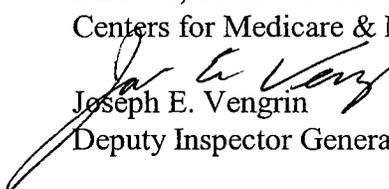




DEC 19 2005

**TO:** Herb Kuhn  
Director, Center for Medicare Management  
Centers for Medicare & Medicaid Services

**FROM:**   
Joseph E. Vengrin  
Deputy Inspector General for Audit Services

**SUBJECT:** Nationwide Review of Compliance With the Interrupted Stay Provision of the Inpatient Rehabilitation Facility Prospective Payment System for Calendar Years 2002 and 2003 (A-01-04-00525)

Attached are two copies of our final report on compliance with the interrupted stay provision of the inpatient rehabilitation facility (IRF) prospective payment system for calendar years 2002 and 2003. Our objective was to determine whether IRFs billed claims in compliance with Medicare prospective payment system regulations for interrupted stays.

The IRF prospective payment system uses Federal prospective payment rates. A number of adjustments may apply to the prospective payment, including adjustments for interrupted stays in which a Medicare inpatient is discharged from an IRF and returns to the same IRF within 3 consecutive calendar days. For payment purposes, the IRF should combine the interrupted stay into a single claim and receive a single discharge payment.

Through a nationwide computer match designed to identify interrupted stays billed as multiple claims, we found that IRFs did not always bill claims in compliance with Medicare prospective payment system regulations for interrupted stays. Specifically, during calendar years 2002 and 2003, Medicare made net overpayments of \$5.9 million to 589 IRFs for interrupted stays billed as 2 or more claims.

Our fieldwork at eight IRFs found that the payment errors occurred because these IRFs did not have the necessary controls to identify or correctly bill interrupted stays. Additionally, Medicare payment controls in the Common Working File were not designed to identify all interrupted stays billed as two or more claims or to prevent improper payments.

We recommend that the Centers for Medicare & Medicaid Services (CMS):

- direct its fiscal intermediaries to recover the \$5.9 million in net overpayments identified in our review;
- use the results of this review to clarify guidance to IRFs regarding the correct billing of interrupted stays;

- strengthen the edit in its Common Working File to detect all interrupted stays incorrectly billed as two or more claims and prevent associated payments; and
- instruct its fiscal intermediaries to conduct matches similar to the one that we conducted, until the Common Working File edit is strengthened, to identify additional payment errors for claims after December 31, 2003.

CMS agreed with our recommendations to recover the overpayments and clarify guidance to IRFs. Additionally, CMS stated that it had implemented the recommended edit in its Common Working File as of April 1, 2005. CMS did not agree with our recommendation to instruct its fiscal intermediaries to conduct matches because it believed that the edit would prevent future inappropriate payments. However, we are concerned that the edit will not detect and correct payment errors that occurred between December 31, 2003, and April 1, 2005. Therefore, we believe that the fiscal intermediaries should conduct matches similar to the one that we conducted to identify additional payment errors for that period.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations in the next 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or 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 [george.reeb@oig.hhs.gov](mailto:george.reeb@oig.hhs.gov). Please refer to report number A-01-04-00525 in all correspondence.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**NATIONWIDE REVIEW OF  
COMPLIANCE WITH THE  
INTERRUPTED STAY PROVISION OF  
THE INPATIENT REHABILITATION  
FACILITY PROSPECTIVE PAYMENT  
SYSTEM FOR CALENDAR YEARS  
2002 AND 2003**



**Daniel R. Levinson  
Inspector General**

**DECEMBER 2005  
A-01-04-00525**

# ***Office of Inspector General***

<http://oig.hhs.gov>

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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 HHS divisions will make final determination on these matters.



## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Section 1886(j) of the Social Security Act established a Medicare prospective payment system for inpatient rehabilitation facilities (IRFs). IRFs provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and a multidisciplinary coordinated team approach to upgrade their ability to function.

The Centers for Medicare & Medicaid Services (CMS) implemented the prospective payment system for cost reporting periods beginning on or after January 1, 2002. The IRF payment system uses Federal prospective payment rates across 100 distinct case-mix groups. A number of adjustments may apply to the case-mix-group payment, including adjustments for interrupted stays in which a Medicare inpatient is discharged from an IRF and returns to the same IRF within 3 consecutive calendar days. For payment purposes, the IRF should combine the interrupted stay into a single claim and receive a single discharge payment.

