

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AN ESTIMATED 87 PERCENT
OF INPATIENT PSYCHIATRIC
FACILITY CLAIMS
WITH OUTLIER PAYMENTS
DID NOT MEET MEDICARE'S
MEDICAL NECESSITY OR
DOCUMENTATION REQUIREMENTS**

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Office of Inspector General

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Report in Brief

Date: April 2020

Report No. A-01-16-00508

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



Why OIG Did This Audit

Under the inpatient psychiatric facility (IPF) prospective payment system (PPS), Medicare pays IPFs a standard per diem rate for inpatient services, modified for patient- and facility-level characteristics and length of stay. In addition, the IPF PPS includes an outlier payment policy that makes an additional payment in cases with unusually high costs to limit financial losses to IPFs.

For this audit, we focused on claims that resulted in outlier payments because the number of those claims increased by 28 percent from fiscal year (FY) 2014 to FY 2015, and total Medicare payments for those claims (including the outlier payment portion) increased from \$450 million to \$534 million (19 percent).

Our objective was to determine whether IPFs complied with Medicare coverage, payment, and participation requirements for services provided in FYs 2014 and 2015 that resulted in outlier payments.

How OIG Did This Audit

Our audit covered 36,120 inpatient claims with nearly \$1 billion in total Medicare payments. We reviewed a stratified random sample of 160 claims. We obtained medical and billing records from IPFs in our sample. Both OIG and a qualified medical review contractor reviewed the records. In addition, we interviewed officials at the Centers for Medicare & Medicaid Services (CMS), a Medicare administrative contractor, and a subset of the IPFs in our sample.

An Estimated 87 Percent of Inpatient Psychiatric Facility Claims With Outlier Payments Did Not Meet Medicare's Medical Necessity or Documentation Requirements

What OIG Found

For our 160 sampled claims, we found that CMS paid 25 claims that did not meet Medicare medical necessity requirements for some or all days of the stay. Based on our sample results, we estimated that Medicare overpaid IPFs \$93 million for FYs 2014 and 2015 for stays that were noncovered or partially noncovered and resulted in outlier payments. However, if the patients had been treated in different settings, Medicare might have covered those treatments. In addition, 142 claims had missing or inadequate medical record elements, including physician certifications. Of those 142 medical records, 12 did not clearly support that the IPF had protected the patient's right to make informed decisions regarding care. We estimated that 87 percent of IPF claims for FYs 2014 and 2015 with outlier payments did not meet Medicare medical necessity or medical record requirements. CMS oversight activities were not adequate to prevent or detect the IPFs' errors.

Finally, we identified three additional areas of concern: (1) outlier payments may have been made for stays that were not unusually costly, (2) beneficiaries used lifetime reserve days to help pay for days when they no longer required inpatient hospitalization but for the unavailability of appropriate posthospitalization placements, and (3) CMS did not track patient falls or fall rates at IPFs.

What OIG Recommends and CMS's Comments

We made seven recommendations to CMS. Although our audit covered only IPF inpatient claims that resulted in outlier payments, our recommendations are relevant to nonoutlier claims. CMS concurred with our recommendations to (1) increase the number of postpayment reviews to provide more feedback to IPFs, (2) promulgate regulations on the patient's right to make informed decisions regarding care, (3) study the accuracy of the outlier payment methodology, and (4) consider tracking patient falls or fall rates.

CMS did not concur with our recommendations to research whether the physician certification requirements are useful in preventing inappropriate payments and then take appropriate followup action. Nor did CMS concur with our recommendation that, in the interim, CMS require certifications to be in a specific format to aid in auditing. Finally, CMS did not concur with our recommendation to study the lifetime reserve day issue. After considering CMS's comments, we stand by our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Under the prospective payment system (PPS) for inpatient psychiatric facilities (IPFs), Medicare covers medically necessary inpatient psychiatric stays as defined by Medicare's coverage requirements. The IPF PPS pays facilities a standard per diem rate, modified for patient- and facility-level characteristics and length of stay. In addition to the per-diem-based payment, the IPF PPS has an outlier payment policy for cases with unusually high costs. IPFs are required to maintain specific types of medical records for services provided to Medicare beneficiaries during all inpatient stays, whether or not an outlier payment is made. The Office of Inspector General (OIG) has conducted several previous audits that focused on specific requirements of the IPF PPS.¹ For this current audit, we focus on claims that resulted in outlier payments because the number of those claims increased by 28 percent from fiscal year (FY) 2014 to FY 2015, and total Medicare payments for those claims (including the outlier payment portion) increased from \$450 million to \$534 million (19 percent).

OBJECTIVE

Our objective was to determine whether IPFs complied with Medicare coverage, payment, and participation requirements for services provided in FYs 2014 and 2015 that resulted in outlier payments.

BACKGROUND

Inpatient Psychiatric Facilities

IPFs that are certified as psychiatric hospitals under Medicare may be either freestanding hospitals or "distinct part" units of acute-care or critical-access hospitals.² IPFs are primarily engaged in providing psychiatric services under the supervision of a psychiatrist for the diagnosis or treatment of mental illness, including drug- and alcohol-related issues.³

¹ For example, in 2008 we issued a report on whether claims processed by one Medicare contractor resulted in overpayments to hospital-based IPFs as a result of incorrect coding on claims for beneficiaries who had been admitted to the IPF on discharge from the acute-care section of the same hospital (available online at <https://oig.hhs.gov/oas/reports/region1/10700519.htm>). Our current report does not include a list of related reports because our prior work did not look specifically at outlier payments to IPFs.

² One difference between freestanding and distinct part IPFs is that Medicare beneficiaries have a lifetime limit of 190 covered days in freestanding psychiatric hospitals. This limit was put in place to prevent Medicare from paying for long-term custodial care costs.

³ Medicare beneficiaries may also receive inpatient treatment for psychiatric illnesses at acute-care hospitals covered by the inpatient PPS (IPPS). In those cases, payment would be made under the IPPS, not the IPF PPS. The

Medicare Requirements

Medical Necessity

For Medicare to cover inpatient services provided by IPFs, the admission must be medically necessary for diagnostic study or for treatment that can reasonably be expected to improve the patient's condition.⁴ Custodial care is not covered by Medicare. Custodial care in the context of an IPF entails services provided to a patient (1) that do not include any inpatient psychiatric services that could reasonably be expected to improve the patient's condition or (2) for diagnostic study (42 CFR § 424.14(c)(1)). For example, medical supervision of a patient may be necessary to ensure the early detection of significant changes in his or her condition, but there is not a specific program of therapy designed to effect improvement of his or her condition.⁵

Physician Certification and Recertification

As a condition of payment under the IPF PPS, Medicare requires physician certification and recertification⁶ of the medical necessity of an inpatient stay.⁷ The purpose of the certification requirements is to help ensure that Medicare pays only for covered stays (42 CFR § 424.14(a)). (See page 9.) Upon admission, or as soon as practicable thereafter, the physician must certify that the inpatient admission is medically necessary for either diagnostic study or treatment that could reasonably be expected to improve the patient's condition.

As of the 12th day of a hospitalization, and no less frequently than every 30 days thereafter, the physician must recertify the stay. The requirements for the recertification are different from those for the initial certification. In the recertification, the physician must state that:

- the inpatient psychiatric services furnished since the previous certification or recertification were, and continue to be, medically necessary for either diagnostic study or for treatment that could reasonably be expected to improve the patient's condition;

190-day lifetime limit on inpatient stays at freestanding psychiatric hospitals does not apply to acute-care hospitals.

⁴ Medicare pays only for items and services that are reasonable and necessary for diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member (the Social Security Act (the Act), § 1862(a)(1)(A)).

⁵ CMS Pub. 100-02, *Medicare Benefit Policy Manual*, chapter 2, § 30.2.2.1 (Rev. 59, eff. 01-01-2005).

⁶ In this report, the term "certification requirements" refers to both initial certification requirements and recertification requirements, except where otherwise specified.

⁷ The Act § 1814(a)(2)(A) and 42 CFR § 424.14.

- the IPF records indicate that the services furnished were one of the following: admission and related services necessary for diagnostic study, intensive treatment services, or equivalent services; and
- the patient continues to need daily active treatment either furnished directly by or requiring the supervision of IPF personnel.

The Centers for Medicare & Medicaid Services (CMS) does not require any specific form, format, or language for a certification or recertification, as long as the medical record demonstrates the required content with entries signed by the physician.⁸

Other Documentation Requirements

As a Medicare condition of participation, IPFs have special medical record-keeping requirements.⁹ IPFs must maintain documentation that permits the determination of the intensity and level of treatment provided. The medical record must include a psychiatric evaluation completed within 60 hours of admission, an individualized treatment plan and updates, multidisciplinary progress notes oriented to the treatment plan, and a discharge summary. Appendix B contains details of the medical records requirements.

