DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

AUG 20 2003

TO: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

FROM: Dara Corrigan
Acting Principal Deputy Inspector General

SUBJECT: Expansion of the Diagnosis Related Group Payment Window (A-01-02-00503)

Attached is a copy of our final report providing the results of our self-initiated review of the potential savings to the Medicare program if the diagnosis related group (DRG) payment window were expanded beyond the present 3-day requirement. We have had a long-standing interest in the area of the DRG payment window because of prior Office of Inspector General (OIG) reports that have identified improper payments made for preadmission services.

Under the inpatient prospective payment system, a hospital is reimbursed a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification within a DRG. Nonphysician outpatient services rendered up to 3 days prior to admission are included in the DRG payment per 45 CFR 412.2(c)(5).

We analyzed a statistical sample of Medicare payments for hospital inpatient stays and outpatient services that preceded the admission. We noted that for selected DRGs there were nonphysician preadmission services paid within a period up to 14 days that were related to the admission. This occurred because physicians and/or hospital preadmission departments had the discretion to schedule when these tests were to be performed. Based on our sample, we projected that Medicare reimbursed providers approximately $37 million while beneficiaries were expected to pay an additional $35 million in coinsurance and deductibles for these nonphysician outpatient services.

We are recommending that the Centers for Medicare & Medicaid Services (CMS) consider proposing legislation to expand the DRG payment window to include admission-related services rendered up to 14 days prior to an inpatient admission.

In response to CMS's technical comments, we are also recommending that admission-related services be defined as those where the first three digits of the outpatient principal diagnosis code match the first three digits of either the inpatient admitting or principal diagnosis code.

In written comments, CMS concurred with our recommendation; however, it raised concerns as to whether expanding the length of the window could increase the health risks for beneficiaries. OIG recognizes that CMS would take such factors into consideration before proposing a

legislative change to expand the DRG payment window. We believe that it is possible that, in response to a change expanding the payment window to 14 days, providers could perform admission-related outpatient services outside of this payment window in order to be reimbursed separately for the services. We acknowledge there could be negative medical consequences to performing some diagnostic tests more than 14 days prior to admission to the hospital. Therefore, we understand CMS's need to address any potential health risks to the beneficiaries before proposing a legislative change.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me or one of your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits at (410) 786-7104 or through e-mail at greeb@oig.hhs.gov. To facilitate identification, please refer to report number A-01-02-00503 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

EXPANSION OF THE DIAGNOSIS RELATED GROUP PAYMENT WINDOW

AUGUST 2003
A-01-02-00503

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov/

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.

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SUBJECT: Expansion of the Diagnosis Related Group Payment Window (A-01-02-00503)

This report provides you with the results of our review of hospital admission-related, nonphysician outpatient services. Our review examined the relationship between nonphysician outpatient services rendered 4 to 14 days prior to an inpatient admission and the date of that subsequent admission.

BACKGROUND

Under the inpatient prospective payment system (PPS), a hospital is reimbursed a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). Included in the prospective payment are nonphysician outpatient services (such as laboratory, radiology, and other diagnostic tests) rendered (1) up to 3 days prior to the date of the admission and (2) by the admitting hospital or a related provider. Reimbursement for services rendered during the DRG payment window (the timeframe encompassing 3 days prior to the date of admission through the date of discharge) was included in the inpatient DRG payment with the intent to shorten inpatient stays by encouraging hospitals to perform some services connected with the stay prior to the actual admission.

OBJECTIVE

Our objective for this review was to estimate the amount and type of preadmission outpatient services relating to subsequent inpatient admissions that were separately reimbursed by Medicare.

For 10 selected DRGs (see Appendix I), we reviewed Calendar Year (CY) 2000 claims for nonphysician outpatient services rendered 4 to 14 days prior to the date of an inpatient admission.

FINDINGS

While the intent of the DRG payment window provisions was to prevent separate reimbursement for preadmission services, we estimate that Medicare reimbursed providers approximately $37 million for preadmission services rendered 4 to 14 days prior to the date of a related

inpatient admission. Beneficiaries were assessed $35 million for coinsurance and deductibles for these services. The preadmission services:

- were rendered in connection with 10 DRGs related predominantly to coronary disease and joint replacement;
- consisted primarily of laboratory, diagnostic radiology, cardiology, and electrocardiograms (EKG/ECG) services; and
- were performed by either the same admitting hospital or a nonrelated provider.

If physicians continue to elect to have preadmission services performed at a nonrelated provider, or if both physicians and admitting hospitals schedule services more than 3 days prior to the date of admission, the current DRG payment window provisions would not apply and savings to the Medicare program would not be realized.

RECOMMENDATIONS

We are recommending that the Centers for Medicare & Medicaid Services (CMS) consider proposing legislation to expand the DRG payment window for admission related services rendered up to 14 days prior to an inpatient admission. All outpatient services that are admission-related would fall within the window, regardless of who provided the service.

