, through December 31, 2020, for 2,542,209 short inpatient stays at 3,340 acute-care hospitals. These claims were paid under the IPPS on behalf of 2,223,592 enrollees, each of whom a hospital indicated on each claim went home after an inpatient stay without additional care, such as home health or hospice care. We defined a short inpatient stay as one in which the claim showed that the enrollee was an inpatient for 1 or 2 days (i.e., a stay that lasted less than two midnights) based on the date of admission and date of discharge on the claim. For example:

- A claim with a date of admission on January 1 and a date of discharge on January 1 was considered a 1-day stay (i.e., zero midnights).
- A claim with a date of admission on January 1 and a date of discharge on January 2 was considered a 2-day stay (i.e., one midnight).

We did not perform an overall assessment of the internal control structures of CMS or its contractors. Rather, we limited our review to those internal controls related to Medicare requirements for the two-midnight rule. Specifically, we interviewed CMS officials to obtain an understanding of policies and procedures and claims processing system edits for short inpatient stays. We also interviewed one QIO to obtain an understanding of its policies and procedures for reviewing claims for short inpatient stays. Because our audit was designed to provide only reasonable assurance that the internal controls we reviewed were effective, it would not necessarily have detected all internal control deficiencies.

Our audit enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History file (NCH), but we did not assess the completeness of the data. We assessed the reliability of the data obtained from the NCH file by: (1) considering prior data reliability assessments on data from the NCH file and (2) performing electronic testing of the data, such as verifying that the data met the parameters of our request and recalculating values such as length of stay. We determined that the data were sufficiently reliable for purposes of this audit.

We conducted our audit from November 2021 to January 2024.

METHODOLOGY

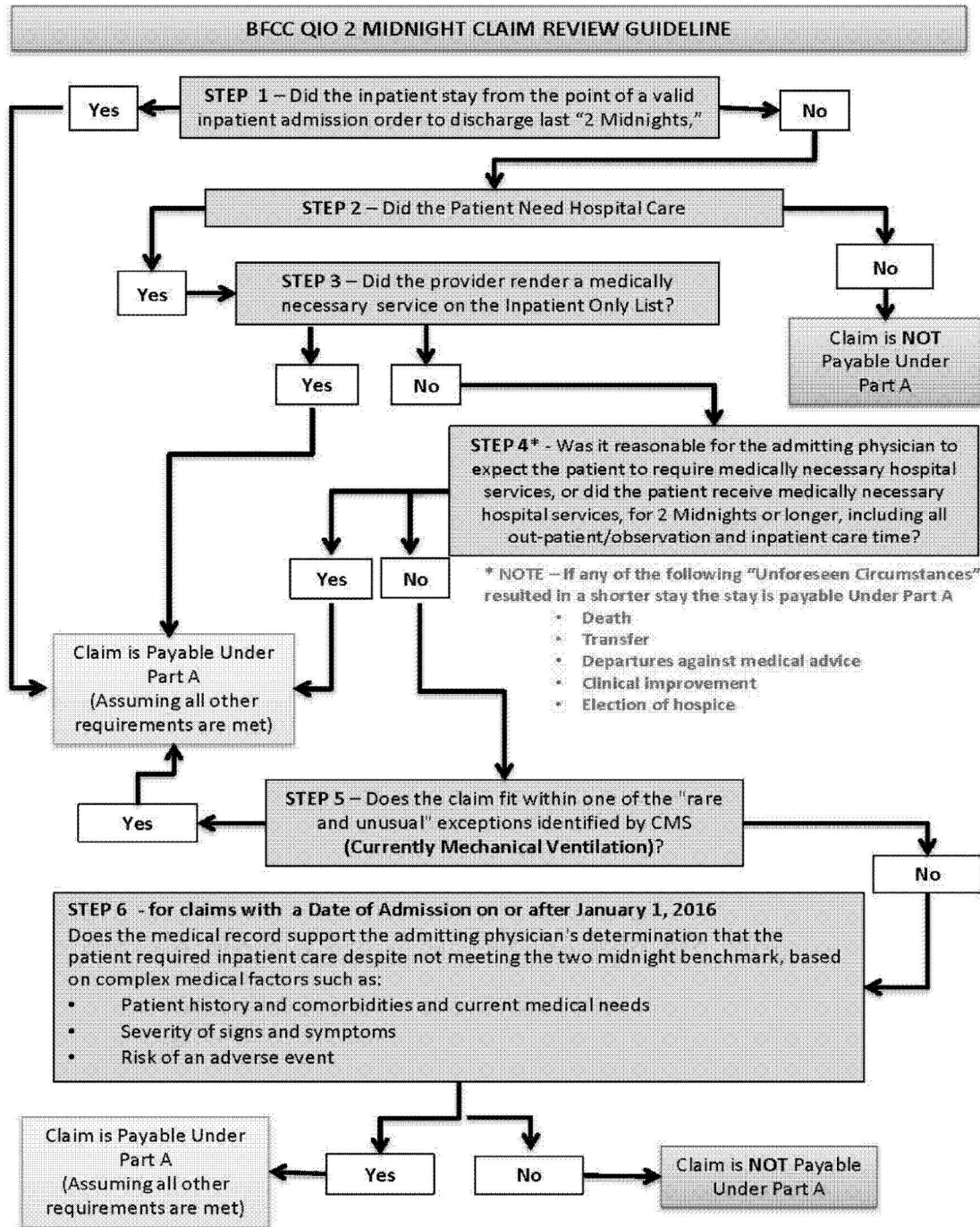
To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- reviewed CMS’s CERT data for FYs 2016 through 2020;
- interviewed CMS officials and officials from one QIO to obtain an understanding of Medicare program safeguards and oversight activities for short inpatient stays;
- obtained from the NCH file the Medicare Part A paid claims data for short inpatient stays (i.e., stays that lasted less than two midnights) with dates of service for our audit period;
- analyzed the Part A paid claims data for short inpatient stays to identify claims at risk for noncompliance with the two-midnight rule; and
- discussed the results of our audit 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.