Protection and Promotion of Patients' Rights

The Medicare conditions of participation require hospitals to protect and promote each patient's rights. This includes the right of the patient or his or her representative (as allowed under State law) to make informed decisions regarding care (42 CFR § 482.13). (See Appendix E for an excerpt.) For noncompliance with conditions of participation, there are enforcement options open to CMS. For example, a hospital may be required to submit an acceptable corrective action plan but continue to be reimbursed for claims. However, hospitals can also face revocation of billing privileges and enrollment in the Medicare program for not meeting the health and safety standards contained in the Medicare conditions of participation. Accordingly, failure to protect each patient's rights, including the right to make informed decisions regarding care, could have a variety of repercussions for hospitals.

⁸ CMS Pub. 100-01, *Medicare General Information, Eligibility, and Entitlement Manual* (the manual), chapter 4, § 10.9 (Rev. 98, eff. 08-15-2016). CMS issued Transmittal 98/Change Request 9522 on May 13, 2016, to clarify the certification and recertification requirements and direct Medicare contractors to cease denials of IPF claims for failure to certify or recertify treatment based on the absence of specific words, procedures, or forms. CMS amended the *Medicare General Information, Eligibility, and Entitlement Manual*, chapter 4, § 10.9, accordingly. We used section 10.9 as revised in 2016 as part of our criteria for reviewing FYs 2014 and 2015 physician certifications and recertifications because CMS stated that the manual changes were effective as of the date of service, unless otherwise specified.

⁹ 42 CFR § 482.61.

Inpatient Psychiatric Facility Prospective Payment System

In the IPF PPS, which was implemented in 2005,¹⁰ Medicare determines payments to IPFs by adjusting a per-diem-base rate (updated annually) in response to patient- and facility-level characteristics and to the length of stay. The adjusted per-diem-based payment is intended to cover all routine, ancillary, and capital-related costs that IPFs are expected to incur in providing inpatient psychiatric care.¹¹ Patient-level adjustments include those relating to the patient's age, diagnosis, and certain comorbidities. Facility-level adjustments include those related to the IPF's geographic location and whether it is a teaching hospital or has a qualified emergency department. The length-of-stay adjustment increases the per diem for the first days of the stay to account for administrative and ancillary costs that are expected to occur disproportionately during that period and then decreases the per diem amount later in the stay.

Outlier Payment Policy

The IPF PPS has an outlier payment policy intended to reimburse IPFs for unusually costly stays by including an additional reimbursement beyond the adjusted per-diem-based payment. Outlier payments promote access to IPFs for patients whose conditions require expensive care by limiting the risk of financial loss to IPFs. Outlier payments are made when the estimated total costs of a stay exceed the total adjusted per-diem-based Federal payment amount plus a fixed loss amount adjusted for facility characteristics such as geographic location. Medicare will reimburse 80 percent of the excess amount for days 1 through 9 of the stay and 60 percent of the excess amount for the remainder of the days in the stay. The lower share for days 10 and later is intended to discourage IPFs from keeping patients hospitalized longer than is medically necessary.

Beneficiary Responsibilities

Medicare beneficiaries are covered for 90 days of care per "spell of illness"¹² at IPFs and acute-care hospitals.¹³ Beneficiaries have a lifetime reserve of 60 days that they can draw on to

¹⁰ The IPF PPS was implemented pursuant to the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999.

¹¹ CMS developed the 2005 base rates through analysis of average daily costs from the most recent cost report and claims data available at that time. CMS adjusts the base rates for inflation as needed as part of the IPF PPS update process.

¹² A "spell of illness," also known as a "benefit period," begins when a beneficiary is admitted to a hospital or other qualified facility and ends when the beneficiary has spent 60 consecutive days outside of a facility (the Act § 1861(a)).

¹³ The Act § 1812.

extend a spell's coverage for up to 150 days.¹⁴ Once a lifetime reserve day is used, it is gone forever and not available for future IPF or acute-care hospital stays.

A Medicare beneficiary is responsible for paying one inpatient hospital deductible amount per spell of illness. The deductible amount was \$1,216 in calendar year (CY) 2014 and \$1,260 in CY 2015.

Medicare beneficiaries are also responsible for coinsurance payments when they receive inpatient services for more than 60 days during a spell of illness. The coinsurance amount per day for days 61 through 90 of a spell of illness is equal to one-fourth of the inpatient deductible and was \$304 for CY 2014 and \$315 for CY 2015. The coinsurance amount per day for days 91 through 150 (lifetime reserve days) is equal to one-half of the inpatient deductible and was \$608 for CY 2014 and \$630 for CY 2015.

Beneficiaries may obtain additional insurance ("Medigap" insurance) to assist them in paying the Medicare deductible and copay liabilities.

CMS Oversight of Inpatient Psychiatric Facilities

CMS oversees IPFs participating in Medicare and engages contractors to perform certain aspects of oversight. CMS's oversight activities are intended to both prevent and detect compliance errors.

CMS issues guidance to IPFs on how to comply with Medicare requirements. Medicare administrative contractors (MACs) also issue guidance to the IPFs whose claims they process. Such guidance is intended to improve awareness of Medicare requirements and how to fulfill them.

MACs may also provide oversight through postpayment reviews of claims. If MACs detect errors in these postpayment reviews, they correct the claims and educate the provider regarding the errors. MACs select providers¹⁵ for postpayment review through risk analysis. We confirmed with one MAC that it had not done any postpayment reviews of IPF PPS claims from FYs 2014 and 2015 because it determined that its efforts were better directed at claims from other payment systems, such as the IPPS, which pays approximately 25 times more in reimbursed dollars than the IPF PPS does.¹⁶

¹⁴ The Act § 1812.

¹⁵ In this paragraph, we use the term "provider" to mean any individual or organization that MACs may select for postpayment reviews.

¹⁶ In other words, the risk analysis focused on the fact that the total number of dollars at risk of being inappropriate payments in the IPF PPS is much lower than the total number of dollars at risk of being inappropriate payments in the IPPS.

Recovery audit contractors (RACs) also conduct postpayment reviews. In September 2017, CMS authorized RACs to begin a program of postpayment medical necessity reviews of IPF PPS claims, but CMS halted the program in September 2018. CMS officials told us that they anticipated that the program would be restarted.

CMS relies on State health agencies to determine whether providers¹⁷ comply with Medicare conditions of participation (the Act § 1864(a)). Onsite surveys are the process by which State agencies evaluate providers for compliance with the conditions of participation and recommend “Medicare/Medicaid certification” to the CMS Regional Offices.

HOW WE CONDUCTED THIS AUDIT

IPFs submitted 36,120 claims for inpatient services provided in FYs 2014 and 2015 that resulted in outlier payments and in total payments of \$956,660,476. These were the most recent complete years of claims when we began this audit. We selected for review a stratified random sample of 160 claims and obtained medical and billing records from the IPFs. A qualified medical review contractor reviewed the records to determine whether IPFs complied with Medicare coverage, payment, and participation requirements. We also reviewed the documentation to determine whether Medicare was billed correctly for the services provided by IPFs.

The objective of our audit did not require an understanding or assessment of the internal control structure at the IPFs that were associated with our sampled claims. Instead, we obtained a general understanding of CMS oversight activities over IPF compliance with Medicare requirements.

The intent of this audit was to provide CMS with information about IPFs’ compliance with Medicare requirements for CMS to consider when conducting program integrity activities to strengthen the Medicare program. Accordingly, this report contains no recommendations regarding recoveries. When IPFs performed self-reviews of their sampled claims in response to this audit and determined that those sampled claims were in error, they generally informed us that they were revising those claims.

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 objective.

Appendix A describes our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates.

¹⁷ In this paragraph, we use the term “provider” to mean any organization that a State agency may survey.

FINDINGS

IPFs did not always comply with Medicare coverage, payment, and participation requirements for inpatient services provided in FYs 2014 and 2015 that resulted in outlier payments.

For the 160 claims in our statistical sample, we found that CMS paid 25 claims that did not meet Medicare medical necessity requirements for some or all days of the stay. Medicare overpaid \$653,000 for the noncovered days. Of the remaining claims, 133 met medical necessity requirements for all days and 2 claims were canceled before we began fieldwork. On the basis of our sample results, we estimated that Medicare overpaid IPFs \$93 million for FYs 2014 and 2015 for stays that were noncovered or partially noncovered and resulted in outlier payments. We estimated that beneficiaries incurred \$10 million in deductible and coinsurance liabilities related to those claims. We recognize that, if the patients had been treated in different settings during the noncovered period, Medicare or Medicaid might have covered treatments in those different settings and the beneficiaries might have had deductibles or copayments associated with them.

In addition to the medical necessity errors mentioned above, we found that many claims did not meet other Medicare requirements. Specifically, of the 160 claims in our statistical sample, 142 claims had errors in 1 or more of the following areas:¹⁸

- for 115 claims, IPFs did not meet Medicare physician certification requirements;
- for 132 claims, IPFs did not meet Medicare medical record requirements separate from the physician certification requirements; and
- for 12 claims, IPFs may not have met Medicare requirements to protect and promote the patients' rights to make informed decisions regarding their treatment.

