



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services  
Region I  
John F. Kennedy Federal  
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Room 2425  
Boston, MA 02203  
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JUL 19 2007

Report Number: A-01-07-00505

Mr. Rodney Woods  
President & CEO  
Riverbend GBA  
730 Chestnut Street  
Chattanooga, Tennessee 37402

Dear Mr. Woods,

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General report entitled "Review of Billing Procedures for Medicare Claims Submitted to Riverbend Government Benefits Administrator by Inpatient Psychiatric Facilities During 2005."

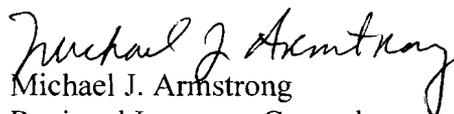
A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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 reports are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

If you have any questions or comments about this report, please do not hesitate to contact me at (617) 565-2684 or through e-mail at [Michael.Armstrong@oig.hhs.gov](mailto:Michael.Armstrong@oig.hhs.gov). Please refer to report number A-01-07-00505 in all correspondence.

Sincerely,

  
Michael J. Armstrong  
Regional Inspector General  
for Audit Services

Enclosures – as stated

Page 2 – Mr. Rodney Woods

**Direct Reply to HHS Action Official:**

Thomas W. Lenz  
Consortium Administrator  
Consortium for Financial Management and Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 E. 12<sup>th</sup> Street, Room 235  
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF BILLING  
PROCEDURES FOR MEDICARE  
CLAIMS SUBMITTED TO  
RIVERBEND GOVERNMENT  
BENEFITS ADMINISTRATOR BY  
INPATIENT PSYCHIATRIC  
FACILITIES DURING 2005**



Daniel R. Levinson  
Inspector General

July 2007  
A-01-07-00505

# ***Office of Inspector General***

<http://oig.hhs.gov>

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## **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 HHS divisions will make final determination on these matters.



## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Pursuant to sections 1886(d)(1)(B)(i) and (v) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) implemented a prospective payment system for inpatient psychiatric facilities (IPF) for IPF cost reporting periods beginning on or after January 1, 2005. Before this date, Medicare paid IPFs for services provided to Medicare beneficiaries pursuant to section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA, Medicare based payments to IPFs on a reasonable cost per discharge, as determined by IPFs' Medicare cost reports. When fully implemented, the IPF prospective payment system will provide for a standardized Federal per diem payment per discharge.

Under the prospective payment system, IPFs must submit a single discharge bill for an entire inpatient stay. CMS instructions state that, if the beneficiary's stay begins before and ends on or after the date on which the IPF becomes subject to the prospective payment system, the fiscal intermediary should base its payments to the facility on prospective payment rates and rules. We refer to these stays as "transition stays." The instructions also state that IPFs that split the stay and submit two separate claims must cancel the split bills and then rebill the fiscal intermediary after the cancellation has been accepted.

Riverbend Government Benefits Administrator (Riverbend) is the Medicare Part A fiscal intermediary for New Jersey and Tennessee. In 2005, 70 IPFs were under Riverbend's administrative responsibility.

### **OBJECTIVE**

Our objective was to determine whether IPFs properly submitted Medicare claims paid by Riverbend for transition stays.

### **SUMMARY OF FINDINGS**

IPFs did not always properly submit claims paid by Riverbend for transition stays in 2005. Specifically, for 82 of the 100 claims that we sampled (from the population of 184 claims), IPFs incorrectly split the beneficiary's stay by submitting 1 claim under the TEFRA payment period and one or more claims under the prospective payment period rather than properly submitting 1 claim for the entire inpatient stay. These 82 claims represented overpayments of \$579,977 because the prospective payment included part of the TEFRA payment. Of the remaining 18 sampled claims, 17 were correctly billed because the beneficiaries had no immediate preceding IPF stay (i.e., the IPF stay started on the same date as the IPF transition to the prospective payment system). The remaining one claim was originally split-billed, but the IPF cancelled the split bills and submitted a correct bill before our audit.

Based on our sample results, we estimate that Riverbend overpaid IPFs a total of \$1,067,157 for incorrectly billed Medicare claims for transition stays in 2005. The payment errors occurred

because the IPFs did not have adequate controls to ensure that claims submitted during their transition to the prospective payment system were in accordance with Medicare requirements. Additionally, Riverbend did not have procedures to identify IPF claims that were billed as two separate claims for one transition stay.

## **RECOMMENDATIONS**

We recommend that Riverbend:

- make the appropriate adjustments to the sampled claims that resulted in overpayments of \$579,977,
- review our information on the additional 84 claims with potential overpayments estimated at \$487,180 (\$1,067,157 less \$579,977) and work with the IPFs that provided the services to recover any overpayments, and
- analyze postpayment data from IPF claims submitted after our review to ensure that the claims were billed properly and paid correctly by Riverbend.

