Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE GENERALLY PAID ACUTE-CARE HOSPITALS FOR INPATIENT STAYS FOR MEDICARE ENROLLEES DIAGNOSED WITH COVID-19 IN ACCORDANCE WITH FEDERAL REQUIREMENTS

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Report in Brief
Date: December 2023
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Generally Paid Acute-Care Hospitals for Inpatient Stays for Medicare Enrollees Diagnosed With COVID-19 in Accordance With Federal Requirements

Why OIG Did This Audit

The Coronavirus Aid, Relief, and Economic Security Act increased the payment amount that acute-care hospitals received for Medicare enrollees who were diagnosed with COVID-19 and discharged during the COVID-19 public health emergency (PHE). OIG's previous work related to pneumonia and other diagnosis codes on claims documented aberrant billing by some hospitals. In addition, acute-care hospitals may have had a financial incentive to include a COVID-19 diagnosis on claims to receive additional payments. For these reasons, we conducted this audit of Medicare payments to acute-care hospitals for inpatient stays with admission dates from September 1 through November 30, 2020, for enrollees diagnosed with COVID-19.

Our objective was to determine whether Medicare paid acute-care hospitals for inpatient stays for enrollees diagnosed with COVID-19 in accordance with Federal requirements.

How OIG Did This Audit

Our audit covered $2.7 billion in Medicare payments for 166,107 claims billed by acute-care hospitals. We selected a random sample of 150 claims and excluded 1 claim because the acute-care hospital did not receive the increased payment. We submitted the remaining 149 claims to an independent medical review contractor to determine whether the claims met coverage, medical necessity, and coding requirements.

What OIG Found

Of the 149 sampled claims for inpatient stays for enrollees diagnosed with COVID-19, 146 claims complied with Federal requirements; however, the remaining 3 claims did not comply with the requirements. As a result, Medicare improperly paid hospitals $18,911. These improper payments occurred primarily because the acute-care hospitals made clerical errors when billing claims for inpatient stays. We provided the Centers for Medicare & Medicaid Services (CMS) with the billing details and our findings for the three improperly paid claims so that it can evaluate these claims and decide whether to recover the improper payments in accordance with the agency's policies and procedures.

At the time of our audit, CMS stated that, with the recent end of the COVID-19 PHE on May 11, 2023, CMS was assessing which actions would be most useful in a future PHE, such as a natural disaster or other emergencies, to: (1) ensure a rapid response to future emergencies, both locally and nationally, or (2) address the unique needs of communities that may experience barriers to accessing health care. CMS also stated that it will use lessons learned from the COVID-19 PHE and assessments of the actions it took in response to the PHE to inform what steps it takes in responding to future emergencies, such as mitigating risk by having a policy in place to ensure that payments are made only for treatments that are reasonable and medically necessary.

What OIG Recommends

This report does not have any recommendations because Medicare generally paid acute-care hospitals for inpatient stays for enrollees diagnosed with COVID-19 in accordance with Federal requirements, the improper payments we identified resulted primarily from clerical errors made by the acute-care hospitals, and Medicare no longer pays hospitals the additional amount for billing a claim for a Medicare enrollee diagnosed with COVID-19.

Because this report contains no recommendations, CMS did not provide written comments on our draft report but did provide technical comments, which we addressed as appropriate.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) increased the payment amount that acute-care hospitals received for Medicare enrollees who were diagnosed with COVID-19 and discharged during the COVID-19 public health emergency (PHE).[1, 2] For admissions on or after September 1, 2020, the Centers for Medicare & Medicaid Services (CMS) required acute-care hospitals to document a positive COVID-19 laboratory test in an enrollee's medical records to receive the increased payment.

The Office of Inspector General's (OIG's) previous work related to pneumonia and other diagnosis codes on claims documented aberrant billing by some hospitals.[3] In addition, acute-care hospitals may have had a financial incentive to include a COVID-19 diagnosis on claims to receive additional payments. During a U.S. House of Representatives hearing on July 31, 2020, investigating the Federal Government's response to the COVID-19 pandemic, then-Director of the Centers for Disease Control and Prevention (CDC) Dr. Robert Redfield was asked about the possibility of providers incorrectly coding claims for higher reimbursement. He stated that there was "some reality" to hospitals preferring to bill for certain diagnoses to receive an increased payment amount, which raises the possibility that hospitals incorrectly billed for enrollee discharges with a COVID-19 diagnosis to receive the increased payment.[4] For these reasons, we conducted this audit of Medicare's payments to acute-care hospitals for inpatient stays with admission dates from September 1 through November 30, 2020 (audit period) for enrollees diagnosed with COVID-19.