In response to technical comments, we are also recommending that CMS define admission-related services as those where the first three digits of the outpatient principal diagnosis match the first three digits of either the inpatient admitting or principal diagnosis code.

CMS COMMENT

CMS concurs with our recommendation to expand the DRG payment window. A concern was raised, however, that such an action could influence medical practice and increase the health risks for beneficiaries (e.g., a diagnostic test performed too far in advance of admission could prove to not be current enough). CMS would take such factors into consideration before proposing a legislative change to expand the DRG payment window.

OFFICE OF AUDIT SERVICES RESPONSE

The Office of Inspector General (OIG) recognizes that CMS would take such factors into consideration before proposing a legislative change to expand the DRG payment window. We believe that it is possible that, in response to a change expanding the payment window to 14 days, providers could perform admission-related outpatient services outside of this payment window in order to be reimbursed separately for the services. We acknowledge there could be negative medical consequences to performing some diagnostic tests more than 14 days prior to

admission to the hospital. Therefore, we understand CMS's need to address any potential health risks to the beneficiaries before proposing a legislative change.

INTRODUCTION

BACKGROUND

Legislation

Section 1886(d) of the Social Security Act, Public Law (P.L.) 98-21, established the hospital inpatient PPS. For inpatient services furnished to Medicare beneficiaries, Medicare fiscal intermediaries reimburse hospitals a predetermined amount, depending on the illness and its classification under a DRG. Included in the prospective payment are nonphysician outpatient services such as laboratory, diagnostic radiology, and other diagnostic tests. Since 1966, CMS's[1] administrative policy was to consider preadmission services rendered from the day before admission through the date of discharge as inpatient services. CMS believed that this policy would shorten an inpatient stay by encouraging hospitals to perform some services connected with the stay prior to the actual inpatient admission. As such, in 1983 when inpatient PPS was implemented, these preadmission services were included in the calculation of the inpatient DRG payments.

In 1990, the Congress enacted legislation to expand the DRG payment window to 3 days prior to the date of admission to curb further unbundling of services which had occurred since the inception of inpatient PPS. The Congressional Budget Office estimated that this expansion would realize program savings of $380 million for the period 1993 through 1997.

Effective January 1, 1991, the Omnibus Budget Reconciliation Act (OBRA) of 1990, P.L. 101-508, section 4003 expanded the DRG payment window to preclude separate payment for nonphysician outpatient services up to 3 days immediately preceding the date of admission. This amendment applied to:

- all diagnostic nonphysician outpatient services rendered up to 3 days before the date of admission; or
- nondiagnostic nonphysician outpatient services rendered up to 3 days before the date of admission which were admission related.[2]

[1] Formerly known as the Health Care Financing Administration.

[2] In the February 11, 1998 final rule (63 FR 6864), CMS defines nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay.

Section 1886(a)(4) of the Social Security Act further requires that outpatient services be treated as inpatient services if provided by the admitting hospital or by an entity wholly-owned or operated by that hospital.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective for this review was to estimate the amount and type of preadmission nonphysician outpatient services relating to subsequent inpatient admissions that were reimbursed separately by Medicare.

Scope

To accomplish our objective, we:

- Researched and evaluated the current law, regulation, and policy on the DRG payment window;
- Developed computer applications using CMS's CY 2000 National Claims History file to identify nonphysician outpatient services rendered 4 to 14 days prior to the date of admission (1,170,520 claims valued at $110 million);
- Limited our review to outpatient claims which contained (1) diagnostic services only or (2) both diagnostic and nondiagnostic (e.g., observation room) services where the outpatient principal diagnosis code had some correlation to either the inpatient admitting or principal diagnosis code;
- Arrayed the total Medicare payments for these outpatient services by DRG; and
- Limited our review to the top 10 DRGs which accounted for $42 million (292,942 claims) of the outpatient services rendered 4 to 14 days prior to the date of admission (see Figure 1). Appendix I contains detailed information on the amounts separately reimbursed by Medicare for nonphysician outpatient services rendered from 4 to 14 days prior to the date of inpatient admissions for each of these DRGs.