## **AUDITEE'S COMMENTS**

In its comments on our draft report, Riverbend agreed with our findings and recommendations and stated that it was taking appropriate action. We have included Riverbend's comments in their entirety as Appendix B.

**TABLE OF CONTENTS**

	<b><u>Page</u></b>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
The Prospective Payment System for Inpatient Psychiatric Facilities.....	1
Riverbend Government Benefits Administrator .....	1
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	1
Objective .....	1
Scope.....	2
Methodology .....	2
<b>FINDINGS AND RECOMMENDATIONS</b> .....	3
<b>PROGRAM REQUIREMENTS</b> .....	3
<b>SPLIT BILLING DURING THE TRANSITION TO THE PROSPECTIVE     PAYMENT SYSTEM</b> .....	3
<b>PAYMENT ERRORS RESULTING FROM INCORRECT BILLING</b> .....	4
<b>INTERNAL CONTROL WEAKNESSES</b> .....	4
<b>RECOMMENDATIONS</b> .....	4
<b>AUDITEE’S COMMENTS</b> .....	5
<b>APPENDIXES</b>	
<b>A - SAMPLING METHODOLOGY, RESULTS, AND PROJECTIONS</b>	
<b>B – AUDITEE’S COMMENTS</b>	

## **INTRODUCTION**

### **BACKGROUND**

#### **The Prospective Payment System for Inpatient Psychiatric Facilities**

Pursuant to sections 1886(d)(1)(B)(i) and (v) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) implemented a prospective payment system for inpatient psychiatric facilities (IPF) for IPF cost reporting periods beginning on or after January 1, 2005. Before this date, Medicare paid IPFs for services provided to Medicare beneficiaries pursuant to section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA, Medicare based payments to IPFs on a reasonable cost per discharge, as determined by IPFs' Medicare cost reports. These fixed payments did not vary from day to day or from patient to patient.

For IPF cost-reporting periods from January 1, 2005, to January 1, 2008, while the new prospective payment system is being phased in, Medicare payments will comprise a blend of the estimated payment under the new system and the fixed TEFRA payment. When fully implemented, the IPF prospective payment system will provide for a standardized Federal per diem payment per discharge. The amount of this payment is based on several factors, including the patient's age and diagnosis and the hospital's characteristics. The prospective payment represents reimbursement in full for the inpatient operating and capital-related costs of furnishing Medicare-covered services in an IPF.

Under the prospective payment system, IPFs must submit a single discharge bill for an entire inpatient stay. CMS instructions issued in Transmittal 384 state that, if the beneficiary's stay begins before and ends on or after the date on which the IPF becomes subject to the prospective payment system, the fiscal intermediary should base its payments to the facility on prospective payment rates and rules. We refer to these stays as "transition stays." The CMS instructions also state that IPFs that split the stay and submit two separate claims must cancel the split bills and then rebill the fiscal intermediary after the cancellation has been accepted.

#### **Riverbend Government Benefits Administrator**

Riverbend Government Benefits Administrator (Riverbend) is the Medicare Part A fiscal intermediary for New Jersey and Tennessee. In 2005, 70 IPFs were under Riverbend's administrative responsibility.

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

#### **Objective**

Our objective was to determine whether IPFs properly submitted Medicare claims paid by Riverbend for transition stays.

## Scope

We reviewed Medicare claims that Riverbend paid for inpatient stays that started on or overlapped the IPF transition date to the prospective payment system.

Our objective did not require an understanding or assessment of the complete internal control structure of the selected IPFs or Riverbend. We limited our review of internal controls to obtaining an understanding of (1) IPFs' procedures for submitting claims that spanned the transition from payments under TEFRA to payments under the prospective payment system and (2) Riverbend's policies and procedures for paying IPF claims during this transition.

We performed our fieldwork from December 2006 through March 2007. Our fieldwork included site visits to selected IPFs in New Jersey and Tennessee.

## Methodology

To accomplish our objective, we:

- reviewed applicable Medicare requirements and CMS guidance regarding IPF billing and fiscal intermediary payments for transition stays;
- used IPFs' cost report start dates to identify the date on which each IPF began implementing the prospective payment system;
- reviewed CMS's Standard Analytical File for the period January 1, 2005, through December 31, 2005, and identified 184 paid claims totaling \$1,750,677 from 35 IPFs that had a claim "from date" that matched the IPF's transition date;
- reviewed CMS's Common Working File information for 100 randomly sampled claims totaling \$902,316 from the population of 184 IPF claims paid by Riverbend to determine whether the beneficiary's stay was immediately preceded by a stay at the same IPF (i.e., whether the beneficiary had a stay that overlapped the IPF's transition to the new payment system);
- reviewed the overlapping claims that we had identified to determine whether Riverbend had reimbursed IPFs under both TEFRA and the prospective payment system for the same stay;
- contacted seven IPFs to determine the cause of the incorrect billing;
- calculated the effect of the incorrect billing by using CMS's Pricer Program and Riverbend's provider-specific information;
- used a variable appraisal program, as detailed in Appendix A, to estimate the total value of overpayments based on our sample results; and

- discussed the results of our review with Riverbend officials.