APPENDIX B: THE CMS GUIDELINE FOR QIO REVIEWS OF CLAIMS FOR SHORT INPATIENT STAYS²⁸



Revised May 3, 2016 1:47pm

²⁸ CMS, Center for Clinical Standards and Quality, Quality Improvement and Innovation Group, BFCC-QIO 2 Midnight Claim Review Guideline, Mar. 23, 2022. Available at <https://www.cms.gov/files/document/bfcc-qio-2-midnight-claim-review-guideline.pdf>. Accessed on Dec. 1, 2022.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



August 2, 2022

TO: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

FROM: Amy J. Frontz
Deputy Inspector General for Audit Services

**AMY
FRONTZ**

Digitally signed by
AMY FRONTZ
Date: 2022.08.02
08:02:28 -04'00'

SUBJECT: OIG Draft Report: *Medicare Providers Did Not Always Comply With Federal Requirements When Billing for Advance Care Planning*, A-06-20-04008

The attached draft report provides the results of our audit of advance care planning services.

This draft report is subject to further review and revision. Please safeguard it against unauthorized use and disclosure. To properly consider your views concerning the facts and reasonableness of our recommendations, please provide written comments within 30 days from the date of this memo. (If you are unable to meet that timeframe, please contact us as soon as possible.) Please include the status of any action taken on our recommendations, as well as any planned action. Your comments will be summarized in the body of our final report and included as an appendix.

Section 8M of the Inspector General Act requires that OIG post its publicly available reports on the OIG website. Accordingly, the final report will be posted at <https://oig.hhs.gov>. Please send us a digitally signed electronic copy of your comments in PDF or Microsoft Word format.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Megan H. Tinker, Assistant Inspector General for Audit Services, at (202) 821-7568 or Megan.Tinker@oig.hhs.gov. Please refer to report number A-06-20-04008 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PROVIDERS DID NOT ALWAYS COMPLY WITH FEDERAL REQUIREMENTS WHEN BILLING FOR ADVANCE CARE PLANNING

NOTICE – THIS DRAFT RESTRICTED TO OFFICIAL USE

This document is a draft report of the Office of Inspector General and is subject to revision; therefore, recipients of this draft should not disclose its contents for purposes other than for official review and comment under any circumstances. This draft and all copies thereof remain the property of, and must be returned on demand to, the Office of Inspector General.



**Amy J. Frontz Deputy
Inspector General
for Audit Services**

**August 2022
A-06-20-04008**

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Report in Brief - DRAFT

Date: August 2022

Report No. A-06-20-04008

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Advance care planning (ACP) is a service consisting of a face-to-face discussion between Medicare physicians or other qualified health care professionals and patients to discuss their health care wishes if they become unable to make decisions about their care. Effective January 1, 2016, Medicare began paying for ACP services. Payments for ACP provided from 2016 through 2019 totaled more than \$340 million. Payments for services provided in an office setting represented 61 percent of all payments.