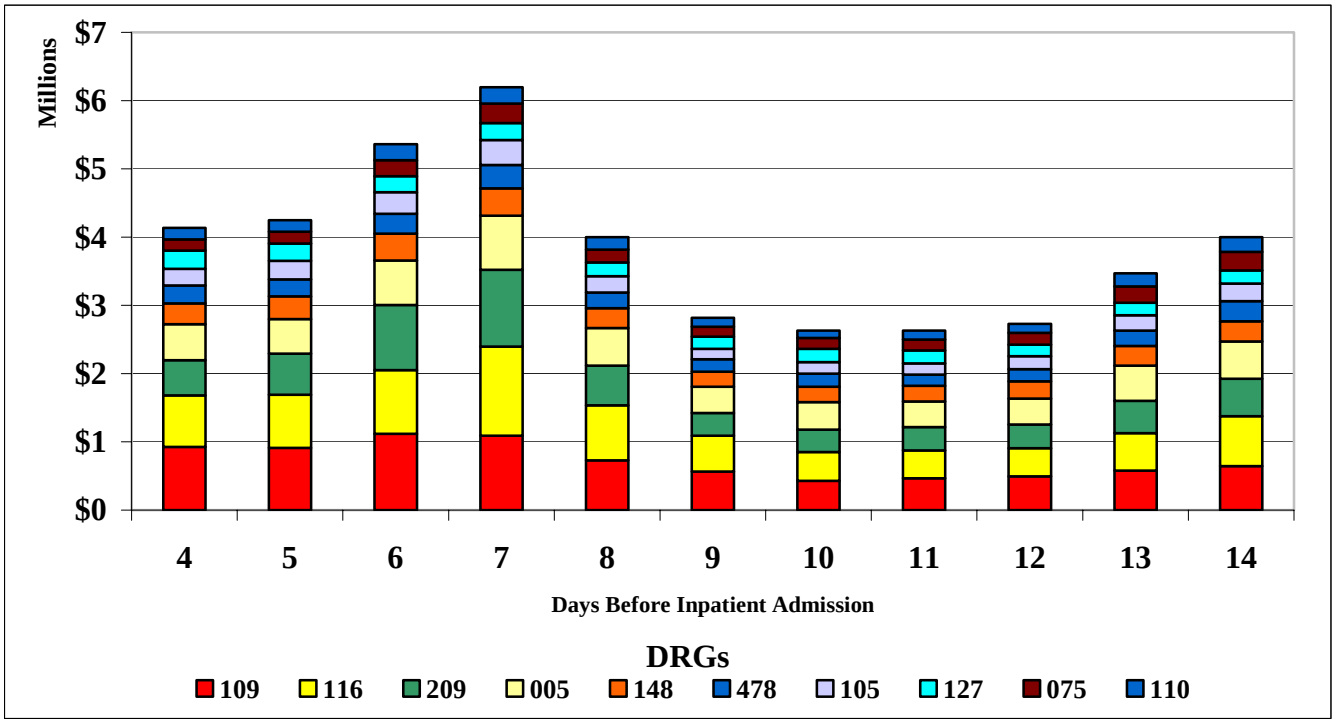

Figure 1 – Distribution of Outpatient Services Associated With 10 DRGs Totaling $42 Million

Methodology

- Employed a multistage sampling design (see Appendix II). Our primary sampling unit consisted of eight States. The secondary sampling unit consisted of 30 claims from each State (a total of 240 claims valued at $38,769).

- Requested each provider to submit documentation (detailed bills, medical records, etc.) to us for each of the 240 randomly selected claims.

- In determining whether the preadmission services were admission-related, we:

  - asked each provider to confirm whether or not the preadmission services were related to the subsequent inpatient admission;
  - relied on the correlation of the outpatient principal diagnosis code and the inpatient principal diagnosis code; and
  - relied on the correlation of the outpatient principal diagnosis code and the inpatient admitting diagnosis code.

- Used a variable appraisal program to estimate the dollar value of admission-related services rendered 4 to 14 days prior to the date of admission.

In completing our review of the sample, we established a reasonable assurance of the authenticity and accuracy of the data. Our audit was not directed towards assessing the completeness of the file from which the data was obtained.

Field work was performed in the Region I Office of Audit Services in Boston, Massachusetts and at the CMS central office.

Our audit was performed in accordance with generally accepted government auditing standards.

The draft report was issued on March 10, 2003. CMS's response to the draft report, dated April 18, 2003, is appended to this report (see Appendix III).

FINDINGS AND RECOMMENDATIONS

The OBRA of 1990 expanded the DRG payment window to 3 days prior to the date of an inpatient admission. The intent of this provision was to prevent hospitals from receiving separate payments for preadmission services that were already included in the inpatient DRG payment.

However, our data match and subsequent sample results raised a question as to whether there is a need to further expand the 3-day payment window. For CY 2000, Medicare reimbursement and beneficiary coinsurance and deductible amounts for preadmission services relating to the 10 DRGs we studied was approximately $72 million.

Specifically, the results of our review of 240 claims for preadmission outpatient services related to 10 selected DRGs disclosed that: (see Figure 2)

- 138 claims (57 percent) were for admission-related services;
- 86 claims (36 percent) were for services which were not related to the admission; and
- 16 claims, for which confirmations were not received (7 percent), did not meet our criteria of being admission-related.