In total, we estimated that 87 percent of IPF claims for FYs 2014 and 2015 with outlier payments did not meet Medicare's medical necessity or documentation requirements. Although CMS could have denied the 115 claims that did not meet physician certification requirements, for the purposes of this report we have chosen not to treat those claims as overpayments if the stays were medically necessary. Similarly, we have not estimated nation-wide overpayments based on those claims.

CMS made payments for claims that did not meet Medicare requirements because CMS oversight activities were not adequate to prevent or detect the IPFs' errors.

¹⁸ The total errors in the three bullets exceed 142 because some claims have more than one type of error. Of the remaining 18 claims in our sample of 160, 16 claims did not have these types of errors and 2 claims were canceled before we began our fieldwork.

While conducting this audit, we also identified three additional areas of concern:

- outlier payments may have been triggered for stays that were not unusually costly,
- the CMS payment policy for administrative necessary days that meet inpatient coverage requirements because the beneficiary has not met his or her discharge objectives may merit reassessment, and
- CMS did not track patient falls or fall rates at IPFs.

CMS OFTEN MADE OUTLIER PAYMENTS FOR CLAIMS THAT DID NOT COMPLY WITH MEDICARE REQUIREMENTS

Some Claims Did Not Meet Medicare Medical Necessity Requirements

For an IPF stay to be covered by Medicare, the admission must be medically necessary for either diagnostic study or treatment reasonably expected to improve the patient's condition. In addition, during the stay, the patient must continue to require either inpatient diagnostic services or active inpatient psychiatric services that are reasonably expected to improve his or her condition. An inpatient IPF stay is not covered by Medicare if the patient could have been diagnosed or treated at a lower level of intensity, such as in an outpatient setting.

Of the 160 claims that we reviewed, 25 did not meet Medicare medical necessity requirements for all or part of the stay. Seven of these claims related to stays that were not covered in their entirety. These consisted of six stays in which the patients' conditions could have been treated at a lower level of intensity and one stay in which there was no reasonable expectation for improvement through inpatient psychiatric treatment because the patient was in the final stages of Alzheimer's disease.¹⁹ The remaining 18 stays met Medicare medical necessity requirements at the beginning of the period, but at some point during the stay, the patient stopped receiving diagnostic services or active treatment reasonably expected to improve their condition.

Medicare overpaid \$653,000 for the noncovered days in our sample. On the basis of our sample results, we estimated that Medicare overpaid IPFs \$93 million for FYs 2014 and 2015 for stays that were noncovered or partially noncovered and resulted in outlier payments. This was 9.7 percent of total payments for claims with an outlier payment. In addition, beneficiaries incurred \$118,000 in deductible and coinsurance costs related to the noncovered days in our sample. On the basis of our sample results, we estimated that for FYs 2014 and 2015,

¹⁹ The patient's physicians recommended palliative care and hospice to the patient's family several times. Our medical reviewer agreed that hospice would have been an appropriate level of care for this patient during the period of the IPF stay. The patient was discharged to an acute-care hospital for treatment after multiple episodes of hypotension.

beneficiaries incurred \$10 million in deductible and coinsurance costs related to noncovered days. However, we recognize that, had the patients been treated in different settings during the noncovered period, Medicare or Medicaid might have covered those treatments and the beneficiaries might have had deductibles or coinsurance associated with those treatments.

Most Claims Did Not Meet Medicare Physician Certification Requirements

To be covered by Medicare, an inpatient IPF stay must be medically necessary, as documented by the medical record. Additionally, the Act and related Federal regulations require as a Medicare condition of payment that a physician certify and recertify the medical necessity of the IPF inpatient stay. Medical necessity and the certification and recertification of medical necessity are two separate requirements. Federal regulations (42 CFR § 424.14(a)) explain the reason for the IPF-specific physician certification requirements:

Certification begins with the order for inpatient admission. The [IPF certification] content requirements differ from those for other hospitals because the care furnished in inpatient psychiatric facilities is often purely custodial and thus not covered under Medicare. The purpose of the [IPF certification] statements, therefore, is to help ensure that Medicare pays only for services of the type appropriate for Medicare coverage. Accordingly, Medicare Part A pays for inpatient services in an inpatient psychiatric facility only if a physician certifies and recertifies the need for services consistent with the requirements of this section, as appropriate. [Emphasis added.]

Section 1814 of the Act (codified at U.S.C. 1395f) states that Medicare may not make payment for inpatient psychiatric hospital services unless a physician certifies (and recertifies where such services are furnished over a period of time) that “such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or should reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes.” Section 1814 also states that the frequency of physician recertifications and accompanying “supporting material, appropriate to the case involved,” may be provided by regulations.²⁰

Federal regulations (42 CFR §§ 424.14(c)-(d)) specify the required timing and content of the physician recertifications. Recertifications must be done as of the 12th day of a stay and no less frequently than every 30 days thereafter. Those regulations require that in a recertification, the physician must state that:

²⁰ The Act specifically requires that the first recertification must occur not later than the 20th day of services.

1. inpatient services furnished since the previous certification or recertification were, and continue to be, required:
 - i. for treatment that could reasonably be expected to improve the patient's condition or
 - ii. for diagnostic study; and
2. the hospital records show that the services furnished were:
 - i. intensive treatment services,
 - ii. admission and related services necessary for diagnostic study, or
 - iii. equivalent services; and
3. the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel.

CMS clarified in 2016 guidance that IPFs are not required to use any specific form, format, or language for a certification or recertification, as long as medical record entries include the required content and are signed by the physician. (See footnote 8.)

Of the 160 claims in our sample, 115 had missing or inadequate physician certifications or recertifications. In keeping with CMS's guidance, we did not require a specific form or specific language or that the required contents be found in one location. For example, if the physician's signed admission order and signed psychiatric evaluation at admission included all the required content, we counted them together as a valid initial certification. When we could not find a certification or recertification, we asked the IPF to identify it and then reviewed the documents to which we were directed. Sometimes IPFs directed us to review a large volume of information. For example, one IPF directed us to review 5 documents totaling 23 pages to find the initial physician certification and 8 documents totaling 75 pages for the day 12 physician recertification. In that case, we determined that neither set of pages included the required certification or recertification.

Of the 115 claims with missing or inadequate certifications or recertifications, 93 met Medicare medical necessity requirements for the entire stay and 22 did not.²¹ Within our sample, claims that met certification requirements were 12 percent more likely also to meet medical necessity

²¹ As detailed in the previous finding, we determined that 25 claims did not meet medical necessity requirements for all or some of the days in the stay. Of those 25 claims, 22 had missing or inadequate certifications or recertifications and 3 had certifications and recertifications with the required contents.

requirements.²² Although this result is suggestive of the value of certification requirements, we cannot rule out other potential explanations for the relationship.²³

Although CMS could have denied these 115 claims, for the purposes of this informational report we have chosen not to treat these claims as overpayments if the stays were medically necessary. Similarly, we have chosen not to estimate nation-wide overpayments from these results.

Most Claims Did Not Meet Medicare Medical Records Requirements

Conditions of participation for IPFs in general, as well as requirements for psychiatric units of hospitals to be paid under the IPF PPS, include specific medical records requirements. Among other things, the medical record must include a psychiatric evaluation completed within 60 hours of admission, an individualized treatment plan and updates, multidisciplinary progress notes oriented to the treatment plan, and a discharge summary that recaps the hospitalization and includes recommendations for followup or aftercare (42 CFR §§ 412.27 (“distinct part” units) and 482.61 (psychiatric hospitals)). These regulations were written under the authority granted by the Act to the Secretary of Health and Human Services to impose additional requirements on hospitals participating in Medicare “in the interest of the health and safety” of beneficiaries (the Act §1861(e)(9)), and they can be expected to promote care that would enhance beneficiary health and safety.

Of the 160 claims that we reviewed, 132 did not meet Medicare medical record requirements in one or more ways.²⁴ Specifically:

- In 25 claims, a physician did not complete a psychiatric evaluation within 60 hours of admission.
- In 99 claims, the individualized treatment plan was missing or inadequate. Common inadequacies were a lack of measurable goals, lack of specific treatment modalities and staff responsibilities, and lack of documentation that the supervising physician had reviewed the plan.

²² In our sample, 19 percent of claims with missing or inadequate certifications or recertifications did not meet Medicare medical necessity requirements and 7 percent of claims with adequate certifications and recertifications did not meet Medicare necessity requirements.

²³ For example, rather than the certification process preventing IPFs from filing claims for fully or partially noncovered stays, it could be that IPFs that comply with one Medicare requirement are more likely to comply with another Medicare requirement. That is, some IPFs might have more widespread success at compliance than others. The objective of our audit did not require us to determine whether certification requirements are effective in preventing inappropriate payments. CMS may be in a position to research that issue.