We conducted our audit in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

IPFs did not always properly submit Medicare claims paid by Riverbend for transition stays in 2005. Specifically, for 82 of the 100 claims that we sampled, IPFs incorrectly split the beneficiary's stay by submitting 1 claim under the TEFRA payment period and 1 or more claims under the prospective payment period, rather than properly submitting 1 claim for the entire inpatient stay. These 82 claims resulted in overpayments of \$579,977 because the prospective payment included part of the TEFRA payment. Of the remaining 18 sampled claims, 17 were correctly billed because the beneficiaries had no immediate preceding IPF stay (i.e., the IPF stay started on the same date as the IPF transition to the prospective payment system). The remaining one claim was originally split-billed, but the IPF cancelled the split bills and submitted a correct bill before our audit.

Based on our sample results, we estimate that Riverbend overpaid IPFs a total of \$1,067,157 for incorrectly billed Medicare claims for transition stays in 2005. The payment errors occurred because the IPFs did not have adequate controls to ensure that claims submitted during the transition to the prospective payment system were in accordance with Medicare requirements. Additionally, Riverbend did not have procedures to identify IPF claims that were billed as two separate claims for one transition stay.

## **PROGRAM REQUIREMENTS**

Pursuant to 42 CFR § 412.422, when the IPF prospective payment system is fully implemented, it will provide for a standardized Federal per diem payment-per-discharge. To receive this payment, an IPF must submit a single discharge bill for an entire inpatient stay.

CMS guidance as set forth in Transmittal 384, dated December 1, 2004, states that when a beneficiary's stay overlaps the time in which the IPF becomes subject to the prospective payment system rules, the payment will be based on the prospective payment system rates and rules. This guidance also states that IPFs should not split the stay and submit two separate claims. IPFs that do so must cancel all split bills and then rebill the fiscal intermediary after the cancellation has been accepted.

## **SPLIT BILLING DURING THE TRANSITION TO THE PROSPECTIVE PAYMENT SYSTEM**

We identified 184 Medicare claims paid to 35 IPFs for stays that were at high risk of being incorrectly billed because they started on or overlapped the IPF transition date to the prospective payment system. Our sample of 100 of these claims identified 82 claims from 27 IPFs for beneficiaries who had an immediately preceding stay in the same IPF. Thus, these claims were

for beneficiaries who had a single stay that overlapped the IPF transition to the prospective payment system. The IPFs incorrectly billed these 82 claims by splitting them into 189 separate claims.

As a result of the incorrect billing, Riverbend paid the IPFs two or more separate payments, one under the TEFRA payment period and others under the prospective payment period, for each transition stay. In accordance with Medicare requirements, the IPFs should have billed each stay as a single claim under the prospective payment system. The 27 IPFs that submitted split bills received overpayments because the prospective payment included part of the TEFRA payment. Riverbend overpaid the 27 IPFs \$579,977 for the 82 claims.

For example, an IPF that transitioned to the prospective payment system on July 1, 2005, billed two separate claims for one patient discharge instead of correctly billing one claim for the entire stay. The IPF billed one claim of \$17,860 for May 15, 2005, through June 30, 2005, and the other claim of \$14,476 for July 1, 2005, through August 29, 2005. The total split reimbursement amount was \$32,336. The IPF should have billed one claim for one inpatient stay totaling \$18,531. Because the IPF split the stay into two claims, Medicare overpaid the IPF \$13,805.

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

Based on our sample results, we estimate that Riverbend overpaid IPFs a total of \$1,067,157 for incorrectly billed claims for transition stays in 2005.

## **INTERNAL CONTROL WEAKNESSES**

Controls at the seven IPFs that we contacted were inadequate to facilitate proper billing during the transition to the prospective payment system. Specifically, these IPFs either were not aware of or did not follow CMS's final billing requirements and therefore had not established the necessary controls to ensure that they submitted claims correctly for transition stays. Riverbend paid the incorrectly billed IPF claims because it had not established procedures to identify claims that were billed as two separate claims for one transition stay.

## **RECOMMENDATIONS**

We recommend that Riverbend:

- make the appropriate adjustments to the sampled claims that resulted in overpayments of \$579,977,
- review our information on the additional 84 claims with potential overpayments estimated at \$487,180 (\$1,067,157 less \$579,977) and work with the IPFs that provided the services to recover any overpayments, and
- analyze postpayment data from IPF claims submitted after our review to ensure that the claims were billed properly and paid correctly by Riverbend.