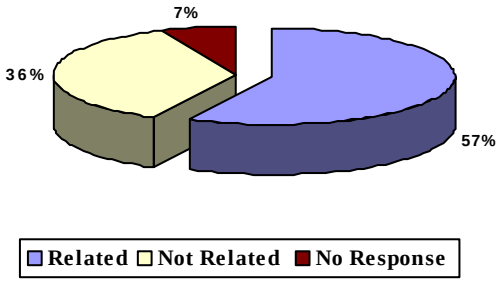

Figure 2 – Sample Results

Laboratory, diagnostic radiology, cardiology, and EKG/ECG services were the predominant services rendered by the admitting hospital and other nonrelated providers 4 to 14 days prior to date of admission.

APPLICATION OF THE DRG PAYMENT WINDOW

The January 12, 1994 Federal Register included CMS's interim final rule entitled ***Payment for Preadmission Services*** implementing the provisions of the OBRA of 1990**.** CMS, in referring to the 3-day window, stated "This regulation will result in program savings from discontinuing separate payment under Part B…without an immediate, corresponding increase in the DRG payments under Part A. *The estimated savings will be reduced if physicians elect to have preadmission services performed at a non-hospital site or more than 3 days before admission* [emphasis added]." The interim final rule stated that beneficiaries will receive benefit from a 3-day window since they will no longer be paying the coinsurance and deductible on these services. CMS further stated "…we do not anticipate that this new provision will cause a significant change in the timing of services that, until now, have been furnished during the preadmission period…The unbundling provision may generate a small amount of additional Part B costs; however,…we anticipate that the overall degree of change that this provision will produce in existing patterns of service delivery will be minimal."

The following claims illustrate the effect of the 3-day window provisions on the timing of services:

> Beneficiary A received laboratory tests and an EKG/ECG on Friday, December 8, 2000 and was subsequently admitted to the same hospital on Tuesday, December 12, 2000. The principal diagnoses for the outpatient and inpatient services were the same. Furthermore, the provider confirmed that the services were admission-related. The Medicare payment was $28.38 and the beneficiary coinsurance was $14.54. Had the services been rendered 1 day later, neither the Medicare program nor the beneficiary would have incurred any expense.
>
> Beneficiary B received laboratory tests, a chest x-ray, and an EKG/ECG from Hospital X on Friday, October 20, 2000 and was later admitted to Hospital Y on Tuesday, October 24, 2000. There was no relationship between the two providers; however, Hospital X confirmed that the services were admission-related (even though the outpatient and the inpatient principal diagnoses were different) and that the results were forwarded to Hospital Y. The Medicare payment was $123.14 and the beneficiary coinsurance was $31.91. In this example, not only did the timing of the services have a financial impact on the Medicare program and the beneficiary, but the location of the services had an impact as well.

ADMISSION-RELATED SERVICES

For each of the 240 sampled claims, we requested from the rendering provider (1) documentation (detailed bills, medical records, etc.) that supported the claim, (2) confirmation as to whether or not the services were admission-related, (3) any preadmission test scheduling policies, and (4) an indication as to the relationship between the two providers, such as wholly-owned or operated by, for those instances where the outpatient and inpatient providers were different.

In determining whether services were admission-related, we first accepted the rendering providers confirmation. Absent a confirmation, we used the relationship between the principal diagnosis codes, which, based on CMS's definition, is the "condition established after study to be chiefly responsible for admission." We also used the relationship between the outpatient principal diagnosis code and the inpatient admitting diagnosis code which is the condition identified by the physician at the time of the patient's admission. Finally, in making this determination, we used the diagnosis category (first 3 digits) versus the sub-category (all digits).

As a result of our review of the 240 claims with a dollar value of $38,769, a total of 138 claims valued at $32,652 were admission-related. Based on our statistical sample, the estimated amount of admission-related services in the universe was $37,203,394 with a precision of this estimate, at the 90 percent confidence level, of ± 34.12 percent.

With respect to the 138 claims for admission-related services, for:

- ⇨ 93 claims, the outpatient principal diagnosis matched the inpatient principal and/or admitting diagnosis (approximately $34 million); and

- ⇨ 45 claims, the outpatient principal diagnosis did not match the inpatient principal and/or admitting diagnosis (approximately $3 million).

Further analysis of the 138 claims showed the following characteristics:

- ⇨ 116 claims - laboratory, cardiology, radiology diagnostic, EKGs/ECGs, pharmacy, and medical supplies accounted for the majority of services (see Figure 3);

- ⇨ 116 claims - the providers of the outpatient and inpatient services were the same;

- ⇨ 22 claims - the providers of the outpatient and inpatient services were different and were neither wholly-owned nor operated by one or the other (see Figure 4).