### **OBJECTIVE**

Our objective was to determine whether IRFs billed claims in compliance with Medicare prospective payment system regulations for interrupted stays.

### **SUMMARY OF FINDING**

IRFs did not always bill claims in compliance with Medicare prospective payment system regulations for interrupted stays. Our nationwide computer match, which was designed to identify interrupted stays billed as multiple claims, showed that 589 IRFs billed incorrectly for 1,458 interrupted stays during calendar years 2002 and 2003. As a result, Medicare made net overpayments of \$5.9 million to these IRFs.

Our fieldwork at eight IRFs found that the payment errors occurred because these IRFs did not have the necessary controls to identify or correctly bill interrupted stays. Additionally, Medicare payment controls in CMS's Common Working File were not designed to identify all interrupted stays billed as two or more claims or to prevent improper payments.

### **RECOMMENDATIONS**

We recommend that CMS:

- direct its fiscal intermediaries to recover the \$5.9 million in net overpayments identified in our review;
- use the results of this review to clarify guidance to IRFs regarding the correct billing of interrupted stays;

- strengthen the edit in its Common Working File to detect all interrupted stays incorrectly billed as two or more claims and prevent associated payments; and
- instruct its fiscal intermediaries to conduct matches similar to the one that we conducted, until the Common Working File edit is strengthened, to identify additional payment errors for claims after December 31, 2003.

We will provide CMS with detailed claims information to assist in the recovery process.

### **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In written comments on our draft report, CMS agreed with our recommendations to recover the overpayments and clarify guidance to IRFs. Additionally, CMS stated that it had implemented the recommended edit in its Common Working File as of April 1, 2005. CMS did not agree with our recommendation to instruct its fiscal intermediaries to conduct matches to identify additional payment errors. CMS believed that the edit would prevent future inappropriate payments and that additional matches therefore would be unnecessary. CMS expected that contractors would consider budgeting appropriate resources for reviewing incorrectly billed claims if the edit identified a large volume of such claims. We have included CMS's comments as Appendix B.

### **OFFICE OF INSPECTOR GENERAL RESPONSE**

Although we commend CMS's prompt implementation of the Common Working File edit to prevent future overpayments, we are concerned that the edit will not detect and correct payment errors that occurred between December 31, 2003, and April 1, 2005. Therefore, we believe that the fiscal intermediaries should conduct matches similar to the one that we conducted to identify additional payment errors for that period.

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# INTRODUCTION

## BACKGROUND

### **Inpatient Rehabilitation Facilities and the Prospective Payment System**

In 1983, amendments to the Social Security Act (the Act) established Medicare prospective payment systems for most inpatient services but excluded certain specialty hospitals, such as inpatient rehabilitation facilities (IRFs) and distinct-part rehabilitation units in hospitals.<sup>1</sup> IRFs provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and a multidisciplinary coordinated team approach to upgrade their ability to function.

To control escalating costs, section 1886(j) of the Act established a prospective payment system for IRFs. The Centers for Medicare & Medicaid Services (CMS) implemented the prospective payment system for cost reporting periods beginning on or after January 1, 2002.

### **Payments for Inpatient Rehabilitation Facility Services**

The prospective payment system provides for a predetermined, discharge-based payment. The payment system uses information from a patient assessment instrument to classify patients into 100 distinct case-mix groups based on clinical characteristics and expected resource needs.

Medicare adjusts the case-mix-group payment in the following circumstances. (Only the first adjustment is at issue in this report.)

- An adjustment is made for an interrupted stay in which a patient is discharged from an IRF and returns to the same IRF within 3 consecutive calendar days. The IRF receives a single discharge payment for the interrupted stay. If a provider submits two or more claims for the interrupted stay, the second and subsequent claims should be canceled and the first claim should be adjusted to add the interruption dates and additional stay(s).
- An adjustment is made for a patient's transfer from an IRF to a facility, such as a hospital, that accepts Medicare and/or Medicaid. If the patient's length of stay at the IRF was less than the average length of stay for the given case-mix group, the IRF receives a per diem payment and an additional half-day payment for the first day instead of a full discharge payment.
- An adjustment is made for short stays (3 days or less) at an IRF that do not involve a transfer. The IRF receives a separate case-mix-group payment without consideration of the patient's clinical characteristics.