²⁴ The total errors in the 4 bullets exceed 132 because some claims had more than 1 type of error.

- In 53 claims, the required physician, nurse, or social worker notes were missing or inadequate. Common inadequacies were notes that did not address progress in accordance with the treatment plan and notes that were illegible and, therefore, not useful for treatment team communication. In addition, in many cases initial nursing or social worker assessments of the patient were not present in the medical record.
- In 23 claims, the discharge summary was inadequate. Common inadequacies included omission of a recap of the stay and the discharge summary not being completed or signed by the physician in time for it to be useful in the patient's followup or aftercare.

Because the medical records requirements were not met, CMS's actions to promote patient health and safety through these requirements might have been impeded and the quality of care received by the patients compromised.

Some Claims May Have Had Patients' Rights Issues

States have guardianship statutes that allow a legal representative to be appointed for a person lacking the capacity to make his or her own medical decisions. Also, States have civil commitment statutes that allow the court to order a person to be hospitalized involuntarily if he or she poses a danger to himself or herself or to others and does not have a guardian already in place to authorize hospitalization.

Medicare conditions of participation require hospitals to protect and promote each patient's rights. This includes the right of the patient or the patient's representative (as allowed under State law) to make informed decisions regarding care (42 CFR § 482.13). (See Appendix E for an excerpt.) The *State Operations Manual* (CMS Pub. 100-07), written for State agencies certifying hospitals' compliance with Medicare conditions of participation, includes extensive interpretive guidelines and survey procedures relating to, among other things, 42 CFR section 482.13. (See Appendix F for an excerpt of the *State Operations Manual*.) The survey procedures for 42 CFR section 482.13 include looking for specific hospital policies that support protection and promotion of this right and for evidence that the hospital has complied with those policies.

The interpretive guidelines describe the steps hospitals should take to determine the patient's wishes concerning designation of a representative and what to do when the patient is incapacitated and has no advance directive. (CMS allows hospitals to accept a spouse, domestic partner, or family member as the patient's representative even without an advance directive or legal guardianship, if State law permits it.) However, the interpretive guidelines and survey procedures are silent on whether a hospital is expected to have a policy addressing how it will ensure that an appropriate representative is found for each incapacitated patient, including mentally incapacitated patients.

In 12 of the 160 claims that we reviewed, the IPFs may not have protected and promoted the right of the patient or his or her representative to make informed decisions regarding care. These 12 patients were allowed to sign consents to hospitalization and treatment; however, on

the basis of the medical records, our medical reviewer questioned whether the patients had the capacity to make informed decisions. Examples include patients with dementia or psychosis who had severe symptoms described in the physicians' notes. During 3 of those 12 stays, the patients' requests to leave the IPF were ignored, although their patient status was "voluntary."²⁵

Our medical reviewer raised the question of whether the IPFs should have taken action, in compliance with Medicare guidance and State law, to identify the patients' representatives or to have the court approve involuntary treatment or appoint guardians to make medical decisions for those patients.

We discussed the matter with officials of two IPFs whose claims were among the 12 discussed in this finding. At the first IPF, the compliance officials said that because of staff turnover,²⁶ they had no further information beyond what was in the medical record, which they agreed did not support the patient's ability to make informed decisions. At the second IPF, the compliance officials pointed out that (1) a patient's mental status may change rapidly and (2) Medicare does not require a physician to document why the physician concluded that a patient had the capacity to make an informed decision to consent to admission and treatment. This IPF had considered creating its own form to document the physician's reasons for accepting a consent to hospitalization and treatment but so far had not done so.

If the 12 patients lacked the capacity to make informed decisions, then the effect of accepting their consent to hospitalization and treatment was to have the IPF take over decision-making for the patients without complying with the *State Operations Manual* guidelines and without legal authority.

OIG IDENTIFIED ADDITIONAL AREAS OF CONCERN WITH POTENTIAL FOR IMPROVEMENT

Outlier Payments May Have Been Triggered for Stays That Were Not Unusually Costly

CMS has stated that outlier payments are meant to "reduce the financial losses that would otherwise be incurred in treating patients who require more costly care and, therefore, reduce the incentives for IPFs to under-serve these patients." If the IPF outlier policy is working as intended, the unusually high costs partially reimbursed through the outlier payment should not be costs already paid for through the adjusted per-diem-based payment. (If the costs of a stay are reimbursed through the usual process, the stay cannot be unusually costly.)

²⁵ Although IPFs are not always required to release a voluntary inpatient immediately upon the patient's request, we would expect the medical record to reflect that the IPF began a determination process after a voluntary patient requested to leave. For instance, State law or the voluntary admission form signed by the patient might allow the hospital 72 hours to comply with a request for release, in which time the IPF would take steps to determine whether it was safe to release the patient or whether the IPF should start proceedings to hold the patient involuntarily.

²⁶ The compliance officials said that they were new to the facility and that the physician in question had left.

Outlier payments are made when the estimated total costs of a stay exceed the total adjusted per-diem-based payment amount plus a fixed loss amount, which is adjusted for facility characteristics, such as geographic location. Total costs are estimated in the CMS computerized claims payment system used by MACs, which multiplies total charges on the inpatient claims by the IPF's cost-to-charge ratio, as developed through the cost reporting process. Estimated total costs for a stay do not necessarily equal actual total costs for a stay.

In reviewing our sample of 160 claims, we observed many cases in which the unusually high total estimated costs did not include specific items of cost that could fully explain how the stay was unusually costly to the IPF. The clearest examples are 11 claims in which room and board represented 100 percent of charges.²⁷ Supplying room and board to an inpatient is standard and should be covered by the per diem payment. The billing and medical records did not explain how these claims were unusually costly in ways not covered by the adjusted per-diem-based payment.

However, even for claims that did have charges for services other than room and board, the charges on those claims did not support that the stays had been unusually costly to the IPFs. The magnitude of those costs seemed to be created by the estimation methodology. For example, one claim included total charges of \$3,580 for home-use glucose testing strips, at approximately \$68 per strip. When the IPF's cost-to-charge ratio of 0.349 is applied to these charges, it yields an estimated cost of \$24 per strip. A retail pharmacy's website showed that a customer could buy a box of home-use glucose strips at a cost of \$0.16 to \$2 per strip, depending on the brand and the size of the box (25 to 100 strips).²⁸ We do not know what this IPF's actual costs were for the test strips, but we believe there is reason to question the accuracy of the estimation methodology.²⁹ The fact that the ratio of an IPF's total costs to its total charges is 34.9 percent does not mean that the cost of each individual charge on a bill is 34.9 percent of the charge, or that the total cost of the items on an itemized bill is 34.9 percent of the total billed.

²⁷ "Charges" are the amounts that a hospital bills for each item or service. Hospitals determine what they will charge, subject to State law (although most States do not regulate hospital charges). CMS does not regulate the amounts that hospitals choose to charge. CMS does not require that hospitals bill for every item or service provided. CMS sometimes approves hospitals to bill an "all-inclusive rate" (AIR), specifically authorizing them to charge only for room and board and no other items or services. Even when hospitals have not been approved to bill an AIR, CMS does not specify items or services for which hospitals must charge. For example, some IPFs charged for therapeutic sessions and some did not. (These sessions were Part A services (hospital services), not Part B services (medical services).)

²⁸ We obtained this information from the retail pharmacy's website in late 2018.

²⁹ This claim also included charges of \$73 per hour for oxygen, for a total of \$19,343. Application of the IPF's cost-to-charge ratio yields an estimated cost of \$26 per hour of oxygen. Our search of the Internet did not show any oxygen available for purchase by the hour. We note that if the oxygen costs were overstated, that overstatement affected the calculation of the IPF's outlier payment.

As a result of using estimated total costs to trigger outlier payments, the IPF outlier payment policy may not limit outlier payments to unusually costly stays.³⁰

The CMS Payment Policy for Administrative Necessary Days That Meet Inpatient Coverage Requirements Because the Beneficiary Has Not Met His or Her Discharge Objectives May Merit Reassessment

For an IPF stay to be covered by Medicare, the admission and ongoing stay must be medically necessary for either diagnostic study or active treatment reasonably expected to improve the patient's condition (the Social Security Act § 1814(a)(4) and 42 CFR § 424.14(c)(3)).

During the rulemaking process implementing the IPF PPS in 2005, commenters requested that CMS provide reimbursement for the cost of "administrative necessary days for continued inpatient care when discharge is delayed due to a lack of community resources."³¹ CMS decided not to provide "additional payment" for administrative necessary days.³² In commenting on the request, CMS reiterated its discharge planning requirements and noted that if a patient cannot safely be discharged because the type of posthospitalization placement called for in his or her discharge plan is unavailable, then the patient has not met the discharge objectives and "requires continued active treatment."³³ In other words, if an IPF patient's discharge is delayed because of a lack of community resources necessary for the patient's safety, the patient still needs inpatient IPF services.

