Program Memorandum Intermediaries

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

Transmittal A-02-126 Date: DECEMBER 20, 2002

CHANGE REQUEST 2528

SUBJECT: Instructions Regarding Hospital Outlier Payments

Change Request (CR) 2500 indicated that there may be potential problems with Medicare inpatient outlier payments to some hospitals. In order to address these potential vulnerabilities, CMS is initiating a progressive compliance strategy to ensure that Medicare payments for outliers and services paid outside the Inpatient Prospective Payment System are appropriate. Our strategy is designed to ensure that the greatest level of scrutiny is placed on hospitals that appear, through data analysis, to present the greatest risk to the program. The reviews described in this Program Memorandum (PM) are intended, in part, to help identify those hospitals apart from hospitals that clearly manage actual high cost cases that appropriately qualify for outlier payments.

You are to perform data analysis to identify those hospitals that: (1) have outlier payments of 80 percent or more of their operating and capital DRG payments for discharges during October and November 2002 (excluding outlier, indirect medical education, and disproportionate share payments); or (2) meet both estimated outlier payments greater than 20 percent of their operating and capital DRG payments for discharges during October and November 2002 (excluding outlier, indirect medical education, and disproportionate share payments) and an increase in average charges per case (calculated including all Medicare discharges) of 20 percent or more from 2000 to 2001 and 2001 to 2002. This comparison may be performed using either hospitals' cost reporting periods or Federal fiscal years.

Type 1 Reviews

For all hospitals falling in category 1 mentioned in the above paragraph you are to perform the following:

Comprehensive Field Audits

These audits should be performed on the most recently filed cost report using all applicable audit steps contained in the Hospital and Skilled Nursing Facility Audit Program (1999) for Indirect Medical Education (IME), Graduate Medical Education (GME), Disproportionate Share Hospital (DSH) payments, bad debts, organ acquisition costs, and any other pass through costs. In addition you are to perform a uniform charge review using the Hospital and Skilled Nursing Facility Audit Program (1999) Exhibit 2 - Revenue Tests, Step 5 - A1 and A2; Step 8 – A; and Step 9 – A, B, and C. Final settlement of the cost reports should be issued based on existing instructions and procedures.

Medical Reviews

The Fiscal Intermediary (FI) will select random samples of 20 hospital outlier records for both inpatient and outpatient claims from the last 12 months. The FI will send the sample of inpatient claims to the appropriate Quality Improvement Organizations (QIO).

The FI will perform a line item review of the 20 outpatient records from the sample to determine whether care is reasonable and necessary. The FI is responsible to use the QIO inpatient findings and their outpatient findings to collect overpayments. Based on the findings from the sample, the FI is responsible to take the appropriate remedial action and/or make a referral to Benefit Integrity when necessary. The FI will also notify Sheila Blackstock (sblackstock@cms.hhs.gov, 410-786-3502), in CMS central office, of the identified hospitals for which these referrals are made.

QIO Activities

Once the sample for inpatient claims is received, the QIO will request inpatient records from the hospital. The QIO will perform cost outlier reviews as directed by CMS under separately issued instructions. The QIO will report its findings to the FI. The QIO will be responsible for educating providers where appropriate.

Type 2 Reviews

For all hospitals in category 2 that have not been subject to a Type 1 review, you should perform the following:

Uniform Charge Reviews

Use Exhibit 2 - Revenue Tests of the Hospital and Skilled Nursing Facility Audit Program (1999) and perform Step 5 - A1 and A2; Step 8 – A; and Step 9 – A, B, and C. These reviews can be performed in your office unless you determine that the data can be obtained only in an on-site visit. The objective of this review is to ensure that providers are applying charges uniformly to all patients in accordance with Medicare regulations. Final settlement of the cost reports should be issued based on existing instructions and procedures.

Medical Review

The FI will select random samples of 20 hospital outlier records for outpatient hospital claims from the last 12 months. The FI will request outpatient records from the hospital. The FI will perform a line item review of the 20 outpatient records from the sample to determine whether care is reasonable and necessary for the outpatient claim sample. These reviews can be performed at the FI's office. The FI is responsible to use the QIO inpatient findings and their outpatient findings to collect overpayments. Based on the findings from the sample, the FI is responsible to take the appropriate remedial action and/or make a referral to Benefit Integrity when necessary.

QIO Activities

The FI will send a State-specific list of hospitals in this range to the appropriate QIO, with a copy to Sheila Blackstock in CMS central office (**sblackstock@cms.hhs.gov**, 410-786-3502). Each QIO will then perform outlier review on a sample of outlier cases from these hospitals and take the appropriate follow up action.

Type 3 Reviews

For all other hospitals identified in your analysis, FIs are to use their judgment to determine if an audit or medical review is indicated.

Scheduling

All FI audits and reviews should be coordinated to the extent possible.

Comprehensive Field Audits

You must schedule your comprehensive audits so that fieldwork starts for some of these audits by February 1, 2003. Fieldwork for all of the comprehensive audits must be scheduled to start no later than July 31, 2003. Engagement letters for all providers receiving either type of audit should be issued by January 13, 2003. Once you have issued the engagement letters please forward a copy of your schedule for both the comprehensive audits and the uniform charge reviews to CMS central office, attention Mark Korpela (mkorpela @cms.hhs.gov). We anticipate that this work will be completed on a flow basis with the entire sample being completed by July 31, 2004. However, if circumstances occur beyond your control, this completion time may be adjusted on a case-by-case basis with the concurrence of CMS. You may not use subcontractors to perform this work. All

instructions and timeframes outlined in PMs A-02-081 and A-01-141 must be followed except when special instructions/timeframes are provided in this PM.

If you have 3 or fewer comprehensive field audits or 10 or fewer uniform charge reviews you should complete this work by modifying your current audit plan and using your current audit funding. If you have more than 3 comprehensive audits or more than 10 uniform charge

reviews you may submit a Supplemental Budget Request identifying the funds needed for these reviews. In all cases you should revise your audit plans to take into account the efforts necessary to perform these special comprehensive audits. You should obtain concurrence of your revised audit plan from your CMS regional office. (Note: exceptions to the cost report currency requirements in the Budget Performance Requirements will be handled by CMS on a case-by-case basis.)

Medical Review

The FI must schedule their type 1 medical reviews to start by February 1, 2003. All medical reviews must be completed no later than July 31, 2003. The FI should send a list of all medical reviews being conducted to CMS CO, attention Karen Daily (kdaily@cms.hhs.gov).

FIs are to conduct all medical reviews within their current budget by offsetting their current medical review workloads and revising their MR strategies.

Further instructions will be forthcoming on information to be collected and reported.

The *effective date* for this PM is December 20, 2002.

The *implementation date* for this PM is immediately December 20, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after December 1, 2003.

If you have any questions, please send an email to outlierpayments@cms.hhs.gov.