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<sup>1</sup>We refer to these IRFs and distinct-part rehabilitation units as IRFs, collectively, throughout the report.

- An adjustment is made for outlier payments, which are made in addition to the case-mix-group payment to reduce the financial losses caused by treating patients who require more costly care.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether IRFs billed claims in compliance with Medicare prospective payment system regulations for interrupted stays.

### **Scope**

The audit included Medicare payments to IRFs nationwide with discharge dates occurring in calendar years (CYs) 2002 and 2003. In CY 2002, 1,180 IRFs were paid \$4.2 billion for 337,487 claims; in CY 2003, 1,221 IRFs were paid \$6.4 billion for 500,143 claims.

We limited our review of internal controls to obtaining an understanding of the controls in CMS's Common Working File to detect improperly billed interrupted stays and prevent payment errors to IRFs. At the eight IRFs that we visited, we limited our review of internal controls to the development and submission of Medicare claims that included interrupted stays.

We performed our fieldwork from July through September 2004 at selected IRFs in Maine, New Hampshire, Massachusetts, and Rhode Island and at one fiscal intermediary, Anthem Health Plans of Maine, Inc.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- reviewed Medicare payment controls in CMS's Common Working File to detect improperly billed interrupted stays and prevent overpayments;
- extracted paid claims data from CMS's National Claims History for CYs 2002 and 2003;
- developed a computer match to identify situations in which IRFs submitted two or more claims for a single IRF stay by matching the "from" date of an IRF claim to the "through" date of a previous claim within a 3-day window;
- calculated the effect of incorrect billing by repricing each interrupted stay as a single claim;
- selected a sample of 28 incorrectly billed interrupted stays from 8 IRFs (6 hospital-based and 2 freestanding) and met with representatives of these IRFs to identify control

weaknesses and validate billing information using medical records and patient assessment instruments;

- reviewed the applicable detailed Common Working File records for the selected interrupted stays to validate the parameters of our computer match and to verify that selected claims had not been canceled; and
- discussed with CMS officials the results of our review and the feasibility of strengthening the edit within the Common Working File.

In completing our review, we established reasonable assurance that the data were accurate. Our audit was not directed toward assessing the completeness of the file from which the data were obtained.

We performed the review in accordance with generally accepted government auditing standards.

## **FINDING AND RECOMMENDATIONS**

IRFs did not always bill claims in compliance with Medicare prospective payment system regulations for interrupted stays. Our nationwide computer match showed that 589 IRFs billed incorrectly for 1,458 interrupted stays during CYs 2002 and 2003. As a result, Medicare made net overpayments of \$5.9 million to these IRFs.

Our fieldwork at eight IRFs found that the payment errors occurred because these IRFs did not have the necessary controls to identify or correctly bill interrupted stays. Additionally, Medicare payment controls in CMS's Common Working File were not designed to identify all interrupted stays billed as two or more claims or to prevent improper payments.