Our objective was to determine whether Medicare providers who received payments for ACP services in an office setting complied with Federal requirements.

How OIG Did This Audit

Our audit covered 873,381 beneficiaries associated with claims for ACP services (CPT codes 99497 and 99498) in an office setting during calendar year 2019 (audit period) with a total paid amount of \$70.1 million. We selected for review a stratified random sample of 125 beneficiaries. We reviewed all 691 paid ACP services for the 125 beneficiaries selected for our sample.

Medicare Providers Did Not Always Comply With Federal Requirements When Billing for Advance Care Planning

What OIG Found

Medicare providers that billed for ACP services in an office setting did not always comply with Federal requirements. Specifically, Of the 691 ACP services associated with our sample, Medicare providers complied with Federal requirements for 225 services totaling \$15,874. However, providers did not comply with Federal requirements for 466 services totaling \$33,332. These services were determined to be errors because Medicare providers did not always document in the medical records that an ACP discussion occurred, nor did they document when another service was performed concurrently with a time-based service. The time associated with the concurrent service should not be included in the time used for reporting the time-based service.

On the basis of our sample results, we estimated that Medicare providers in an office setting were paid approximately \$42.3 million for ACP services that did not comply with Federal requirements. These payments occurred because the providers did not understand the Federal requirements for billing ACP services.

We also identified questionable claims associated with 12 sampled beneficiaries for whom 15 or more ACP services were received. Although the billing of these ACP services did not reflect noncompliance with Medicare requirements, the billings do not align with guidance contained in CMS's Frequently Asked Questions.

What OIG Recommends

We recommend that CMS educate providers on documentation and time requirements for ACP services to comply with Federal requirements. (That is, when another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service, and time and ACP discussion must be documented. Had the requirements been followed, Medicare could have saved an estimated \$42.3 million during our audit period. In addition, CMS should instruct the MACs to recoup \$33,332 for ACP services paid in error for claims in our sample. Also, CMS should instruct the MACs, based on the results of this audit, to notify appropriate providers (i.e., those for whom CMS determines that this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence in identifying, reporting, and returning any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation. Finally, CMS should establish Medicare requirements that address the allowable frequency of ACP services and any additional documentation requirements that would apply to multiple ACP services for a single beneficiary.

The final report will be available on the OIG website.

CMS000070_0000395_0004

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Audit.....	1
Objective	1
Background.....	1
Medicare Program	1
Advance Care Planning Services	2
Federal Requirements and Other Guidance	2
Medicare Requirements for Providers To Identify and Return Overpayments	5
How We Conducted This Audit.....	5
FINDINGS.....	6
Advance Care Planning Services Did Not Comply With Federal Requirements	6
Federal Requirements	6
Providers Did Not Properly Document Advance Care Planning Services	6
Providers Submitted Questionable Claims for Advance Care Planning Services	8
RECOMMENDATIONS	8
APPENDICES	
A: Audit Scope and Methodology.....	10
B: Statistical Sampling Methodology.....	12
C: Sample Results and Estimates.....	13

INTRODUCTION

WHY WE DID THIS AUDIT

Advance care planning (ACP) is a service consisting of a face-to-face discussion between Medicare physicians or other qualified health care professionals (collectively called providers in this report) and patients to discuss their health care wishes if they become unable to make decisions about their care. Effective January 1, 2016, Medicare began paying for ACP services under the Medicare Physician Fee Schedule. ACP services may be provided in various places of service. Payments for ACP services provided from 2016 through 2019 totaled more than \$340 million. Payments for services provided in an office setting represented 61 percent of all ACP payments. In January 2018, the Comprehensive Error Rate Testing (CERT) program identified payments for ACP services that were improper due to insufficient documentation.^{1, 2, 3} The Office of Inspector General (OIG) also identified payments that were improper due to insufficient documentation in survey work performed on paid 2018 ACP claims.⁴ On the basis of this information, we conducted this audit of providers' compliance with Medicare requirements for ACP services provided in an office setting.

OBJECTIVE

Our objective was to determine whether Medicare providers who received payments for ACP services provided in an office setting complied with Federal requirements.

BACKGROUND

Medicare Program

The Medicare program, established by Title XVIII of the Social Security Act (the Act), provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Part B of the Medicare program provides supplementary insurance for

¹ The Centers for Medicare & Medicaid Services implemented the CERT program to measure improper payments in the Medicare fee-for-service program.