OBJECTIVE

Our objective was to determine whether Medicare paid acute-care hospitals for inpatient stays for enrollees diagnosed with COVID-19 in accordance with Federal requirements.

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[1] Acute-care hospitals are hospitals that provide inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

[2] CARES Act, P.L. No. 116-136, § 3710 (Mar. 27, 2020).

[3] *DRG 89: Simple Pneumonia and Pleurisy* (OAI-12-88-01140) June 1989; *Monitoring the Accuracy of Hospital Coding* (OEI-01-98-00420) Jan. 21, 1999.

[4] *The Urgent Need for a National Plan To Contain the Coronavirus,* Hearing Before the Select Subcommittee on the Coronavirus Crisis of the Committee on Oversight and Reform, House of Representatives (Serial No. 116-109), July 31, 2020. The transcript is available online at https://www.govinfo.gov/content/pkg/CHRG-116hhrg41909/pdf/CHRG-116hhrg41909.pdf. Accessed on Oct. 26, 2023.

BACKGROUND

Medicare Part A and the Hospital Inpatient Prospective Payment System

The Medicare program provides health insurance for people aged 65 and older, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for Medicare enrollees after they are discharged from the hospital. CMS administers the Medicare program. CMS uses Medicare Administrative Contractors (MACs) to, among other things, process and pay claims submitted by acute-care hospitals.

Medicare uses an inpatient prospective payment system (IPPS) to pay for inpatient hospital services provided to Part A enrollees (the Social Security Act (the Act) §§ 1886(d) and (g)). Under the IPPS, CMS pays acute-care hospital costs at predetermined rates for patient discharges. The rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which an enrollee's stay is assigned. The MS-DRG payment is, with certain exceptions, intended to be payment in full to an acute-care hospital for all inpatient costs associated with an enrollee's stay. The MS-DRG payment for an enrollee's stay is calculated by multiplying the weighting factor for the MS-DRG by the hospital's base payment rate.[5]

COVID-19 Public Health Emergency

COVID-19 is a disease caused by a highly contagious coronavirus, called SARS-CoV-2. COVID-19's symptoms include fever, fatigue, cough, and shortness of breath. The disease is fatal in some cases. Older adults and people who have severe underlying medical conditions, such as heart or lung disease or diabetes, are at higher risk for developing more serious complications from COVID-19.

On January 31, 2020, acting within his authority under section 319 of the Public Health Service Act, then-Secretary of Health and Human Services (HHS) Alex Azar declared a PHE for the United States for COVID-19 retroactive to January 27, 2020, and extended the PHE at regular intervals throughout his time in office. HHS Secretary Xavier Becerra, after extending the PHE on several occasions, ended the PHE on May 11, 2023. During the PHE, CDC reported 6.1 million hospitalizations from COVID-19 in the United States.

[5] Each year, CMS assigns a weighting factor to each MS-DRG based on the average amount of resources that it takes to care for an enrollee assigned to that MS-DRG relative to the average resources used to treat cases in all MS-DRGs (e.g., cases assigned to MS-DRGs with a weighting factor less than 1.0 are less resource-intensive to treat and are generally less costly to treat). A hospital's base payment rate is calculated based on labor and nonlabor factors (including the costs of health care resources and labor, generally based on where the hospital is located). The labor-related share is adjusted by the wage index applicable to the area where the hospital is located (calculated by dividing the area's average hourly wage by the national average hourly wage), and if the hospital is located in Alaska or Hawaii, the nonlabor share is adjusted by a cost-of-living adjustment factor.