CMS reimburses IPFs at the same rate whether a patient continues to require active inpatient psychiatric treatment under the supervision of a psychiatrist or no longer requires inpatient

³⁰ Although 42 CFR § 412.424(d)(3)(i) allows MACs to perform "outlier reconciliations," that procedure addresses a problem that is unrelated to the potential problem described in this report. Sometimes, to make timely outlier payments, MACs must use an interim cost-to-charge ratio calculated from a preliminary version of the IPF's cost report. "Outlier reconciliation" is the process by which a MAC adjusts the aggregate outlier payments made to an IPF that were calculated using an interim cost-to-charge ratio that turned out to be substantially different from the finalized cost-to-charge ratio. The potential problem described in this report (overestimation of costs) is not connected to the issue of interim versus final cost-to-charge ratios and cannot be addressed through "outlier reconciliation."

³¹ *Prospective Payment System for Inpatient Psychiatric Facilities*, 69 Fed. Reg. 66922, 66952 (Nov. 15, 2004)).

³² CMS stated, "After careful review, we have decided not to provide additional payment for administrative necessary days for several reasons. Since claim data does not include coding or documentation for administrative data, we are unable to identify and discern the cost of these days. Therefore, we are unable to determine the extent to which the costs of administrative necessary days are included in the Federal per diem base payment amount. Finally, since the IPF PPS is a per diem payment methodology, we are concerned about inadvertently creating an incentive to unnecessarily delay discharge in order to receive additional payment for administrative necessary days" (69 Fed. Reg. 66922, 66952 (Nov. 15, 2004)).

³³ CMS expanded upon this in its comments on our draft report. (See page 39.)

hospitalization *but for* the unavailability of an appropriate posthospitalization placement. Further, CMS does not know the extent to which the costs of the latter are included in the Federal per diem base payment amount. (See footnote 32.) CMS’s current process may result in payments for these days that are equal to, greater than, or less than costs.

In reviewing the claims in our sample, we noted that 8 of the 160 beneficiaries had their discharges delayed because of the unavailability of the posthospitalization placements called for in their discharge plans or because they had to obtain Medicaid or disability insurance coverage to be granted such placements. Six of the eight beneficiaries had to use a total of 132 lifetime reserve days while awaiting placements or insurance coverage for such placements.³⁴

Table 1: Discharges Delayed Because Posthospitalization Placements Were Not Available

Claim	Waiting For	Total Length of Stay (IPF) (days)	Days Awaiting Placement	Lifetime Reserve Days Used While Awaiting Placement
1	Insurance coverage for own home with day program	137	8	8
2	Partial hospitalization program placement	24	10	0
3	Family care home placement	55	15	15
4	State psychiatric center placement	73	18	0
5	State psychiatric center placement	97	25	23
6	Insurance coverage for group home	103	27	27
7	Support services for own home	119	41	41
8	Insurance coverage for nursing home	73	65	18
Total			209	132

On the basis of our sample results, we estimated that beneficiaries whose claims resulted in outlier payments used between 6,496 and 28,543 lifetime reserve days³⁵ in FYs 2014 and 2015 while awaiting posthospitalization placements.

We bring this to CMS’s attention because its current payment policy may have unintended consequences. Reimbursing for days that meet IPF coverage requirements because the

³⁴ The use of lifetime reserve days in some of these stays is explained by the fact that the IPF stay is part of a longer spell of illness. Additionally, the total number of days in the delays (209) is higher than the total number of lifetime reserve days used in association with the delayed discharges (132). This difference occurs because patients do not always use a lifetime reserve day for every day in a delay. For example, a delay could begin on day 65 of a spell of illness but lifetime reserve usage on day 91.

³⁵ This range reflects the 90-percent two-sided confidence interval of our estimate.

beneficiary has not met his or her discharge objectives at the same rate as other covered days may result in Medicare paying for inpatient services (as part of the PPS rate) even though the services have been discontinued because patients no longer need them. Another possible consequence is that Medicare might pay for inpatient services (as part of the PPS rate) that patients who are awaiting placement receive but no longer need. Other consequences pertain to beneficiary responsibilities. When a stay reaches a certain length, the beneficiaries become responsible for inpatient coinsurance payments for days for which they need not have been hospitalized had an appropriate placement been available. They also may have to use lifetime reserve days. Once a lifetime reserve day is used, it is gone forever and not available for future IPF or acute-care hospital stays.

In-Hospital Falls and Fall Rates Are Not Tracked

Current law requires CMS to have an IPF Quality Reporting (IPFQR) Program, but in-hospital patient fall rates are not among the quality measures that CMS has selected as IPF quality reporting requirements. In comparison, under the IPPS, the rate of falls with major injury is tracked in the long-term-care hospital quality reporting program. Additionally, the rate of falls resulting in hip fractures is tracked in the hospital-acquired condition reporting program that covers acute-care hospitals. Also, unlike acute-care hospitals under the IPPS, IPFs are not required to code fall-related diagnoses as present or not present on admission.³⁶ Therefore, injuries related to in-hospital falls cannot be tracked through claims data. Currently, to research the occurrence of falls at IPFs, CMS and its contractors would have to do labor-intensive reviews of medical records, because falls data are not collected by other means, such as quality reporting or claims data.

While reviewing the medical records of our sampled claims for evidence regarding IPFs' compliance with Medicare coverage, payment, and participation requirements, we noted that in 25 of the 160 claims, the patients experienced falls in the IPF. Two of those patients experienced multiple falls (two and five, respectively). Most falls did not result in injury, but some did, including lacerations, swelling, and a brain hemorrhage. In 13 of the 25 claims with patient falls, the IPF followed up with one or more medical imaging scans or x-rays. According to our medical reviewer, some of the falls were likely preventable. Based on the events or conditions described in the medical records, the IPF should have implemented stronger fall prevention protocols, such as "one-to-one" observation by a patient monitor.

³⁶ Section 1886(d)(4)(D) of the Act allows CMS to adjust Medicare payments to acute-care hospitals under the IPPS to encourage prevention of hospital-acquired conditions (HACs). HAC reporting requirements do not apply to IPFs under the IPF PPS. Under the acute-care IPPS, if coded as present on admission (POA), certain complication or comorbidity codes result in a higher DRG-based payment to IPPS hospitals. If the complication or comorbidity is not coded as POA (that is, if it is acquired in the hospital), then the hospital is not paid the higher DRG-based payment. A byproduct of this HAC/POA coding requirement is that, if claims are coded correctly, in-hospital fall-related injuries can be identified by using claims data.

CONCLUSIONS

CMS made outlier payments for claims that did not comply with Medicare requirements because IPFs made errors, which the IPFs did not prevent or detect and which CMS did not prevent or detect. Given that an estimated 87 percent of IPF claims with outlier payments did not meet Medicare's medical necessity or documentation requirements, we concluded that IPFs had not previously been provided with adequate feedback on their compliance. Additional postpayment reviews could have detected errors, and the results could have been used to educate IPFs about how to prevent future errors. With respect to future reviews of physician certification requirements, CMS's current policy of not requiring a specific form, format, or language makes postpayment review more difficult. Also, review of IPFs' compliance with the requirement to protect the patient's right to informed consent was hindered by the lack of *State Operations Manual* guidance on whether a hospital is expected to have a policy addressing how it will ensure that an appropriate representative is identified for each incapacitated patient, including mentally incapacitated patients.

With respect to the three areas of concern that we identified, we think there is potential for improvement and are making recommendations to CMS for its consideration.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- increase the number of postpayment reviews of IPF claims to provide IPFs with more feedback on their compliance with Medicare requirements;
- research whether the physician certification and recertification requirements are useful in preventing inappropriate payments and:
 - if they are useful, continue to enforce them but
 - if they are not useful, take the steps necessary to eliminate or amend those requirements;
- while the certification requirements remain in place, revise regulations or guidance to IPFs to require that physician certifications and recertifications be in a specific form, format, or language;
- promulgate regulations to require that each IPF should have a policy compliant with State law to protect and promote the patient's right to make informed decisions that includes standards for documenting the patient's ability to make informed decisions;

- conduct a study to determine whether outlier payments are being made only for cases with unusually high costs, and, if not, consider designing and testing alternatives to the current outlier payment methodology;
- reassess the current CMS reimbursement policy for administrative necessary days that meet inpatient coverage requirements because the beneficiary has not met his or her discharge requirements to determine payment accuracy and effects on beneficiaries; and
- determine whether patient in-hospital fall rates should be added to the IPFQR program and whether CMS should require present-on-admission indicators on claims as an aid to tracking in-hospital falls.