² *Medicare Quarterly Provider Compliance Newsletter*, CERT Finding: Advance Care Planning. Available online at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN904144.pdf>. Accessed on Jan. 11, 2022.

³ Documentation is insufficient when something is missing from the submitted medical records to support payment for the services billed. Many claims with insufficient documentation lacked clinical documentation to support that a face-to-face service that included the discussion of ACP was performed, clinical documentation of the time spent discussing ACP, or both.

⁴ Claims with an office setting produced a 50-percent error rate, and all the errors were due to lack of documentation to support the amount of time the physician spent with the beneficiary to discuss ACP.

medical and other health services, including ACP. CMS contracts with Medicare administrative contractors (MACs) to process and pay Part B claims submitted by providers. CMS provides education and guidance to Medicare providers through various methods, including Quarterly Provider Updates, Change Requests, Medicare Learning Network Matters Articles, and on its website.

Advance Care Planning Services

ACP is a service consisting of a face-to-face discussion between Medicare providers and patients to discuss the patients' health care wishes if they become unable to make decisions about their care. Medicare beneficiaries may request ACP services at no cost to them as part of the Annual Wellness Visit available to Medicare beneficiaries. However, when a beneficiary elects to receive ACP services separate from the Annual Wellness Visit, a provider should notify the beneficiary that Part B coinsurance will apply, as it does for other providers' services. Because the services are voluntary, Medicare beneficiaries may decline to receive ACP services.⁵

Federal Requirements and Other Guidance

Federal Requirements

Under section 1833(e) of the Act (42 U.S.C. § 1395(e)), the Department of Health and Human Services may deny payment to any provider of services or other person unless there is furnished such information as may be necessary to determine the amounts due to any provider or other person.

Providers' services are covered and paid by Medicare in accordance with section 1862(a)(1)(A) of the Act, which states that no payment may be made for any expenses incurred for items and services unless such items or services are reasonable and necessary for the diagnosis or treatment of illness or injury. Providers report Current Procedural Terminology (CPT) code(s)⁶ when they provide services that are reasonable and necessary for the diagnosis or treatment of illnesses or injuries.^{7, 8}

⁵ 80 Fed. Reg. 70886, 70956 (Nov. 16, 2015).

⁶ The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT), copyright 2018 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this document should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

⁷ 80 Fed. Reg. 70955 (Nov. 16, 2015).

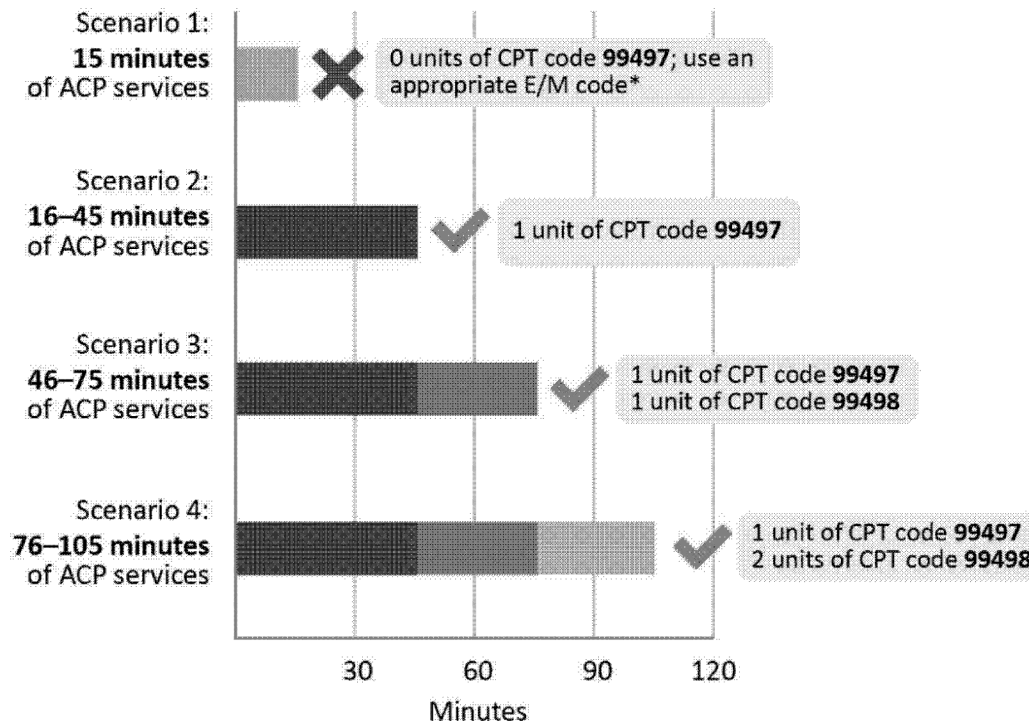
⁸ 45 CFR § 162.1002(c)(1).