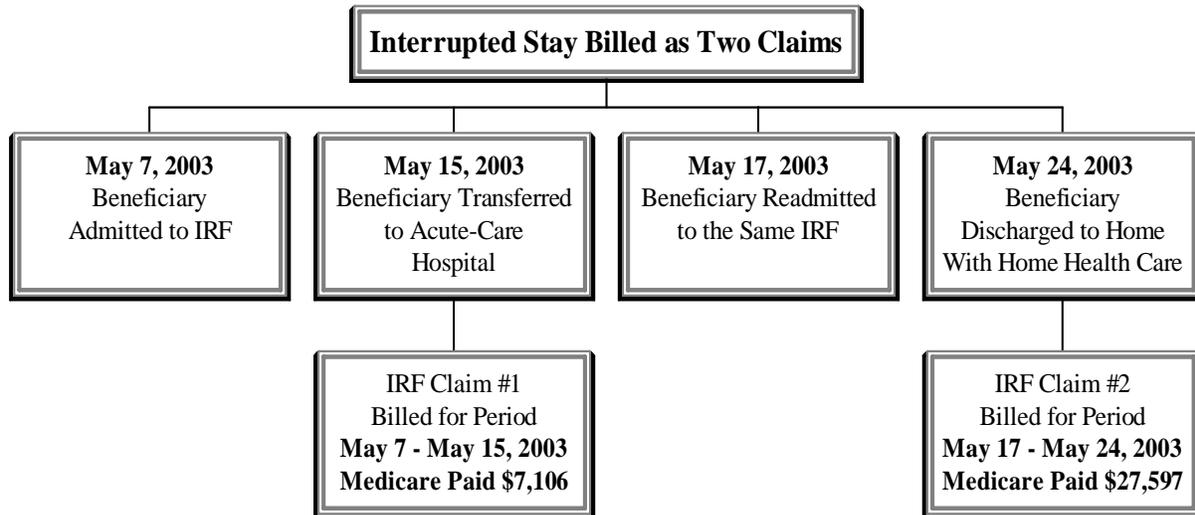
### **INTERRUPTED STAY REGULATIONS**

Pursuant to 42 CFR § 412.602, an interrupted stay at an IRF is a stay during which a Medicare inpatient is discharged from the IRF and returns to the same IRF within 3 consecutive days. The duration of the interrupted stay begins with the day of discharge from the IRF and ends on midnight of the third day. For payment purposes, 42 CFR §§ 412.618(a) and 412.624(g)(2) state that IRFs will receive one discharge payment for an interrupted stay based on the case-mix-group classification that is determined by the patient assessment performed at the initial admission.

### **INTERRUPTED STAYS INCORRECTLY BILLED AS TWO OR MORE CLAIMS**

On the basis of the results of our computer match and subsequent fieldwork, we found that IRFs did not always bill claims in compliance with the interrupted stay provision of the IRF prospective payment system regulations. During CYs 2002 and 2003, 589 IRFs incorrectly billed 1,458 interrupted stays. For 1,433 of the incorrect billings, IRFs billed each of the interrupted stays as 2 separate claims, with each claim representing the portion of the stay either before or after the interruption. IRFs incorrectly billed the remaining 25 interrupted stays as 3 separate claims. In these cases, the beneficiary's IRF stay was interrupted twice.

According to patient status codes billed on the first claim(s) for the 1,458 incorrectly billed interrupted stays, 1,102 of the interruptions were due to a discharge/transfer to a hospital.<sup>2</sup> In the following example, an IRF received both a per diem transfer payment (\$7,106) and a full case-mix-group payment (\$27,597) instead of a single payment of \$27,597 because it billed Medicare for two claims.



Pursuant to CMS regulations, the entire IRF stay for May 7 through May 24, 2003, should have been billed on CMS Form 1450 (UB-92) as a single IRF claim with an occurrence span code 74 to indicate that an interruption had occurred. The interruption dates of May 15 through May 16, 2003, should also have been entered on the UB-92. To bill the stay as a single claim, the IRF should have used the case-mix group determined on the initial admission assessment, adjusted for a specific condition that was secondary to the patient’s principal diagnosis or impairment. The IRF in this example received an overpayment of \$7,106 by billing the interrupted stay as two separate claims.

### **PAYMENT ERRORS RESULTING FROM INCORRECT BILLING**

During CYs 2002 and 2003, Medicare made net overpayments totaling \$5.9 million to IRFs nationwide for interrupted stays billed as two or more claims. (See the table on the next page.) Approximately 83 percent of the incorrect billings resulted in an overpayment. However, some IRFs received underpayments when they failed to combine two or more claims into a single claim that, once combined, would have caused certain thresholds to be exceeded. As a result, outlier payments would have been due or full case-mix-group payments would have been warranted, instead of the reduced transfer payments or short-stay payments that were made based on incorrect billings.

<sup>2</sup>The patient status code indicates the patient’s status as of the “through” date of the billing period. For purposes of this analysis, when an interrupted stay was billed as three claims, the patient status codes for the first two claims were both counted because two interruptions of the IRF stay occurred.

To identify the effect of incorrect billing, we combined each incorrectly billed interrupted stay into a single stay and repriced the resulting single stays using CMS's PRICER program. When we did not find an IRF's provider-specific information in CMS's PRICER program, we repriced the stay using information received from the IRF's fiscal intermediary and Medicare regulations.