Hospital Billing of Inpatient Claims for Enrollees Diagnosed With COVID-19

On March 27, 2020, Congress passed the CARES Act, which allotted $2.2 trillion to provide fast and direct economic aid to those negatively impacted by the COVID-19 PHE. Section 3710 of the CARES Act directed the HHS Secretary to increase by 20 percent the weighting factor that would otherwise apply to the assigned MS-DRG for an enrollee diagnosed with COVID-19 discharged during the PHE.[6] This provision stated that the Secretary may implement this provision "by program instruction or otherwise," notwithstanding any other provision of law.

Diagnosis Codes for Enrollees Discharged With a Diagnosis of COVID-19

To implement section 3710 of the CARES Act, CMS notified MACs and acute-care hospitals that a discharge of an enrollee diagnosed with COVID-19 would be identified by the presence of one of two *International Classification of Diseases*, 10th Revision, Clinical Modification (ICD-10-CM), diagnosis codes on a claim:[7]

- For discharges from January 27 through March 31, 2020, hospitals were to bill for confirmed cases of COVID-19 using ICD-10-CM diagnosis code B97.29.

- For discharges on or after April 1, 2020, through the duration of the COVID-19 PHE, hospitals were to bill for confirmed cases of COVID-19 using ICD-10-CM diagnosis code U07.1.[8]

CMS made changes to its claims processing system in April 2020 to apply the 20-percent increase to the MS-DRG weighting factor for IPPS claims submitted with the ICD-10-CM diagnosis code related to COVID-19 that was appropriate for the timeframe (e.g., U07.1 on or after April 1, 2020).[9] We refer to diagnosis code U07.1 as the "COVID-19 diagnosis code" throughout this report because our audit period started after April 1, 2020.

[6] Only the relative weight that is used to calculate the MS-DRG payment was increased by 20 percent, not the entire MS-DRG payment.

[7] HHS adopted the ICD-10-CM as the official code set for coding diagnoses and inpatient hospital procedures effective Mar. 17, 2009 (74 Fed. Reg. 3328 (Jan. 16, 2009)). The ICD-10-CM was developed and is maintained by CDC's National Center for Health Statistics.

[8] CMS, Change Request (CR) 11764 (Apr. 24, 2020); Medicare Learning Network (MLN) Matters Number: MM11764; MLN Matters Number: SE20015 (Revised); CDC, *ICD-10-CM Official Coding Guidelines – Supplement Coding Encounters Related to COVID-19 Coronavirus Outbreak*; CDC, *New ICD-10-CM Official Code for the 2019 Novel Coronavirus (COVID-19)*.

[9] In CR 11764, CMS instructed the MACs to identify and reprocess IPPS claims billed with ICD-10-CM diagnosis code B97.29 with discharge dates on or after Jan. 27 through Mar. 31, 2020, and ICD-10-CM diagnosis code U07.1 with discharge dates on or after Apr. 1, 2020, so that hospitals could receive the increased payment for such claims processed before the change in the claims processing system.

Documentation Requirements for Receiving an Increased Payment for Inpatient Claims Submitted With the COVID-19 Diagnosis Code

To address potential Medicare program integrity risks, effective with admissions on or after September 1, 2020, claims eligible for the 20-percent increase in the MS-DRG weighting factor were required to have a positive COVID-19 laboratory test documented in the enrollee's medical records. Positive tests had to be demonstrated using only the results of viral testing (i.e., antigen or molecular), consistent with CDC guidelines.[10] The viral test had to be performed either during or before an enrollee's admission to the hospital. For this purpose, a viral test performed within 14 days before the hospital admission, including a test performed by an entity other than the hospital, could be manually entered into the enrollee's medical record to satisfy this documentation requirement.[11]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $2.7 billion in Medicare payments for 166,107 claims with a payment amount greater than $1,000 for inpatient stays billed by acute-care hospitals and paid under the IPPS with admission dates during our audit period with the COVID-19 diagnosis code (i.e., U07.1) in any of the claims' fields for diagnosis codes.

We selected for review a stratified random sample of 150 claims, with payments totaling $3.4 million. We did not review one sampled claim because the hospital billed the claim with the COVID-19 diagnosis code in the field for the admitting diagnosis code but not in the fields for either the principal diagnosis code or other diagnosis codes, resulting in the hospital not receiving the increased payment.[12] We submitted the remaining 149 claims to an independent medical review contractor to determine whether the claims met coverage, medical necessity, and coding requirements.