CMS adopted CPT codes 99497 and 99498 for ACP services and CPT provisions regarding the reporting of timed services.⁹ CPT code 99497 covers the first 30 minutes of ACP, which includes a face-to-face explanation and discussion of advance directives, such as standard forms, between the provider and the patient, family member(s) or a surrogate, or both. CPT code 99498 should be used for each additional 30 minutes and listed separately in addition to code 99497.

Medicare Coverage for Advance Care Planning Services

According to the *American Medical Association CPT 2018 Professional* (CPT codebook), a unit of time is billable when the midpoint of the allowable unit of time is passed. Thus, to bill code 99497, which is a code for 30 minutes, the provider must have at least 16 minutes of face-to-face time with the patient discussing ACP services. Any ACP discussion of 15 minutes or less should not be billed as ACP services. A provider may use the 99498-add-on code once the visit reaches 46 minutes. When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based services. See the Figure (next page) for an explanation on how to bill ACP services according to the amount of time spent providing ACP services.

⁹ 80 Fed. Reg. 70956 (Nov. 16, 2015).

Figure: Advance Care Planning Minutes and Corresponding CPT Codes and Units

*E/M = evaluation and management.¹⁰

Medicare Guidance on Advance Care Planning Services

According to CMS frequently asked questions (FAQs)¹¹ on what a provider must document to be paid for ACP services, examples of appropriate documentation would include an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter, documentation indicating the explanation of advance directives, who was present, and the time spent in the face-to-face encounter.¹² Providers should follow CPT provisions regarding the minimum time required to report timed services. If the required minimum time is not spent with the beneficiary, family member or surrogate, or both, to bill

¹⁰ Evaluation and management (E/M) coding is the use of CPT codes from the range 99202-99499 to represent services provided by a provider. As the name E/M indicates, these medical codes apply to visits and services that involve evaluating and managing patient health.

¹¹ CMS, Frequently Asked Questions about Billing the Physician Fee Schedule for Advanced Care Planning services, July 14, 2016. Available online at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf>. Accessed on Jan. 6, 2022.

¹² We did not question ACP services based on CMS FAQs but presented information from the FAQs here to provide more details on what CMS would expect from providers that bill for ACP services.

CPT codes 99497 or 99498, the provider may consider billing a different E/M service, such as an office visit, provided the requirements for billing the other E/M service are met.^{13, 14}

CMS does not place limits on the number of times ACP services may be reported for a beneficiary. When the service is billed multiple times for a beneficiary, CMS would expect a documented change in the beneficiary's health status, end-of-life care wishes, or both.¹⁵

Medicare Requirements for Providers To Identify and Return Overpayments

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.¹⁶

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.¹⁷

HOW WE CONDUCTED THIS AUDIT

Our audit covered 873,381 beneficiaries associated with claims for ACP services (CPT codes 99497 and 99498) in an office setting during calendar year 2019 (audit period) with a total paid amount of \$70,059,745.

We selected for review a stratified random sample of 125 beneficiaries. From all beneficiaries who received fewer than 15 ACP services during our audit period, we randomly selected for

¹³ CMS, Frequently Asked Questions about Billing the Physician Fee Schedule for Advanced Care Planning services, July 14, 2016. Available online at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf>. Question #1. Accessed on Jan. 6, 2022.

¹⁴ The required minimum time is 16 minutes based on code 99497 being for a 30-minute service.

¹⁵ CMS, Frequently Asked Questions about Billing the Physician Fee Schedule for Advanced Care Planning services, July 14, 2016. Available online at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf>. Question #2. Accessed on Jan. 6, 2022.

¹⁶ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

¹⁷ 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. 7670.

review 100 beneficiaries, who received a total of 137 ACP services. We also selected for review the remaining 25 beneficiaries, who received 15 or more ACP services during our audit period, totaling 554 ACP services. We reviewed all 691 paid ACP services for the 125 beneficiaries selected for our sample.¹⁸ We requested from providers the medical records to support the paid ACP services and reviewed them for documentation supporting the ACP face-to-face discussion with beneficiaries and the time providers spent talking to the beneficiaries about ACP.

