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OIG: QIO Reviews Haven't Cut Overpayments for Short Stays Enough, Prepayment Edit Is Needed

By Nina Youngstrom

CMS could do much more to identify and prevent overpayments for short inpatient stays under the two-midnight rule, according to a June 13 report from the HHS Office of Inspector General (OIG).[1] Medicare may be losing billions of dollars because CMS doesn't have enough information on claims or use prepayment edits to flag high-risk short stays, and postpayment reviews by Beneficiary and Family Centered Care-Quality Improvement Organizations (QIOs) aren't cutting it, OIG said. They didn't appreciably reduce the improper payment rate for short stays.

OIG recommended CMS add prepayment edits for short stays at high risk of noncompliance with the two-midnight rule and recover overpayments through more reviews (e.g., by recovery auditor contractors), among other changes.

"Without strengthening program safeguards, CMS and its contractors may not be able to prevent and detect improper payments for short inpatient stays and recover overpayments for claims that did not comply with Medicare requirements," the OIG report asserted.

CMS was noncommittal about the recommendations but said it will take them into consideration as it determines next steps. One way or another, though, hospitals should expect an increased audit burden in the wake of OIG's report, said Ronald Hirsch, M.D., vice president of R1 RCM. "Hospitals that aren't being diligent with reviewing their short stays need to develop a process to review these admissions," he said.

But Hirsch took issue with aspects of the OIG report. He said the data is a bit old, with an audit period of Jan. 1, 2016, through Dec. 31, 2020. Maybe the findings would be the same, but Livanta, the QIO, is "actively auditing these cases and it seems like it would add to the validity of their findings" if the data were more recent. Also, the report is vague about the risk of noncompliant short stays caused by canceled procedures. Hirsch noted that Medicare allows hospitals to bill inpatient admissions for surgeries that are canceled after the surgery begins (i.e., the patient is put under anesthesia). For example, if the surgery is canceled because the patient develops ventricular tachycardia while on the operating table, hospitals still bill for an MS-DRG even though the patient probably won't be there for two midnights, he explained. "If OIG is concerned about inpatient stays for canceled procedures, it should release clear guidance on how to address them," Hirsch said.