### **Incorrectly Billed Interrupted Stays**

<b>Period</b>	<b>Overpayments</b>		<b>Underpayments</b>		<b>Net Overpayments</b>
	<b>No.</b>	<b>Amount</b>	<b>No.</b>	<b>Amount</b>	
CY 2002	478	\$2,962,878	78	\$330,010	\$2,632,868
CY 2003	734	3,899,067	168	663,238	3,235,829
<b>Total</b>	<b>1,212</b>	<b>\$6,861,945</b>	<b>246</b>	<b>\$993,248</b>	<b>\$5,868,697</b>

Net overpayments increased significantly in CY 2003. The increase may have occurred because most IRFs were not under the prospective payment system for a full year in CY 2002.

### **CAUSES OF INCORRECT BILLING**

Our fieldwork at eight IRFs found that the payment errors occurred because these IRFs did not have adequate billing controls. Additionally, Medicare payment controls in CMS's Common Working File were not designed to identify all interrupted stays billed as two or more claims or to prevent improper payments.

#### **Inadequate Inpatient Rehabilitation Facility Controls**

The payment errors at the eight IRFs that we visited occurred because these IRFs did not have adequate controls to identify or correctly bill interrupted stays. Our fieldwork at the eight IRFs determined the following causes that contributed to incorrect billing of interrupted stays.

##### **Interrupted Stays an Infrequent Occurrence**

The eight IRFs said that interrupted stays were an infrequent occurrence. Therefore, the IRFs had not made potentially costly modifications to their billing systems to electronically detect interrupted stays. Instead, determining that an interrupted stay had occurred and communicating this information to the billing department remained a manual process.

##### **Identification and Communication of Interrupted Stays**

At five of the six hospital-based IRFs, the clinical or administrative staff correctly identified the interrupted stay on the patient assessment instrument. However, these IRFs did not have controls in place to ensure that the information was communicated to the billing department so that the two or more IRF stays could be combined in a single claim. The sixth hospital-based IRF did not have controls to either identify the interrupted stay on the patient assessment instrument or report the interruption to the billing department.

## **Misunderstanding of the Criteria Regarding Interrupted Stays**

Two freestanding IRFs that we visited had implemented controls to identify and correctly bill some interrupted stays, but their procedures addressed only transfers to acute-care settings. At these IRFs, the incorrectly billed interrupted stays involved patients who were discharged to home and returned to the IRF within 3 days. Four hospital-based IRFs also incorrectly believed that an interrupted stay occurred only when a patient was transferred to an acute-care setting and returned to the IRF within 3 days.

## **Inadequate Medicare Payment Controls**

Medicare payment controls in CMS's Common Working File were not designed to identify and prevent all interrupted stays billed as two or more claims or to prevent improper payments. The interrupted stay edit was effective only if the initial IRF claim in the Common Working File was coded correctly as an interrupted stay and identified the dates of the interruption. Then, any subsequent IRF claims submitted with dates of service during the interruption would be subject to the edit. The interrupted stay edit was not effective if the IRF stays were billed as two separate claims with no dates of interruption and with each claim representing the portion of the stay either before or after the interruption.

## **RECOMMENDATIONS**

We recommend that CMS:

- direct its fiscal intermediaries to recover the \$5.9 million in net overpayments identified in our review;
- use the results of this review to clarify guidance to IRFs regarding the correct billing of interrupted stays;
- strengthen the edit in its Common Working File to detect all interrupted stays incorrectly billed as two or more claims and prevent associated payments; and
- instruct its fiscal intermediaries to conduct matches similar to the one that we conducted, until the Common Working File edit is strengthened, to identify additional payment errors for claims after December 31, 2003.

We will provide CMS with detailed claims information to assist in the recovery process.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In written comments on our draft report, CMS agreed with our recommendations to recover the overpayments and clarify guidance to IRFs. Additionally, CMS stated that it had implemented the recommended edit in its Common Working File as of April 1, 2005. CMS did not agree with our recommendation to instruct its fiscal intermediaries to conduct matches to identify additional payment errors. CMS believed that the edit would prevent future inappropriate payments and

that additional matches therefore would be unnecessary. CMS expected that contractors would consider budgeting appropriate resources for reviewing incorrectly billed claims if the edit identified a large volume of such claims. We have included CMS's comments as Appendix B.