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 A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

ADVANCE CARE PLANNING SERVICES DID NOT COMPLY WITH FEDERAL REQUIREMENTS

Federal Requirements

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act § 1833(e)). CPT codes 99497 and 99498 are time-based codes. The provider must have at least 16 minutes of face-to-face time with the patient discussing ACP services to bill code 99497 and at least 46 minutes discussing ACP services to bill code 99498. When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service.^{19, 20}

Providers Did Not Properly Document Advance Care Planning Services

Of the 691 ACP services associated with our sample, Medicare providers complied with Federal requirements for 225 services totaling \$15,874. However, providers did not comply with Federal requirements for 466 services totaling \$33,332. Specifically, we found that:

¹⁸ The 691 services were performed by 108 providers.

¹⁹ 80 Fed. Reg. 70956 (Nov. 16, 2015).

²⁰ *AMA CPT 2018 Professional*, page xvi.

- For 268 services associated with payments totaling \$18,912, the provider documented the ACP service but did not distinguish between time spent face-to-face with the beneficiary discussing ACP and time spent on concurrent services. For example, the patient notes for one beneficiary said that the patient has a living will in place and is to remain full code and that her husband will become the primary medical decision-maker should the patient become incapacitated.²¹ The notes go on to say: “We have spent 35 minutes in obtaining interval history and performing clinical exam. We have reviewed her medications, allergies, and ROS.”²² We have reviewed her medications and she continues her current meds. Her recent eye exam was good and her xerophthalmia has been controlled. We have reviewed her advanced directives and performed medication reconciliation.”²³ According to the provider’s documentation, the entire visit lasted 35 minutes. The documentation does not specify what portion of the 35 minutes was spent discussing ACP.
- For 174 services associated with payments totaling \$12,672, providers did not document in the medical records that an ACP discussion occurred, nor did they distinguish between time spent face-to-face with the beneficiary discussing ACP and time spent on concurrent services.
- For 24 services associated with payments totaling \$1,748, we were unable to obtain any medical records from the provider.

Some providers told us that they did not comply with Federal requirements because they did not know that the time for ACP services had to be distinguished between time spent discussing ACP and time spent on concurrent services or because they were unaware there was a time requirement. Additionally, some providers stated that ACP services should not have been billed.

Table 1 shows a summary of the claims that did not comply with Federal requirements.

²¹ Full code means that if a person’s heart stops beating or the person stops breathing, or both, all resuscitation procedures will be provided to keep the person alive. This process can include chest compressions, intubation, and defibrillation and is referred to as “CPR.”

²² ROS stands for “Review of Systems” and is an inventory of the body systems that is obtained through a series of questions used to identify signs or symptoms that the patient may be experiencing.

²³ Medication reconciliation is the process of ensuring that a patient’s medication list is as up-to-date as possible.

Table 1: Summary of Claims That Did Not Comply With Federal Requirements

Requirements Not Met	Number of Services	Total Paid for Non-compliant Services
Time Not Documented	268	\$18,912
ACP Discussion and Time Not Documented	174	12,672
Medical Records Not Submitted by the Provider	24	1,748
Total Services With Errors	466	\$33,332

On the basis of our sample results, we estimated that Medicare providers in an office setting were paid approximately \$42.3 million for ACP services that did not comply with Federal requirements from January 1 through December 31, 2019.²⁴

Providers Submitted Questionable Claims for Advance Care Planning Services

Providers submitted questionable claims for ACP services associated with 12 sampled beneficiaries for whom 15 or more ACP services were received during our 12-month audit period. Although the billing of these ACP services did not reflect noncompliance with Medicare requirements, the billings do not align with CMS's guidance contained in an FAQ. The FAQ states that when ACP services are billed multiple times for a beneficiary, CMS would expect a documented change in the beneficiary's health status, end-of-life care wishes, or both. The providers' medical records that we received did not mention a change in the beneficiaries' health status or wishes for end-of-life care. For example, for one beneficiary in our sample, CPT code 99497 was billed on 22 dates of service by one provider during 2019. All of the appointments on these days were for followup or medication refills, and no documentation supporting that a change in the beneficiary's health status or wishes for end-of-life care had changed between any of these 22 dates of service was included in the medical records submitted to us by the provider.