Although our audit covered only IPF inpatient claims that resulted in outlier payments, our recommendations are relevant to nonoutlier claims as well.³⁷

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with four of the seven recommendations we made and described steps it has taken or plans to take in response to those recommendations. Specifically, CMS concurred with our recommendations to increase the number of postpayment reviews, issue regulations on the patient’s right to make informed decisions, study the accuracy of the current outlier payment methodology, and determine whether patient in-hospital falls should be added to the IPFQR program and whether CMS should require present-on-admission indicators on claims as an aid to tracking in-hospital falls.

We summarize CMS’s nonconcurrences and provide OIG’s responses below.

CMS’s comments, excluding technical comments that we addressed in the report as appropriate, are included as Appendix G.

PHYSICIAN CERTIFICATION AND RECERTIFICATION

CMS Comments

CMS did not concur with two of our recommendations relating to physician certifications and recertifications. First, it did not concur with our second recommendation that it research whether the physician certification and recertification requirements are useful in preventing inappropriate payments (the requirements’ stated intent), and if they are useful, continue to

³⁷ IPFs do not know in advance which claims will result in outlier payments and do not have different procedures for outlier and nonoutlier claims with respect to the areas discussed in this report. For example, an IPF would not have one set of medical record-keeping procedures for outlier claims and another for nonoutlier claims.

enforce them, but if they are not useful, take the steps necessary to eliminate or amend those requirements. CMS stated that the physician certification and recertification requirements are statutory and that its regulations are in line with the statute. CMS also stated, “Absent a legislative change, CMS will continue to require physician certification and recertification for inpatient psychiatric facility stays.”

Second, CMS did not concur with our recommendation that, while the certification and recertification requirements remain in place, CMS revise its regulations or guidance to IPFs to require that those certifications be in a specific form, format, or language. In its comments, CMS did not state a rationale for its nonconurrence but indicated that it had recently updated its policy guidance, which states that no specific certification forms or procedures are required.

OIG Response

We stand by our recommendation that CMS research whether the physician certification and recertification requirements are useful in preventing inappropriate payments and, if they are useful, continue to enforce them, but if they are not useful, take the steps necessary to eliminate or amend those requirements. We found that only 45 out of the 160 claims in our sample included certification and recertifications that met CMS requirements. The implications of this high non-compliance rate depend on the relationship between the certifications and the medical necessity of the underlying claims. If, after researching this relationship, CMS believes the benefit to the program does not justify the statutory requirement, CMS could submit a legislative proposal to the Secretary of Health and Human Services for possible inclusion in the next set of departmental legislative proposals sent to the Office of Management and Budget as part of the President’s Budget process. When we used the phrase “the steps necessary” in our recommendation, we were including the legislative proposal process.

We also stand by our recommendation that, while the certification and recertification requirements remain in place, CMS require a specific form, format, or language for those certifications. Compliance would be made more straightforward if CMS mandates that certification statements must contain language specific either to the reasonable expectation of improvement or to the necessity of inpatient diagnostic study. Many IPFs requested that we infer physician certifications or recertifications from the admission order, diagnosis, and progress notes. However, frequently there was no language in the record that conveyed the physician’s intent to certify that the care was anything other than custodial. Documentation that would support a certification cannot take the place of the certification. Given that the stated purpose of the certifications is “to help ensure that Medicare pays only for services of the type appropriate for Medicare coverage,” then the certification should be plainly stated rather than implied.

CMS PAYMENT POLICY FOR ADMINISTRATIVE NECESSARY DAYS THAT MEET INPATIENT COVERAGE REQUIREMENTS BECAUSE THE BENEFICIARY HAS NOT MET HIS OR HER DISCHARGE OBJECTIVES

CMS Comments

CMS did not concur with our recommendation that it reassess its current reimbursement policy for administrative necessary days to determine payment accuracy and effects on beneficiaries. In its response, CMS stated that “[t]ypically, administrative necessary days are when an inpatient of a hospital setting is clinically ready for discharge but an appropriate post-hospital setting placement is not available.” CMS also stated that it “does not have an administrative necessary days policy under the [IPF PPS] to provide payment for days that do not meet an active level of treatment.”

However, CMS went on to acknowledge the guidance it gave in response to a comment in the *Medicare Program Prospective Payment System for Inpatient Psychiatric Facilities Final Rule* for CY 2005 (69 Fed. Reg. 66922, 66952 (Nov. 15, 2004)):

[I]f an IPF determines that a patient needs post-hospitalization placement, then a statement to this effect is expected to be included in their discharge plan. Furthermore, if a patient cannot be safely discharged without this post-hospitalization placement and this placement is not available, *then the patient has not met their discharge objectives and requires continued active treatment.* [Emphasis added.]

Further, in its response, CMS specified that, “[i]f the physician determines continued inpatient hospitalization is medically necessary it is conveyed through a physician recertification.” Finally, CMS stated that it “will review the cases identified by the OIG to determine whether the claims were properly billed.”

OIG Response

In our draft report, our recommendation did not include the complete phrase “administrative necessary days *that meet inpatient coverage requirements because the beneficiary has not met his or her discharge objectives.*” We have added that phrase to the recommendation in the final report for greater clarity.

If it is still the case, as it was in 2004, that CMS does not know “the extent to which the costs of administrative necessary days are included in the Federal per diem base payment amount,” we stand by the first half of our recommendation (that CMS assess payment accuracy). However, our greater concern is that a very vulnerable population (beneficiaries with severe mental illness) is using lifetime reserve days because of the unavailability of appropriate posthospitalization placements or funding for those placements. We stand by the second half of our recommendation (that CMS consider the effects of the status quo on beneficiaries). We

encourage CMS to take the steps necessary to protect beneficiaries, which could include, if warranted by the policy reassessment, rule-making or legislative proposals, and note that CMS could decline to reassess payment accuracy but reassess impact on, and take steps to protect, beneficiaries from loss of lifetime reserve days in this situation.

We did not recommend that CMS review the eight stays in our finding to determine whether the claims were properly billed. The medical records for those eight stays supported the medical necessity of delaying the patients' discharges because of the lack of availability of appropriate posthospitalization placements. Further, the records show thorough and timely discharge planning. Accordingly, we did not categorize any of these eight claims as overpayments for this informational report.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 36,120 IPF PPS claims for inpatient services provided in FYs 2014 and 2015 that resulted in outlier payments, with total claim payments of \$956,660,476. FYs 2014 and 2015 were the most recent full years of data available at the start of the audit.

We obtained claims data from the CMS National Claims History (NCH) file. Our review and analysis of the claims data allowed us to establish reasonable assurance of the authenticity and accuracy of the data, but we did not assess the completeness of the file.

The objective of our audit did not require an understanding or assessment of the internal control structure at the IPFs that were associated with our sampled claims. Instead, we obtained a general understanding of CMS oversight activities relating to IPF inpatient claims.

We conducted our fieldwork from November 2016 through February 2018.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal laws, regulations, standards, and guidance to obtain an understanding of Medicare coverage, payment, participation, and billing requirements for IPFs, as well as an understanding of the IPF PPS outlier payment policy;
- extracted paid claims data from CMS's NCH file;
- identified a sampling frame of 36,120 claims and selected a stratified random sample of 160 claims for review (Appendix C);
- reviewed data from CMS's Common Working File for the 160 sampled claims to validate claim information extracted from the NCH file and determine whether any of the selected claims had been canceled or adjusted;
- reviewed medical and billing records obtained from the IPFs associated with the sampled claims;
- used an independent medical review contractor to determine whether the IPFs had met Medicare coverage, payment, and participation requirements;

- questioned IPFs about their medical and billing records as necessary to complete our determinations;
- used the sample results to estimate Medicare overpayments to IPFs related to Medicare coverage errors to do with medical necessity and to estimate beneficiaries' liabilities relating to those errors (Appendix D);
- used the sample results to estimate the number of lifetime reserve days used by beneficiaries while awaiting safe posthospitalization placements (Appendix D);
- researched CMS and MAC oversight activities with respect to IPF claims, including claims with outlier payments;
- analyzed our audit data and results to identify areas of concern with potential for improvement; 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: INPATIENT PSYCHIATRIC FACILITY MEDICAL RECORD REQUIREMENTS

42 CFR § 482.61 Condition of participation: Special medical record requirements for psychiatric hospitals.

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

(a) *Standard: Development of assessment/diagnostic data.* Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

- (1) The identification data must include the patient's legal status.
- (2) A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.
- (3) The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.
- (4) The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.
- (5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

(b) *Standard: Psychiatric evaluation.* Each patient must receive a psychiatric evaluation that must—

- (1) Be completed within 60 hours of admission;
- (2) Include a medical history;
- (3) Contain a record of mental status;
- (4) Note the onset of illness and the circumstances leading to admission;
- (5) Describe attitudes and behavior;

(6) Estimate intellectual functioning, memory functioning, and orientation;
and

(7) Include an inventory of the patient's assets in descriptive, not
interpretative, fashion.

(c) Standard: Treatment plan.