#### **OFFICE OF INSPECTOR GENERAL RESPONSE**

Although we commend CMS's prompt implementation of the Common Working File edit to prevent future overpayments, we are concerned that the edit will not detect and correct payment errors that occurred between December 31, 2003, and April 1, 2005. Therefore, we believe that the fiscal intermediaries should conduct matches similar to the one that we conducted to identify additional payment errors for that period.

# **APPENDIXES**

**SUMMARY BY FISCAL INTERMEDIARY**  
**Incorrectly Billed Interrupted Stays**

Medicare Contractor #	Fiscal Intermediary	CY 2002		CY 2003		Total No.	Net Overpayments
		No.	Amount	No.	Amount		
52280	Mutual of Omaha Insurance Company	113	\$340,397	148	\$417,539	261	\$757,936
00308	Empire Medicare Services	63	422,535	69	275,737	132	698,272
00453	United Government Services, LLC	17	152,331	37	263,832	54	416,163
00131	Anthem Insurance Companies, Inc.	25	152,749	54	248,943	79	401,691
00090	Blue Cross and Blue Shield of Florida, Inc.	22	146,715	33	222,017	55	368,732
00452	United Government Services, LLC	37	197,570	42	148,624	79	346,195
00400	TrailBlazers Health Enterprises, LLC	38	174,891	61	112,364	99	287,256
00010	Blue Cross and Blue Shield of Alabama	18	122,051	21	155,140	39	277,191
00332	Anthem Insurance Companies, Inc.	32	117,961	55	157,144	87	275,105
00454	United Government Services, LLC	20	87,737	36	133,438	56	221,176
00230	TriSpan Health Services	14	46,207	32	153,196	46	199,403
00363	Veritus Medicare Services	16	34,748	52	140,023	68	174,771
00430	Premera Blue Cross	22	105,258	27	54,967	49	160,225
00390	Riverbend Government Benefits Administrator	16	63,396	27	81,973	43	145,369
00130	Anthem Insurance Companies, Inc.	14	93,321	19	49,933	33	143,254
00020	Arkansas Blue Cross and Blue Shield	7	17,494	22	114,422	29	131,916
00382	Palmetto GBA	8	37,318	32	70,465	40	107,783
00380	Palmetto GBA	0	0	20	107,774	20	107,774
00260	Blue Cross and Blue Shield of Nebraska	3	53,048	5	22,672	8	75,721
00150	Blue Cross and Blue Shield of Kansas, Inc.	6	37,255	7	37,880	13	75,136
00101	Blue Cross and Blue Shield of Georgia, Inc.	6	26,826	10	45,718	16	72,544
00350	Regence BlueCross BlueShield of Oregon	9	33,863	16	37,916	25	71,779
00160	Anthem Insurance Companies, Inc.	7	33,088	4	16,301	11	49,389
00320	Noridian Mutual Insurance Company	17	15,107	11	30,204	28	45,311
00450	United Government Services, LLC	6	28,627	16	15,911	22	44,538

Medicare Contractor #	Fiscal Intermediary	CY 2002		CY 2003		Total No.	Net Overpayments
		No.	Amount	No.	Amount		
00181	Anthem Health Plans of Maine, Inc.	2	10,387	3	27,023	5	37,410
00011	Blue Cross and Blue Shield of Alabama	3	7,231	8	28,680	11	35,911
00030	Blue Cross and Blue Shield of Arizona, Inc.	3	3,416	9	30,750	12	34,167
00180	Anthem Health Plans of Maine, Inc.	1	20,124	1	8,204	2	28,328
00340	Blue Cross and Blue Shield of Oklahoma	4	17,547	9	8,787	13	26,334
00190	Blue Cross and Blue Shield of Maryland, Inc.	2	17,801	0	0	2	17,801
00370	Blue Cross and Blue Shield of Rhode Island	0	0	9	12,114	9	12,114
00250	Blue Cross and Blue Shield of Montana, Inc.	1	5,213	1	4,833	2	10,046
00270	Anthem Blue Cross and Blue Shield of New Hampshire	4	10,657	5	(4,093)	9	6,564
00460	Blue Cross and Blue Shield of Wyoming	0	0	1	5,394	1	5,394
<b>Total *</b>		<b>556</b>	<b>\$2,632,868</b>	<b>902</b>	<b>\$3,235,829</b>	<b>1,458</b>	<b>\$5,868,697</b>

\*Differences are due to rounding.