CMS did not have Medicare requirements that address when it is appropriate to provide ACP services multiple times to a single beneficiary and how these services should be documented. Without these requirements, Medicare may continue to make questionable payments.

RECOMMENDATIONS

We recommend the following:

- The Centers for Medicare & Medicaid Services should educate providers on documentation and time requirements for ACP services to comply with Federal

²⁴ The estimated improper Medicare payment amount was \$42,266,931.

requirements. (That is, when another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service, and time and ACP discussion must be documented). Had the requirements been followed, Medicare could have saved an estimated \$42,266,931 during our audit period.

- The Centers for Medicare & Medicaid Services should instruct the MACs to recoup \$33,332 for ACP services paid in error for claims in our sample.
- The Centers for Medicare & Medicaid Services should instruct the MACs, based on the results of this audit, to notify appropriate providers (i.e., those for whom CMS determines that this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence in identifying, reporting, and returning any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.
- The Centers for Medicare & Medicaid Services should establish Medicare requirements that address the allowable frequency of ACP services and any additional documentation requirements that would apply to multiple ACP services for a single beneficiary.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicare Part B payments for ACP services provided from January 1 through December 31, 2019. Our sampling frame consisted of 873,381 beneficiaries who received ACP services in an office setting. Payments for these services totaled \$70,059,745. We selected a stratified random sample of 125 beneficiaries. From the 873,356 beneficiaries who received fewer than 15 ACP services during our audit period, we randomly selected for review 100 beneficiaries. We also selected for review all of the 25 remaining beneficiaries in our sampling frame who received 15 or more ACP services during our audit period. We reviewed all 691 paid ACP services for the 125 beneficiaries during our audit period, totaling \$49,206.

We did not audit CMS's overall internal control structure. Rather, we reviewed only those internal controls related to our audit objective. Specifically, we reviewed the CMS communication to providers on billing for ACP services. We also consulted CMS officials to verify that we understood requirements related to billing for ACP services.

We conducted our audit from June 2020 through June 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- obtained an understanding of the Medicare requirements related to ACP services;
- obtained from CMS's Integrated Data Repository the paid Medicare Part B claims for ACP services performed in an office setting during our audit period;
- created a sampling frame of 873,381 beneficiaries who received ACP services in an office setting and selected a stratified random sample of 125 beneficiaries (Appendix B);
- obtained from Medicare providers medical records to support paid ACP services and reviewed them to determine whether ACP services complied with Medicare requirements;
- contacted providers to discuss ACP services determined to be noncompliant with Medicare requirements;
- estimated overpayments to Medicare providers for ACP services that did not comply with Medicare requirements; and

- met with CMS officials to discuss the results of this audit.

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: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 873,381 beneficiaries with ACP claim payments totaling \$70,059,745 for ACP services rendered in an office setting during our audit period (January 1 through December 31, 2019). The sampling frame included non-railroad claim lines for ACP services for which a payment of \$20 or more was made from the Medicare Trust Fund.

SAMPLE UNIT

The sample unit was a beneficiary.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample based on the number of ACP services each beneficiary received. One stratum included all beneficiaries who received 15 or more ACP services during our audit period.

Stratum	ACP Services per Beneficiary	Number of Beneficiaries	Frame Dollar Amount	Sample Size
1	1	842,181	\$65,075,066	70
2	2 to 14	31,175	4,945,602	30
3	15 or more	25	39,077	25
	Total	873,381	\$70,059,745	125

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE UNITS

We sorted each stratum by descending order of the number of ACP services and then by ascending HIC number. Then we consecutively numbered the items in each stratum of the sampling frame. We generated random numbers for each stratum and then selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of unallowable Medicare payments for ACP services. We calculated a point estimate and a two-sided 90-percent confidence interval for this estimate.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	ACP Services Per Beneficiary	Number of Beneficiaries	Frame Dollar Amount	Sample Size	Value of Sample	Value of Unallowable ACP Services
1	1	842,181	\$65,075,066	70	\$5,489	\$3,290
2	2 to 14	31,175	4,945,602	30	4,640	2,560
3	15 or more	25	39,077	25	39,077	27,482
	Total	873,381	\$70,059,745	125	\$49,206	\$33,332

Estimated Value of Unallowable ACP Services in the Sampling Frame
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$42,266,931
Lower limit	35,692,512
Upper limit	48,841,351