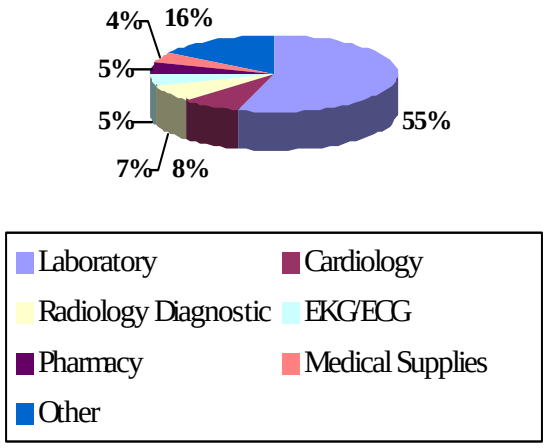

Figure 3 – Admission-Related Services

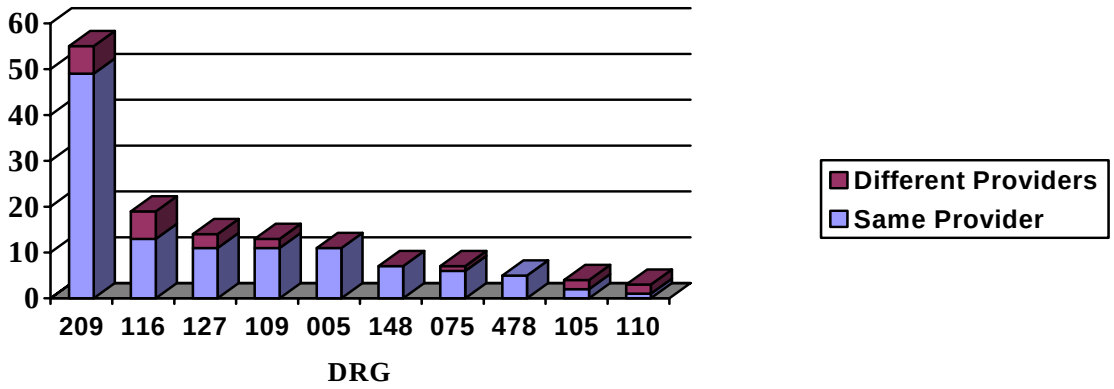

Figure 4 – Admission-Related Claims by DRG

In response to our inquiry regarding preadmission policies:

- 55 hospitals indicated that the scheduling of services is at the discretion of the physician;
- 61 hospitals indicated that they determine the scheduling of services;
- 12 hospitals indicated that they had no policy; and
- 62 providers did not respond.

Further, one provider noted "The Pre-Admission Department schedules preadmission services for all scheduled inpatient admissions. These services are scheduled from one to twenty-one days prior to the inpatient admission." Another provider indicated that "Patients may choose to have their preadmission testing done at any facility of their choice.…"

Whenever program savings are attained, corresponding savings to the beneficiary are also achieved. We found 103 of the 138 claims for admission-related services included beneficiary coinsurance and deductible amounts of $26,428. Based on our statistical sample, we estimate the beneficiary coinsurance and deductible for admission-related service totaled $35,503,845.[3] By expanding the DRG payment window and folding nonphysician outpatient services rendered 4 to 14 days prior to the date of admission into the inpatient DRG payment, beneficiaries would no longer be responsible for Part B coinsurance and deductible amounts for these admission-related services. They would, however, continue to be responsible for inpatient coinsurance and deductible amounts.

[3] Estimate is based on a ratio of estimated beneficiary coinsurance and deductible of related services to estimated value of the population applied to the actual value of the population.

SUMMARY

For CY 2000, we identified for all DRGs over $110 million in outpatient services rendered 4 to 14 days prior to subsequent inpatient admissions. An estimated $37 million of these outpatient services were in fact related to subsequent inpatient admissions for 10 DRGs. Further, these outpatient services were rendered by admitting hospitals and related providers, as well as nonrelated providers.

It has been CMS's longstanding policy to treat nonphysician outpatient services related to an admission as inpatient services. Furthermore, it was the intent of the Congress to curb further unbundling of services which occurred since the inception of inpatient PPS by expanding the DRG payment window to 3 days.

RECOMMENDATIONS

We are recommending that CMS consider proposing legislation to expand the DRG payment window as it relates to the bundling of admission-related services rendered up to 14 days prior to an inpatient admission regardless of whether the outpatient services were rendered by the admitting provider or by any other provider.

In response to technical comments, we are also recommending that CMS define admission-related services as those where the first three digits of the outpatient principal diagnosis match the first three digits of either the inpatient admitting or principal diagnosis code.

CMS COMMENT

CMS concurs with our recommendation; however, it raises concerns as to whether expanding the length of the window could influence medical practice in such a way that increases the health risks for beneficiaries. CMS would take such factors into consideration before proposing a legislative change to expand the DRG payment window.

OFFICE OF AUDIT SERVICES RESPONSE

OIG recognizes that CMS would take such factors into consideration before proposing a legislative change to expand the DRG payment window. We believe that it is possible that, in response to a change expanding the payment window to 14 days, providers could perform admission-related outpatient services outside of this payment window in order to be reimbursed separately for the services. We acknowledge there could be negative medical consequences to performing some diagnostic tests more than 14 days prior to admission to the hospital. Therefore, we understand CMS's need to address any potential health risks to the beneficiaries before proposing a legislative change.