(1) Each patient must have an individual comprehensive treatment plan that
must be based on an inventory of the patient's strengths and disabilities.
The written plan must include—

(i) A substantiated diagnosis;

(ii) Short-term and long-range goals;

(iii) The specific treatment modalities utilized;

(iv) The responsibilities of each member of the treatment team; and

(v) Adequate documentation to justify the diagnosis and the treatment
and rehabilitation activities carried out.

(2) The treatment received by the patient must be documented in such a
way to assure that all active therapeutic efforts are included.

(d) Standard: Recording progress. Progress notes must be recorded by the
doctor of medicine or osteopathy responsible for the care of the patient as
specified in § 482.12(c), nurse, social worker and, when appropriate, others
significantly involved in active treatment modalities. The frequency of progress
notes is determined by the condition of the patient but must be recorded at
least weekly for the first 2 months and at least once a month thereafter and
must contain recommendations for revisions in the treatment plan as indicated
as well as precise assessment of the patient's progress in accordance with the
original or revised treatment plan.

(e) Standard: Discharge planning and discharge summary. The record of each
patient who has been discharged must have a discharge summary that includes a
recapitulation of the patient's hospitalization and recommendations from
appropriate services concerning follow-up or aftercare as well as a brief
summary of the patient's condition on discharge.

42 CFR § 412.27 Excluded psychiatric units: Additional requirements.

In order to be excluded from the prospective payment system as specified in § 412.1(a)(1), and paid under the prospective payment system as specified in § 412.1(a)(2), a psychiatric unit must meet the following requirements:

(a) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the Fourth Edition, Text Revision of the American Psychiatric Association's *Diagnostic and Statistical Manual*, or in Chapter Five ("Mental Disorders") of the *International Classification of Diseases*, Ninth Revision, Clinical Modification.

(b) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, and therapeutic activities.

(c) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements:

(1) *Development of assessment/diagnostic data.* Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.

(i) The identification data must include the inpatient's legal status.

(ii) A provisional or admitting diagnosis must be made on every inpatient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(iii) The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both.

(iv) The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

(v) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

(2) *Psychiatric evaluation.* Each inpatient must receive a psychiatric evaluation that must

- (i) Be completed within 60 hours of admission;
- (ii) Include a medical history;
- (iii) Contain a record of mental status;
- (iv) Note the onset of illness and the circumstances leading to admission;
- (v) Describe attitudes and behavior;
- (vi) Estimate intellectual functioning, memory functioning, and orientation; and
- (vii) Include an inventory of the inpatient's assets in descriptive, not interpretative fashion.

(3) *Treatment plan.*

- (i) Each inpatient must have an individual comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized; the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out; and
- (ii) The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.

(4) *Recording progress.* Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the inpatient but must be recorded at least weekly for the first two months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the inpatient's progress in accordance with the original or revised treatment plan.

(5) *Discharge planning and discharge summary.* The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.

42 CFR § 412.404: Conditions for payment under the prospective payment system for inpatient hospital services of psychiatric facilities.

(e) Reporting and recordkeeping requirements. All inpatient psychiatric facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements as specified in §§ 412.27(c), 413.20, 413.24, and 482.61 of this chapter.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of IPF paid claims that included outlier payments for inpatient services provided in FYs 2014 and 2015.

SAMPLING FRAME

We extracted claims data from the CMS NCH file into a database. These claims data were for all paid IPF claims for inpatient services provided in FYs 2014 and 2015. We created database queries to select the claims that included outlier payments, 37,242 in total. We removed 1,122 claims that met the following criteria:

- canceled claims not excluded by our original selection criteria,
- claims not coded with an IPF PPS diagnosis-related group,
- claims from IPFs under investigation by the OIG Office of Investigations, or
- claims previously under review by recovery audit contractors.

The resulting sampling frame consisted of 36,120 IPF claims with payments totaling \$956,660,476.

SAMPLE UNIT

The sample unit was a claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We separated the sample units into four strata as follows:

Stratum	Range of Paid Amounts in the Sampling Frame	Number of Claims in the Sampling Frame	Sample Size	Dollar Value of Total Medicare Payments
1	≥\$73.50 and ≤\$20,378.10	17,501	40	\$224,339,419
2	≥\$20,378.26 and ≤\$33,652.41	9,517	40	\$248,921,202
3	≥\$33,652.90 and ≤\$54,024.48	5,943	40	\$249,842,592
4	≥\$54,027.05 and ≤\$241,244.57	3,159	40	\$233,557,263
Total		36,120	160	\$956,660,476

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the claims in strata 1, 2, 3, and 4. After generating 40 random numbers for each stratum, we selected the 160 corresponding claims for review.

ESTIMATION METHODOLOGY

For IPF PPS claims for inpatient services provided in FYs 2014 and 2015 that resulted in outlier payments, we used the OIG, OAS statistical software to calculate the point estimates and the 90-percent confidence intervals for:

- the total Medicare overpayments for noncovered or partially noncovered stays and
- the total beneficiary liabilities for noncovered or partially noncovered stays.

We also used the OIG, OAS software to calculate the point estimate for the number of lifetime reserve days used by beneficiaries awaiting safe posthospitalization payments after they no longer required inpatient treatment or diagnostic services. We calculated the 90-percent confidence interval for this estimate by using the empirical likelihood approach, which we programmed using Microsoft Excel.

Finally, we used the OIG, OAS software to calculate the point estimate and the 90-percent confidence interval for the percentage of IPF claims with outlier payments that did not meet Medicare's medical necessity or documentation requirements.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

**Table 2: Sample Details and Results for Noncovered or Partially Noncovered Claims—
Medicare Payments**

Stratum	Frame Size	Total Medicare Payments in the Frame	Sample Size	Total Medicare Payments in the Sample	Number of Fully or Partially Noncovered Claims	Value of Medicare Payments for Noncovered Days
1	17,501	\$224,339,419	40	\$483,681	4	\$32,932
2	9,517	\$248,921,202	40	\$1,058,278	4	\$85,803
3	5,943	\$249,842,592	40	\$1,693,654	9	\$224,744
4	3,159	\$233,557,263	40	\$2,871,721	8	\$309,588
Total	36,120	\$956,660,476	160	\$6,107,334	25	\$653,067

**Table 3: Sample Details and Results for Noncovered or Partially Noncovered Claims—
Beneficiary Liabilities**

Stratum	Frame Size	Total Beneficiary Liabilities in the Frame	Sample Size	Total Beneficiary Liabilities in the Sample	Number of Fully or Partially Noncovered Claims*	Value of Beneficiary Liabilities for Noncovered Days
1	17,501	\$25,098,284	40	\$41,462	1	\$1,216
2	9,517	\$17,356,128	40	\$69,278	1	\$1,260
3	5,943	\$19,919,955	40	\$166,606	3	\$4,224
4	3,159	\$34,413,906	40	\$466,445	7	\$111,346
Total	36,120	\$96,787,463	160	\$743,791	12	\$118,046

*Not every noncovered or partially noncovered claim included beneficiary liabilities affected by the noncovered days.

**Table 4: Overall Estimates for Noncovered or Partially Noncovered Claims
(Limits Calculated at the 90-Percent Confidence Level)**

	Estimated Value of Medicare Overpayments	Estimated Value of Beneficiary Liabilities
Point Estimate	\$92,664,392	\$10,252,947
Lower Limit	\$60,831,062	\$2,915,715
Upper Limit	\$124,497,721	\$17,590,179

Table 5: Sample Details and Results for Covered Claims for Which Discharge Was Delayed Because Beneficiaries Were Awaiting a Safe Posthospitalization Placement

Stratum	Frame Size	Sample Size	Number of Claims Where Beneficiaries' Discharge Was Delayed	Number of Lifetime Reserve Days Used Because Discharge Was Delayed
1	17,501	40	0	0
2	9,517	40	2	15
3	5,943	40	1	27
4	3,159	40	5	90
Total	36,120	160	8	132

**Table 6: Overall Estimates for Lifetime Reserve Days Used During Covered Stays While Beneficiaries Were Awaiting a Safe Posthospitalization Placement
(Limits Calculated at the 90-Percent Confidence Level)**

	Estimated Lifetime Reserve Days Used
Point Estimate	14,688
Lower Limit	6,496
Upper Limit	28,543

**Table 7: Overall Estimates of the Percentage of IPF Claims with Outlier Payments That Did Not Meet Medicare's Medical Necessity or Documentation Requirements
(Limits Calculated at the 90-Percent Confidence Level)**

	Estimated Percentage Not Meeting Requirements
Point Estimate	87 percent
Lower Limit	81 percent
Upper Limit	92 percent

APPENDIX E: CONDITION OF PARTICIPATION—PATIENT’S RIGHTS

42 CFR § 482.13: Condition of participation: Patient’s rights.

A hospital must protect and promote each patient's rights.

