Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-01-113 **Date: SEPTEMBER 19, 2001**

CHANGE REQUEST 1340

SUBJECT: Prospective Payment System (PPS) Patient Transfers Improperly Paid as Hospital Discharges----ACTION

This is to advise you of a forthcoming joint CMS and Office of Inspector General (OIG) initiative concerning incorrectly reported PPS transfers. OIG found significant numbers of Medicare patients discharged from one PPS hospital and admitted to a second PPS hospital on the same day. However, the first PPS hospital did not use the correct patient status code 02 -- transferred to another short-term hospital. As a result of these incorrect codings, a full PPS payment, rather than the lesser per diem based transfer payment, was made to the provider.

During 1992, you received listings of PPS hospital transfers incorrectly reported as PPS discharges. These listings covered inpatient claims data from January 1, 1986, through November 1991.

OIG will soon complete the identification of incorrectly reported PPS transfers for the post-1991 period. Based upon servicing fiscal intermediary (FI) information, listings will be prepared and transmitted to each of you. Along with the listings, you will receive formats for reporting your recoveries for the adjustments and corrections of the incorrectly reported transfers. A CMS Regional Office (RO) representative will work with you to ensure timely completion of the recoveries, use of correct PRICER files to adjust the claims, coordination of any transfers of listed providers between FIs, and monthly reporting to OIG beginning with the month ending October 31, 2001.

This administrative recovery initiative is being pursued under 42 CFR 405.750. The applicable subsections (b)(1) & (b)(2) of 42 CFR 405.750 allow for a reopening up to four years after the date of initial determination upon establishment of good cause for reopening such determination and at any time when the payment decision involves fraud or similar fault. We maintain that OIG's discovery of the PPS transfer claims at issue provides good cause for reopening these claims. At this time, your recovery efforts are limited to those claims identified by OIG that are four years old or less from the date of the initial determination (bill processing date). At a later date, you may be instructed to pursue reopening recoveries beyond the four-year limitation on a case by case basis.

For this initiative, the following are the only acceptable reasons for not recovering incorrectly reported transfers:

- the FI previously adjusted the claim to a transfer and made recovery,
- the provider can substantiate that the beneficiary was actually admitted to an excluded unit and the receiving hospital provided the incorrect provider number,
- the hospital has ceased to operate (the provider's assets and liabilities were not purchased) and neither the FI nor CMS can identify a source of repayment for the liability, or
- the provider can substantiate that its action in discharging the beneficiary was appropriate and that there was an intervening event that necessitated the same day admission to another hospital.

An exception report format will be provided to report any claims for which a recovery is not made.

The payments at issue are PPS payments, made on behalf of patients transferred to another facility, which were incorrectly made at the full Diagnostic Related Group (DRG) rate instead of the proper per diem rate in accordance with 42 CFR 412.4. These adjustments are determinations that deal with claims on behalf of individuals and are subject to the applicable appeal rights set forth in Subpart G (Reconsideration and Appeals Under Medicare Part A) of 42 CFR Part 405.

All overpayment determinations in these cases must advise the affected provider of its appeal rights and may be in the form of standard appeals language that is usually contained in the intermediary's reopening determination. Preferably, the provider should accomplish recovery of these overpayments through the submission of adjustment requests.

Changes to DRG payments made under PPS affect payments for indirect medical education and disproportionate share. Therefore, you should assess the effects of adjustment requests that have been submitted by the provider and reopen and revise cost report settlements where you estimate that the adjustments will have a material effect on program payments and are within the three year limitation period.

The applicable appeal rights with regard to the reopened cost report are set forth in 42 CFR 405 Subpart R (Provider Reimbursement Determination and Appeals) containing sub-sections 405.1801 through 405.1889. Where any revision is made, it shall be considered a separate determination to which the appeals provisions of section 405.1811 apply. Therefore, your revised Notice of Program Reimbursement must contain the appropriate standard appeals language.

The fact that these overpayments are being collected does not release or absolve the hospitals of liability under the False Claims Act. If hospitals inquire about their False Claims Act liability, the FI should make clear to them that the overpayment collection is unrelated to any potential False Claims Act liability. If the hospital insists on further information about False Claims Act issues, the hospital should be told to contact the OIG auditor, Michael Weisner, identified below.

Consistency in the treatment of providers is essential, and there should be no deviations from the above or other initiative instructions. Questions concerning the policies and procedures on the PPS adjustments and claims reopenings should be addressed to:

Stephen Phillips at (410) 786-4548 or Nora Kraemer at (410) 786-6908
Provider Purchasing and Administration Group
Center for Health Plans and Providers

Questions concerning the recovery of the determined overpayments should be addressed to your Regional Office representative or to:

Tom Noplock (410)786-3378 or Jerry Warfield (410)786-7481, Medicare Overpayments Branch, Office of Financial Management.

All of the transfers on the listings you will receive have lengths of stay less than the geometric mean length of stay (GMLOS) for the applicable DRG. Please note that any incorrectly reported transfers with a length of stay beyond the GMLOS have been eliminated from the listings. As a result, all of the transfers on the listings are overpayment cases. To ensure the adjustment actions are correctly processed, you must make the adjustment using the PRICER file for the original date of discharge. If you use the incorrect PRICER file, rather than making a recovery you could improperly make an additional payment to the provider. If you are unable to use the correct PRICER file, please let your RO representative know of the problem immediately and your proposed solution.

During the initiative, your adjustment of any transfer on the listing should not result in a negative recovery amount (you determine that the provider is owed an additional amount). If this situation occurs, you must immediately bring this to the attention of your RO representative and the OIG official named below.

Should you identify providers on the listing for which you are no longer the servicing FI, coordinate transmission of the listings of transfers for these providers to the correct FI through the RO representative. The RO representative will inform OIG of the providers reassigned and the FI to which the providers are reassigned.

Upon receipt of your listing, you will be provided with the formats to make your monthly progress and final reports to your RO and to the OIG. The final report must account for each transfer on your listing and must be completed within 120 days of receipt of the claims data. For reporting to OIG, address your progress and final reports to:

PPS Transfer Recovery Initiative
HHS OIG OAS—Attn: Michael Weisner
9100 Bluebonnet Centre Boulevard
Suite 504
Baton Rouge, LA 70809
Phone (225) 389-0406 ext. 21

The effective date of this Program Memorandum (PM) is October 1, 2001.

This PM will be implemented October 31, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2002.

If you have any questions contact Tom Noplock on (410) 786-3378 or Stephen Phillips on (410) 786-4548.