SUMMARY OF MEDICARE PAYMENTS AND BENEFICIARY DEDUCTIBLE AND COINSURANCE AMOUNTS BY DRG BY NUMBER OF DAYS PRIOR TO AN ADMISSION

109: Coronary Bypass Without Percutaneous Transluminal Cardiac Angioplasty or Cardiac Catheterization

Days Before Inpatient Admission	Dollars For:			Number of Instances
	Paid	Deductible	Coinsurance	
4	$925,790.18	$1,433.90	$985,029.31	1,951
5	$910,759.04	$1,723.74	$966,499.35	1,966
6	$1,118,908.36	$1,869.35	$1,146,444.58	2,266
7	$1,090,149.82	$1,516.60	$1,145,775.02	2,269
8	$728,265.76	$1,504.15	$776,646.66	1,565
9	$564,423.75	$838.45	$557,429.40	1,135
10	$427,832.46	$1,321.37	$442,586.35	1,021
11	$466,704.00	$1,253.15	$484,084.17	1,049
12	$494,987.16	$1,292.80	$521,376.79	1,102
13	$578,819.37	$1,653.51	$619,319.97	1,340
14	$640,849.31	$2,221.12	$644,850.30	1,507
Totals For DRG:	**$7,947,489.21**	**$16,628.14**	**$8,290,041.90**	**17,171**

116: Other Permanent Cardiac Pacemaker Implant or Percutaneous Transluminal Cardiac Angioplasty with Coronary Artery Stent Implant

Days Before Inpatient Admission	Dollars For:			Number of Instances
	Paid	Deductible	Coinsurance	
4	$756,374.25	$4,275.47	$761,604.25	4,454
5	$777,907.48	$4,572.21	$818,219.43	4,260
6	$931,496.02	$6,255.11	$998,647.46	4,748
7	$1,304,528.62	$5,991.20	$1,433,362.93	5,603
8	$805,047.25	$3,962.07	$843,050.56	4,105
9	$524,599.87	$3,793.55	$544,185.48	3,077
10	$423,587.57	$4,018.72	$435,278.96	2,625
11	$406,558.34	$3,062.84	$417,953.37	2,512
12	$408,850.36	$4,257.13	$427,596.66	2,565
13	$549,604.01	$4,733.03	$567,144.03	3,155
14	$733,660.36	$5,600.61	$765,063.25	3,597
Totals For DRG:	**$7,622,214.13**	**$50,521.94**	**$8,012,106.38**	**40,701**

209: Major Joint & Limb Reattachment Procedures of Lower Extremity

Days Before Inpatient Admission	Dollars For:			Number of Instances
	Paid	Deductible	Coinsurance	
4	$513,356.86	$5,244.82	$330,325.85	7,411
5	$600,801.35	$7,854.18	$373,470.15	8,621
6	$954,229.06	$11,384.33	$547,599.35	12,844
7	$1,127,756.19	$14,075.47	$623,520.11	15,408
8	$585,805.49	$8,068.15	$328,213.09	8,608
9	$334,590.43	$4,579.53	$197,157.14	5,099
10	$324,689.69	$5,383.57	$193,418.38	5,115
11	$344,634.48	$6,449.48	$202,750.96	5,323
12	$351,435.38	$5,719.23	$211,585.01	5,678
13	$470,847.05	$10,690.73	$269,893.58	7,395
14	$552,432.96	$11,999.51	$311,640.33	8,294
Totals For DRG:	**$6,160,578.94**	**$91,449.00**	**$3,589,573.95**	**89,796**

005: Extracranial Vascular Procedures

Days Before Inpatient Admission	Dollars For:			Number of Instances
	Paid	Deductible	Coinsurance	
4	$527,294.25	$1,795.91	$532,729.39	2,769
5	$508,587.38	$2,350.89	$527,440.23	2,738
6	$654,762.62	$3,215.30	$690,000.06	3,447
7	$792,702.32	$4,283.07	$818,739.59	4,029
8	$549,810.30	$3,504.72	$609,407.81	2,547
9	$382,240.05	$2,311.80	$424,653.27	1,747
10	$407,325.49	$1,791.98	$437,930.54	1,647
11	$371,465.90	$2,893.24	$413,558.84	1,620
12	$379,316.05	$3,228.89	$415,846.99	1,708
13	$515,754.62	$4,411.79	$564,315.95	2,206
14	$544,043.86	$4,495.19	$631,772.33	2,325
Totals For DRG:	**$5,633,302.84**	**$34,282.78**	**$6,066,395.00**	**26,783**