(a) *Standard: Notice of rights.*

(1) A hospital must inform each patient, or when appropriate, the patient’s representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

* * *

(b) *Standard: Exercise of rights.*

(1) The patient has the right to participate in the development and implementation of his or her plan of care.

(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient’s rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with § 489.100 of this part (Definition), § 489.102 of this part (Requirements for providers), and § 489.104 of this part (Effective dates).

(4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

APPENDIX F: STATE OPERATIONS MANUAL INTERPRETIVE GUIDELINES FOR PATIENT'S RIGHTS³⁸

Interpretive Guidelines [42 CFR] § 482.13(b)(2)

The right to make informed decisions means that the patient or patient's representative is given the information needed in order to make "informed" decisions regarding his/her care.

Patient's Representative

A patient may wish to delegate his/her right to make informed decisions to another person (as allowed under State law).

Hospitals are expected to take reasonable steps to determine the patient's wishes concerning designation of a representative. Unless prohibited by applicable State law:

- When a patient who is not incapacitated has designated, either orally to hospital staff or in writing, another individual to be his/her representative, the hospital must provide the designated individual with the information required to make an informed decision about the patient's care. * * *
- In the case of a patient who is incapacitated, when an individual presents the hospital with an advance directive, medical power of attorney or similar document executed by the patient and designating an individual to make medical decisions for the patient when incapacitated, the hospital must, when presented with the document, provide the designated individual the information required to make informed decisions about the patient's care. * * *
- When a patient is incapacitated or otherwise unable to communicate his or her wishes, there is no written advance directive on file or presented, and an individual asserts that he or she is the patient's spouse, domestic partner . . . parent . . . or other family member and thus is the patient's representative, the hospital is expected to accept this assertion, without demanding supporting documentation, and provide the individual the information required to make informed decisions about the patient's care. * * * Hospitals are expected to treat the individual as the patient's representative unless:

³⁸ CMS Pub. 100-07, A-0131 (Rev. 95, issued: 12-12-13, effective: 06-07-13, implemented: 06-07-13).

- More than one individual claims to be the patient’s representative. In such cases, it would be appropriate for the hospital to ask each individual for documentation supporting his/her claim to be the patient’s representative. The hospital should make its determination of who is the patient’s representative based upon the hospital’s determination of who the patient would most want to make decisions on his/her behalf. * * *
- Treating the individual as the patient’s representative without requesting supporting documentation would result in the hospital violating State law. State laws, including State regulations, may specify a procedure for determining who may be considered to be the incapacitated patient’s representative, and may specify when documentation is or is not required; or
- The hospital has reasonable cause to believe that the individual is falsely claiming to be the patient’s spouse, domestic partner, parent or other family member.

Hospitals are expected to adopt policies and procedures that facilitate expeditious and non-discriminatory resolution of disputes about whether an individual is the patient’s representative, given the critical role of the representative in exercising the patient’s rights. * * *

Informed Decisions

The right to make informed decisions regarding care presumes that the patient or the patient’s representative has been provided information about his/her health status, diagnosis, and prognosis. Furthermore, it includes the patient’s or the patient’s representative’s participation in the development of his/her plan of care, including providing consent to, or refusal of, medical or surgical interventions, and in planning for care after discharge from the hospital. The patient or the patient's representative should receive adequate information, provided in a manner that the patient or the patient’s representative can understand, to assure that the patient or the patient’s representative can effectively exercise the right to make informed decisions.

Hospitals must establish processes to assure that each patient or the patient's representative is given information on the patient’s health status, diagnosis, and prognosis.



APPENDIX G: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: October 16, 2019

TO: Joanne Chiedi
Acting Inspector General
Office of Inspector General

FROM: Seema Verma
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: An Estimated 87 Percent of Inpatient Psychiatric Facility Claims With Outlier Payments Did Not Meet Medicare's Medical Necessity or Documentation Requirements (A-01-16-00508)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS recognizes the importance of providing Medicare beneficiaries with access to medically necessary services and, at the same time, protecting the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system and prepayment and postpayment medical reviews. As part of this strategy, CMS recovers identified improper payments in accordance with relevant law and agency policies and procedures.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing under the Inpatient Psychiatric Facility Prospective Payment System. CMS continues to educate providers on Medicare billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. For example, in March 2019 CMS published a booklet, targeted for Medicare fee-for-service providers, which provides information pertaining to the Inpatient Psychiatric Facility Prospective Payment System, including information about the physician certification and recertification requirements and the inpatient psychiatric facility quality reporting program¹.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services increase the number of postpayment reviews of IPF claims to provide IPFs with more feedback on their compliance with Medicare requirements.

CMS Response

CMS concurs with this recommendation. CMS will direct its Medicare contractors to consider increasing the number of postpayment reviews of inpatient psychiatric facility claims to provide

¹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Inpatient-Psychiatric-Facility-Prospective-Payment-System.pdf>

inpatient psychiatric facilities with more feedback on their compliance with Medicare requirements.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services consider whether the physician certification and recertification requirements are useful in preventing inappropriate payments, and if they are not, take the steps necessary to eliminate or amend those requirements.

CMS Response

CMS does not concur with this recommendation. The physician certification and recertification requirements are statutory requirements outlined in Section 1814(a)(2)(A) of the Social Security Act and CMS is required to follow the law as written. The regulations at 42 CFR 424.14 are in line with the statutory requirement. Absent a legislative change, CMS will continue to require physician certification and recertification for inpatient psychiatric facility stays.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services, while the certification requirements remain in place, revise the guidance to IPFs to require that physician certifications be in a specific form, format, or language.

CMS Response

CMS does not concur with this recommendation. CMS recently updated its policy guidance contained in the Medicare Benefit Policy Manual. Pursuant to section 30.2.1 of the Medicare Benefit Policy Manual, the “format of all certifications and recertifications and the method by which they are obtained is determined by the individual facility. No specific procedures or forms are required.” In addition, claim denials may not be made for failure to use a certain certification or recertification form or failure to use particular language or format, provided that the medical record demonstrates the necessary content requirements are met.²

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services issue interpretive guidelines to State agencies via the State Operations Manual to clarify that each IPF should have a policy compliant with State law to protect and promote the patient’s right to make informed decisions that includes standards for documenting the patient’s ability to make informed decisions.

CMS Response

CMS concurs with this recommendation. A patient or a patient’s representative, as allowed under state law, has the right to make informed decisions regarding the patient’s care. Interpretive guidelines regarding informed consent are addressed in the patient’s rights, medical record services, and surgical services sections of Appendix A of the State Operations Manual (482.13(b)(2), 482.24(c)(4)(v), and 482.51(b)(2), respectively). CMS will take the OIG’s findings and this recommendation into consideration when determining if additional guidance is necessary or if rulemaking is required regarding patient’s rights for making informed decisions, including standards for documenting the patient’s ability to make informed decisions.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services conduct a study to determine whether outlier payments are being made only for cases with unusually high costs,

² <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c02.pdf>
CMS Outlier Payments for Inpatient Psychiatric Facilities (A-01-16-00508)

and, if not, consider designing and testing alternatives to the current outlier payment methodology.

CMS Response

CMS concurs with this recommendation. CMS will review the cases identified by the OIG to determine whether the outlier payments were made for patients for whom the inpatient psychiatric facility incurred higher costs. CMS may take action, as deemed appropriate, as a result of this review.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services reassess the current CMS reimbursement policy for administrative necessary days to determine payment accuracy and effects on beneficiaries.

CMS Response

CMS does not concur with this recommendation. Typically, administrative necessary days are when an inpatient of a hospital setting is clinically ready for discharge but an appropriate post-hospital setting placement is not available. However, CMS would like to clarify that Medicare does not have an administrative necessary days policy under the Inpatient Psychiatric Facility Prospective Payment System to provide payment for days that do not meet an active level of treatment. The November 15, 2004 Inpatient Psychiatric Facility Prospective Payment System final rule (69 FR 66952) explains, in a response to comment, that the IPF PPS does not have an administrative necessary days policy and does not provide payment for days that do not meet an active level of treatment. Only a physician can determine the need for continued hospitalization and or discharge. If the physician determines continued inpatient hospitalization is medically necessary it is conveyed through a physician recertification. When a patient falls below an active level of care, the provider identifies the day as such on the claim, and it is not paid under the Inpatient Psychiatric Facility Prospective Payment System. Instead, the provider can bill, if applicable, Medicare Part B services. Lifetime reserve days should not be billed in these cases.

CMS will review the cases identified by the OIG to determine whether the claims were properly billed. CMS may take action, as deemed appropriate, as a result of this review.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services determine whether patient in-hospital fall rates should be added to the IPFQR program and whether CMS should require present-on-admission indicators on claims as an aid to tracking in-hospital falls.

CMS Response

CMS concurs with this recommendation. CMS will determine whether patient in-hospital fall rates should be added to the IPFQR program and whether CMS should require present-on-admission indicators on claims as an aid to tracking in-hospital falls.