[10] An antigen test identifies the presence of a particular kind of protein that is found on the exterior of the COVID-19 coronavirus and is performed on a sample taken by swabbing an enrollee's nose or the upper part of the throat behind the nose. A molecular test identifies COVID-19's genetic material of and is performed on a sample taken by: (1) swabbing an enrollee's nose, the upper part of the throat behind the nose, or the middle part of the throat just behind the oral cavity or (2) collecting an enrollee's saliva.

[11] MLN Matters Number: SE20015 (Revised).

[12] The claim's field for the admitting diagnosis code is used to indicate the condition that a physician identified at the time of the patient's admission requiring hospitalization. For a hospital to receive the increased payment, it must include the COVID-19 diagnosis code in either the field for the principal diagnosis code (i.e., the condition established after study to be chiefly responsible for the enrollee's admission) or the fields for secondary diagnosis codes (i.e., other conditions that coexist or develop subsequently during the enrollee's treatment). Of the 166,107 claims, 598 had the COVID-19 diagnosis code in the field for the admitting diagnosis code but not in either the field for the principal diagnosis code or the fields for secondary diagnosis codes. We provided CMS with the billing details for the 598 claims so that it is aware of which acute-care hospitals did not receive the increased payment.

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 A contains the details of our audit scope and methodology, and Appendix B describes our statistical sampling methodology.

FINDING

Medicare generally paid acute-care hospitals for inpatient stays for enrollees diagnosed with COVID-19 in accordance with Federal requirements. Of the 149 sampled claims, 146 complied with Federal requirements; however, the remaining 3 claims did not comply with the requirements. As a result, Medicare improperly paid hospitals $18,911. These improper payments occurred primarily because the acute-care hospitals made clerical errors when billing claims for inpatient stays.

FEDERAL REQUIREMENTS AND GUIDANCE

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider without information necessary to determine the amount due the provider (the Act § 1815(a)). Federal regulations state that an acute-care hospital must furnish to the MAC sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)). MS-DRGs are assigned to specific hospital discharges based on claim data submitted by hospitals, including the principal diagnosis and secondary diagnoses (42 CFR § 412.60(c)); therefore, claim data must be accurate. The *Medicare Claims Processing Manual* states that "in order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

Effective with enrollee admissions on or after September 1, 2020, claims eligible for the 20-percent increase in the MS-DRG weighting factor were required to have documentation of a positive COVID-19 laboratory test. Positive tests had to be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC's guidelines. The viral test had to be performed either during or before an enrollee's admission to the hospital. For this purpose, a viral test performed within 14 days before the hospital admission, including a test performed by an entity other than the hospital, could be manually entered into the enrollee's medical record to satisfy this documentation requirement. For admissions through

May 11, 2023 (the end of the PHE), claims billed with the COVID-19 diagnosis code were eligible for a 20-percent increase in the MS-DRG weighting factor.[13]

MEDICARE GENERALLY PAID ACUTE-CARE HOSPITALS FOR INPATIENT STAYS FOR ENROLLEES DIAGNOSED WITH COVID-19 IN ACCORDANCE WITH FEDERAL REQUIREMENTS

Of the 149 sampled claims, 146 complied with Medicare billing requirements. However, three claims did not comply with the requirements. Specifically:

- For two claims, acute-care hospitals incorrectly billed the COVID-19 diagnosis code for an inpatient stay in which: (1) an enrollee received a positive COVID-19 test more than 14 days before their hospital admission date and (2) a hospital did not include the documentation of a positive laboratory test in an enrollee's medical records. This incorrect billing resulted in the hospitals receiving the 20-percent increase in the MS-DRG weighting factor and Medicare improperly paying the hospitals for these claims.

- For one claim, an acute-care hospital correctly billed the COVID-19 diagnosis code for an inpatient stay but incorrectly billed diagnosis code J69.0 (pneumonitis due to inhalation of food and vomit[14]) as the principal diagnosis instead of diagnosis code J96.01 (acute respiratory failure with hypoxia[15]), which was incorrectly billed as a secondary diagnosis code. This incorrect billing resulted in the incorrect MS-DRG being assigned to this specific hospital discharge and Medicare improperly paying the acute-care hospital for this claim.