148: Major Small & Large Bowel Procedures with Complication and/or Comorbidity

Days Before Inpatient Admission	Dollars For:			Number of Instances
	Paid	Deductible	Coinsurance	
4	$306,774.79	$1,875.70	$304,296.86	2,763
5	$333,562.43	$2,354.34	$337,832.58	2,956
6	$391,763.17	$3,316.05	$395,338.02	3,333
7	$398,393.87	$3,281.88	$403,214.98	3,442
8	$290,020.90	$2,097.05	$303,000.45	2,351
9	$223,156.73	$1,383.78	$241,273.18	1,853
10	$224,099.29	$1,374.03	$241,968.21	1,798
11	$232,602.98	$2,300.46	$258,932.71	1,814
12	$253,242.01	$2,530.95	$282,689.74	1,922
13	$288,860.70	$3,194.85	$313,745.35	2,185
14	$295,673.09	$3,622.43	$322,598.71	2,303
Totals For DRG:	**$3,238,149.96**	**$27,331.52**	**$3,404,890.79**	**26,720**

478: Other Vascular Procedures with Complication or Comorbidity

Days Before Inpatient Admission	Dollars For:			Number of Instances
	Paid	Deductible	Coinsurance	
4	$261,835.38	$791.42	$262,704.41	1,507
5	$249,166.62	$1,484.97	$252,549.55	1,543
6	$290,754.52	$1,573.41	$271,062.95	1,655
7	$344,847.54	$2,454.49	$345,339.37	2,013
8	$228,973.48	$2,230.57	$248,577.54	1,308
9	$180,408.66	$1,502.89	$176,996.33	1,020
10	$194,288.93	$780.35	$189,558.37	981
11	$163,298.48	$1,040.49	$166,627.84	917
12	$176,592.83	$1,222.16	$197,504.89	1,023
13	$227,293.51	$2,174.42	$236,106.91	1,211
14	$292,546.46	$1,618.11	$296,283.68	1,406
Totals For DRG:	**$2,610,006.41**	**$16,873.28**	**$2,643,311.84**	**14,584**

105: Cardiac Valve & Other Major Cardiothoracic Procedure Without Cardiac Catheterization

Days Before Inpatient Admission	Dollars For:			Number of Instances
	Paid	Deductible	Coinsurance	
4	$244,321.32	$375.29	$225,837.06	702
5	$272,593.19	$411.63	$259,783.47	738
6	$314,405.06	$301.12	$301,502.33	885
7	$363,611.57	$680.98	$346,883.22	925
8	$240,749.34	$782.36	$231,386.54	649
9	$153,969.86	$485.85	$150,461.17	443
10	$165,963.93	$380.04	$150,607.56	412
11	$164,240.54	$330.99	$165,749.30	402
12	$188,972.13	$451.72	$181,102.58	506
13	$222,351.31	$436.46	$220,853.06	617
14	$261,153.42	$789.44	$258,677.16	662
Totals For DRG:	**$2,592,331.67**	**$5,425.88**	**$2,492,843.45**	**6,941**

127: Heart Failure & Shock

Days Before Inpatient Admission	Dollars For:			Number of Instances
	Paid	Deductible	Coinsurance	
4	$265,956.83	$4,640.60	$188,286.51	5,001
5	$252,700.27	$3,649.59	$182,061.47	4,647
6	$234,708.23	$4,613.34	$166,456.32	4,726
7	$247,851.03	$5,078.66	$172,064.23	5,038
8	$201,585.55	$3,735.11	$138,907.37	4,093
9	$177,002.96	$3,603.96	$120,444.03	3,719
10	$191,585.85	$4,940.58	$134,412.66	3,932
11	$188,267.60	$4,270.97	$123,928.91	3,821
12	$170,223.34	$3,634.54	$119,499.30	3,684
13	$185,379.46	$4,408.36	$124,472.01	3,939
14	$190,730.99	$4,974.93	$126,994.54	4,273
Totals For DRG:	**$2,305,992.11**	**$47,550.64**	**$1,597,527.35**	**46,873**

075: Major Chest Procedures

Days Before Inpatient Admission	Dollars For:			Number of Instances
	Paid	Deductible	Coinsurance	
4	$165,522.51	$373.56	$138,821.57	1,269
5	$174,406.29	$404.56	$158,353.02	1,300
6	$235,266.73	$999.76	$204,358.71	1,571
7	$287,625.96	$841.52	$252,867.91	1,657
8	$188,397.98	$640.40	$174,613.50	1,199
9	$146,653.80	$480.39	$133,080.22	873
10	$161,262.16	$892.42	$156,950.06	877
11	$162,105.07	$778.86	$160,763.03	920
12	$172,372.97	$618.51	$169,633.00	975
13	$235,916.70	$1,716.98	$219,021.21	1,253
14	$274,980.09	$2,106.83	$274,969.44	1,448
Totals For DRG:	**$2,204,510.26**	**$9,853.79**	**$2,043,431.67**	**13,342**