OCT 26 2005

Administrator  
Washington, DC 20201

**TO:** Daniel R. Levinson  
Inspector General  
Office of Inspector General

**FROM:** Mark B. McClellan, M.D., Ph.D. *MM*  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report, "Nationwide Review of Compliance with the Provisions of the Inpatient Rehabilitation Facility Prospective Payment System for Calendar Years 2002 and 2003" (A-01-04-00525)

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The Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) interrupted stay policy was established when CMS published the August 7, 2001, final rule (66 FR 41316), and is defined at 42 Code of Federal Regulations (CFR) 412.602. An interrupted stay occurs when an inpatient that is discharged from an IRF returns to the same IRF within 3 consecutive calendar days. The duration of the interruption of the stay begins with the day of discharge from the IRF and ends on midnight of the third day.

The intent of the interrupted stay policy is for Medicare to avoid paying more than one IRF PPS claim when a re-admission to the same IRF occurs within a very short period of time. Thus, the interrupted stay policy discourages IRFs from inappropriately discharging patients and then re-admitting them in order to maximize payment.

The OIG analyzed whether IRFs billed claims in compliance with Medicare PPS regulations through a nationwide computer match. The computer match was designed to identify interrupted stays that were billed as multiple claims. The results of this investigation identified that 589 IRFs were billed incorrectly for 1,458 interrupted stays, resulting in net overpayments of \$5.9 million.

We commend the OIG for their investigation into this program vulnerability and appreciate the opportunity to comment on this report.

**OIG Recommendation**

The OIG recommends that CMS direct its fiscal intermediaries (FIs) to recover \$5.9 million in net overpayments identified in this review.

Page 2 – Daniel R. Levinson

**CMS Response**

The OIG recommends that CMS direct its FIs to recover the overpayments identified in this investigation. CMS concurs with the findings and will collaborate with both the OIG and the FIs to ensure that the overpayments identified are collected.

**OIG Recommendation**

The OIG recommends that CMS use the results of this review to clarify guidance to IRFs regarding the correct billing of interrupted stays.

**CMS Response**

The CMS agrees with the OIG's second recommendation that CMS use the results of this review to clarify guidance to IRFs regarding the correct billing of interrupted stays. In section 140.2.3 of Chapter 3 of the Medicare Claims Processing Manual (Publication 100-4) CMS states the general policy regarding payment for an interrupted stay. Prior to the IRF PPS being implemented, the FIs trained the IRFs regarding the billing procedures that the IRFs must use when a patient had an interrupted stay. As part of that training, the IRFs were instructed to use occurrence span code 74 to list the dates associated with the interruption in the patient's stay. In order to reinforce the billing instructions that were given to the IRFs, CMS anticipates posting a provider education article on the CMS' Medlearn Web site regarding how providers must bill an interrupted stay.

**OIG Recommendation**

The OIG recommends that CMS strengthen the edit in the common working file (CWF) to detect all interrupted stays incorrectly billed as two or more claims and prevent associated payments.

**CMS Response**

The CMS has already complied with the OIG's third recommendations that we strengthen the edit in the CWF to detect all interrupted stays incorrectly billed as two or more claims and prevent associated payments. CMS issued a change request (CR) to implement the recommended edits into the CWF. CWF incorporated IRFs into the interrupted stay editing effective April 1, 2005.

**OIG Recommendation**

The OIG recommends that CMS instruct its FIs to conduct matches similar to the one that the OIG conducted, until the CWF edit is strengthened, to identify additional payment errors for claims after December 31, 2003.

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**CMS Response**

CMS believes that the OIG's fourth recommendation, to instruct the FIs to conduct similar matches, is unnecessary. CMS is confident that with the implementation of the CWF edit, we are confident that future inappropriate payments will be detected and prevented. We will once again share the results of this report with our contractors and encourage them to consider previously submitted claims for interrupted IRF stays as a potential vulnerability. Each contractor must determine where to allocate its medical review and claims processing review resources based on the individual needs facing that particular contractor. We expect that contractors have experienced a large volume of these claims would consider this as they develop their budgets.

Once again CMS would like to thank the OIG for their efforts in identifying IRF PPS payment vulnerabilities. CMS looks forward to continued collaboration with the OIG in order to ensure that the necessary system improvements and educational outreach activities are performed in an effort to reduce the risk of improper billing.