The improper payments for these three claims totaled $18,911.

These improper payments occurred primarily because the acute-care hospitals made clerical errors when billing claims for inpatient stays. For example, according to one of the acute-care hospitals that incorrectly billed the COVID-19 diagnosis code for an inpatient stay, it erroneously deleted on its claim the "No Pos Test" remark code (this code indicates "no positive COVID-19 test"). This remark code is used to notify a MAC that a hospital diagnosed an enrollee with COVID-19 consistent with the *ICD-10-CM Official Coding and Reporting Guidelines* but does not have evidence of a positive test result. Based on Medicare requirements, adding this remark code would have prevented the hospital from receiving the additional payment

[13] Section 3710 of the CARES Act; CR 11764; MLN Matters Number: MM11764; MLN Matters Number: SE20015 (Revised).

[14] Pneumonitis is inflammation of lung tissue.

[15] Acute respiratory failure occurs when the lungs cannot release enough oxygen into the blood, preventing the organs from properly functioning. Hypoxia is low levels of oxygen in body tissues, which can cause symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin.

associated with the 20-percent increase in the MS-DRG weighting factor for billing the claim with the COVID-19 diagnosis code (MLN Matters Number: SE20015 (Revised)).

CONCLUSION

Medicare properly paid acute-care hospitals for most of our sampled claims for inpatient stays for enrollees diagnosed with COVID-19. We provided CMS with the billing details and our findings for the three improperly paid claims so that it can evaluate these claims and decide whether to recover the improper payments in accordance with the agency's policies and procedures. This report does not have any recommendations because Medicare generally paid acute-care hospitals for inpatient stays for enrollees diagnosed with COVID-19 in accordance with Federal requirements, the improper payments we identified resulted primarily from clerical errors made by the acute-care hospitals when billing the claims, and Medicare no longer pays hospitals the additional amount associated with the 20-percent increase in the MS-DRG weighting factor for billing a claim with the COVID-19 diagnosis code.

At the time of our audit, CMS stated that, with the recent end of the COVID-19 PHE on May 11, 2023, CMS was assessing which actions would be most useful in a future PHE, such as a natural disaster or other emergencies, to: (1) ensure a rapid response to future emergencies, both locally and nationally, or (2) address the unique needs of communities that may experience barriers to accessing health care. CMS also stated that it will use lessons learned from the COVID-19 PHE and assessments of the actions it took in response to the PHE to inform what steps it takes in responding to future emergencies, such as mitigating risk by having a policy in place to ensure that payments are made only for treatments that are reasonable and medically necessary.

Because this report contains no recommendations, CMS did not provide written comments on our draft report but did provide technical comments, which we addressed as appropriate.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $2,664,514,986 in Medicare payments for 166,107 claims with a payment amount greater than $1,000 for inpatient stays billed by acute-care hospitals paid under the IPPS with admission dates from September 1 through November 30, 2020, with the COVID-19 diagnosis code in any of the claims' fields for diagnosis codes.

We selected for review a stratified random sample of 150 claims, with payments totaling $3,447,932. We did not review one sampled claim because the hospital billed the claim with the COVID-19 diagnosis code in the field for the admitting diagnosis code but not in the fields for either the principal diagnosis code or other diagnosis codes, resulting in the hospital not receiving the increased payment.[16] We submitted the remaining 149 claims to an independent medical review contractor to determine whether the claims met coverage, medical necessity, and coding requirements.

We did not perform an overall assessment of the internal control structures of CMS. Rather, we limited our review to those controls that were significant to our objective. Specifically, we assessed provider education and CMS's procedures to identify and monitor acute-care hospitals that were potentially at risk of incorrectly receiving the increased MS-DRG payment by billing for the COVID-19 diagnosis code (e.g., acute-care hospitals with a high percentage of short-stay claims).[17]

Our audit enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file. We assessed the reliability of the claims data from OIG's copy of CMS's NCH file by: (1) considering prior data reliability assessments from OIG's copy of this file and (2) performing electronic testing on the data, such as testing for missing data. We determined that the data were sufficiently reliable for the purposes of this audit.