110: Major Cardiovascular Procedures with Complication or Comorbidity

Days Before Inpatient Admission	Dollars For:			Number of Instances
	Paid	Deductible	Coinsurance	
4	$170,608.47	$685.06	$165,326.58	977
5	$170,076.16	$640.41	$177,596.80	995
6	$234,915.27	$1,086.68	$209,303.66	1,290
7	$241,441.96	$1,079.75	$239,486.59	1,434
8	$179,244.43	$1,118.84	$184,179.78	898
9	$127,839.04	$1,092.83	$136,712.38	679
10	$108,241.82	$729.70	$116,586.33	630
11	$130,492.30	$1,081.39	$142,316.24	668
12	$133,035.01	$1,184.48	$148,171.43	678
13	$194,384.98	$1,111.28	$202,252.77	861
14	$212,530.79	$1,264.37	$233,701.86	921
Totals For DRG:	**$1,902,810.23**	**$11,074.79**	**$1,955,634.42**	**10,031**

Totals for the 10 DRGs				
Days Before Inpatient Admission	**Dollars For:**			**Number of Instances**
	Paid	**Deductible**	**Coinsurance**	
4	$4,137,834.84	$21,491.73	$3,894,961.79	28,804
5	$4,250,560.21	$25,446.52	$4,053,806.05	29,764
6	$5,361,209.04	$34,614.45	$4,930,713.44	36,765
7	$6,198,908.88	$39,283.62	$5,781,253.95	41,818
8	$3,997,900.48	$27,643.42	$3,837,983.30	27,323
9	$2,814,885.15	$20,073.03	$2,682,392.60	19,645
10	$2,628,877.19	$21,612.76	$2,499,297.42	19,038
11	$2,630,369.69	$23,461.87	$2,536,665.37	19,046
12	$2,729,027.24	$24,140.41	$2,675,006.39	19,841
13	$3,469,211.71	$34,531.41	$3,337,124.84	24,162
14	$3,998,601.33	$38,692.54	$3,866,551.60	26,736
TOTALS:	**$42,217,385.76**	**$310,991.76**	**$40,095,756.75**	**292,942**

Appendix II

STATISTICAL SAMPLING METHODOLOGY

To select a sample for validation of our data and to estimate the amount of admission-related nonphysician outpatient services, we employed a multistage sample design based on probability-proportional-to-size weighted by the dollar value of the claims for each state. The sample was drawn from 49 PPS states, the District of Columbia, and Puerto Rico for a total of 51 primary sample units with 292,942 claims valued at $42 million. For our multistage sample, the primary sampling units consisted of 8 states and our secondary units consisted of 30 claims in each state (a total of 240 claims).

To select the primary unit, the following steps were performed:

- ⇨ for each state, the number of claims and the total value of these claims (outpatient paid amount) was determined;
- ⇨ the 51 primary units were randomly assigned to 8 groups; and
- ⇨ one state was selected from each of the eight groups with a chance of selection proportional to their respective dollar value within that group.

The following states were selected:

State	Claim Count	Total Amount Paid
Oregon	3,249	$559,467
Ohio	16,812	$2,363,306
Texas	12,934	$2,131,686
North Carolina	7,267	$1,234,230
Missouri	7,551	$992,056
Florida	15,847	$1,772,432
Illinois	14,058	$1,840,759
New Jersey	5,851	$1,326,247

The selection of the secondary units was by a simple random sample of claims for nonphysician outpatient services. Thirty claims were selected from the population of claims in each of the 8 states. We evaluated our sample based on a confidence level at 90 percent.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR 18 2003

TO: Janet Rehnquist
Inspector General

FROM: Thomas A. Scully
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: *Expansion of the Diagnosis Related Group Payment Window* (A-01-02-00503)

Thank you for the opportunity to comment on the above-referenced report. We agree that expanding the diagnosis related group (DRG) window as OIG recommends should result in savings for the Medicare program and decreased out-of-pocket spending for program beneficiaries. However, such a policy would have to be evaluated in light of other goals as well.

As the OIG report states, the Centers for Medicare & Medicaid Services (CMS) would have to propose legislation to expand the DRG window as recommended. The OIG's report does not address any risks that may be associated with its proposal; for example, if expanding the length of the window could influence medical practice in such a way that increases health risks for beneficiaries. The CMS would have to take such factors into consideration before proposing a legislative change to expand the DRG payment window.

We concur with OIG's recommendations. Our specific and technical comments are as follows.

OIG Recommendations

CMS should consider proposing legislation to expand the DRG payment window as it relates to: the length of time prior to the day of admission for which services could still be considered inpatient services; and the bundling of admission-related services regardless of where the services were rendered.

CMS Response

We concur. However, as previously mentioned, the report does not address any risks that may be associated with its recommendations; for example, if expanding the length of the window could influence medical practice in such a way that increases health risks for beneficiaries. The CMS would have to take such factors into consideration before proposing a legislative change to expand the DRG payment window.