We conducted our audit from August 2020 to November 2023, which included contacting CMS in Baltimore, Maryland, and the acute-care hospitals that received payments for the 150 sampled claims.

[16] The claim's field for the admitting diagnosis code is used to indicate the condition that a physician identified at the time of the patient's admission requiring hospitalization. For a hospital to receive the increased payment, it must include the COVID-19 diagnosis code in either the field for the principal diagnosis code (i.e., the condition established after study to be chiefly responsible for the enrollee's admission) or the fields for secondary diagnosis codes (i.e., other conditions that coexist or develop subsequently during the enrollee's treatment). Of the 166,107 claims, 598 had the COVID-19 diagnosis code in the field for the admitting diagnosis code but not in either the field for the principal diagnosis code or the fields for other diagnosis codes. We provided CMS with the billing details for the 598 claims so that it is aware of which acute-care hospitals did not receive the increased payment.

[17] A short-stay claim is a claim in which a hospital billed for an enrollee's stay as inpatient and the stay did not exceed 2 days.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed staff at CMS regarding the types of procedures, system edits, and provider education materials specific to acute-care hospitals billing for COVID-19 inpatient stays;
- used CMS's NCH file to identify Medicare Part A claims billed with the COVID-19 diagnosis code with admission dates from September 1 through November 30, 2020;
- created a sampling frame of 166,107 Medicare Part A paid claims, totaling $2,664,514,986, consisting of claims with a payment amount greater than $1,000 for stays billed by acute-care hospitals paid under the IPPS with admission dates during our audit period with the COVID-19 diagnosis code in any of the claims' fields for diagnosis codes;
- selected for review a stratified random sample of 150 claims, totaling $3,447,932 (Appendix B), and:
    - reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been canceled or adjusted,
    - obtained from acute-care hospitals supporting documentation for each sampled claim,
    - used an independent medical review contractor to determine whether each sample claim complied with selected billing requirements, and
    - for each sampled claim that was incorrectly billed, obtained the calculated improper payment amount from the MAC that processed and paid the claim; and
- discussed the results of our audit with CMS officials.

On November 28, 2023, we provided CMS with our draft audit report. CMS had no written comments but did provide technical comments.

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: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame contained 166,107 Medicare Part A paid claims, totaling $2,664,514,986. The frame consisted of claims with a payment amount greater than $1,000 for stays billed by acute-care hospitals paid under the IPPS with admission dates during our audit period with the COVID-19 diagnosis code in any of the claims' fields for diagnosis codes.

SAMPLE UNIT

The sample unit was a Medicare Part A paid claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We selected 150 sampled claims for review. See the table for the details of each stratum.

Table: Claims by Stratum

Stratum	Claim Type	Frame Size (Claims)	Value of Frame	Sample Size
1	Claims for which the COVID-19 diagnosis code did not indicate that COVID-19 was present on admission (POA)*	3,648	$83,324,744	30
2	Short-stay claims not included in stratum 1	27,675	315,291,402	30
3	All remaining claims not included in strata 1 or 2 with payment amounts less than or equal to $20,000	112,120	1,359,030,080	45
4	All remaining claims not included in strata 1 or 2 with payment amounts greater than $20,000	22,664	906,868,760	45
	Total	**166,107**	**$2,664,514,986**	**150**

*CMS requires the principal and all other diagnosis codes reported on claims involving inpatient admissions to acute-care hospitals to include a POA indicator so that the diagnoses can be grouped into the proper MS-DRG. We included claims in stratum 1 if the hospitals did not indicate that COVID-19 was present at the time of inpatient admission (i.e., the COVID-19 diagnosis code did not include POA indicator "Y," which indicates that the diagnosis was present at the time of inpatient admission).

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services, statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the items in each stratum in the sampling frame by a unique identifier assigned to each claim in OIG's copy of CMS's NCH file. Then, we consecutively numbered the items in each stratum in the sampling frame. After generating the random numbers for our sample according to our sample design, we selected the corresponding claims in each stratum for review.