## **AUDITEE'S COMMENTS**

In its comments on our draft report, Riverbend agreed with our findings and recommendations and stated that it was taking appropriate action. We have included Riverbend's comments in their entirety as Appendix B.

# **APPENDIXES**

**SAMPLING METHODOLOGY, RESULTS, AND PROJECTIONS**

**OBJECTIVE**

Our objective was to determine whether inpatient psychiatric facilities (IPFs) properly submitted Medicare claims paid by Riverbend for transition stays.

**POPULATION**

The population included 184 paid claims from the Centers for Medicare & Medicaid Services Standard Analytical File for the period January 1 through December 31, 2005, from 35 IPFs that had a paid claim “from date” that matched the IPF’s transition date.

**SAMPLE DESIGN**

We designed a simple random sample.

**SAMPLE SIZE**

The sample consisted of 100 claims that had a paid claim “from date” that matched the IPFs’ transition date.

**SAMPLE RESULTS**

For 82 of the 100 sampled claims, the IPFs had incorrectly split the beneficiary’s stay into two or more claims and received overpayments totaling \$579,977.

**SAMPLE PROJECTIONS**

Point estimate	\$1,067,157
Confidence level	90%
Lower confidence limit	\$894,991
Upper confidence limit	\$1,239,324
Sample precision	16.13%



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## Medicare

Part A Intermediary

June 14, 2007

Mr. Michael J. Armstrong  
OIG Office of Audit Services  
Region I  
John F. Kennedy Federal Building  
Boston, MA 02203

**RE: Report Number A-01-07-00505**  
***Review of Billing Procedures for Medicare Claims Submitted to Riverbend Government Benefits Administrator by Inpatient Psychiatric Facilities During 2005***

Dear Mr. Armstrong:

On behalf of Riverbend Government Benefits Administrator (Riverbend), I would like to thank the Office of Inspector General for the opportunity to comment on your findings. Within the context of the authority and funding made available to us as a contractor, Riverbend is committed to assist the Centers for Medicare and Medicaid Services (CMS) in identifying and reducing the Medicare Program's vulnerability to reimbursements of inappropriate claims for payments to providers. We consider the information contained in this review as important feedback that we will use in assessing our processes as part of our continuous improvement commitment. Our more specific comments to your findings are reflected below.

CMS released Change Request 3541 on December 1, 2004. This contractor instruction from CMS placed the primary responsibility for correctly billing Inpatient Psychiatric Facility Prospective Payment System (PPS) claims on the provider. Riverbend followed the intermediary instructions in this change request.

Riverbend staff attended CMS-sponsored training for Inpatient Psychiatric Facility Prospective Payment System on January 25-27, 2005 (handouts provided are available via the internet: [http://www.cms.hhs.gov/InpatientPsychFacilPPS/04\\_tools.asp#](http://www.cms.hhs.gov/InpatientPsychFacilPPS/04_tools.asp#)). We offered training (using the CMS materials) to our providers on March 22 and March 23, 2005 (two individual sessions). We also provided discretionary training as requested by individual providers subsequent to those general training dates.

Based upon the information available to us, we are not aware of any fiscal intermediary that continued to heavily scrutinize these claims on a prepayment basis after the release of CR 3541.

Riverbend Government Benefits Administrator  
730 Chestnut Street, Chattanooga, Tennessee 37402-1790  
[www.riverbendgba.com](http://www.riverbendgba.com)

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A CMS Contracted Intermediary



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## Medicare

Part A Intermediary

On April 27, 2007, Draft Change Request 5474 was released. In response to this Change Request, Riverbend analyzed our internal processes and identified an opportunity for improvement. As a result, Riverbend implemented preventative measures (see item 4) to reduce program vulnerability.

Riverbend has reviewed each of the 184 claims in the universe sampled for the OIG Office of Audit Service's audit of Inpatient Psychiatric Facility PPS claims. We have determined the primary issues are 1) providers were incorrectly billing these claims; and 2) there was a lack of a system edit designed to identify these specific situations. Below is a summary of our overall findings:

- Claims with TOB 111 are "admit through discharge." Only one of the 19 claims in this category is a split bill and therefore was filed incorrectly by the provider. The other 18 claims were billed correctly.
- Claims with TOB 117 are either providers adjusting claims for usual billing corrections or providers adjusting due to interim billing requirements. There were five claims in this category. Four were adjustments against incorrectly processed interim bills; as a result, these adjustments were also processed incorrectly. The providers should have cancelled these claims and combined all interim bills. The one remaining claim was submitted correctly to adjust the original TOB 112 per CMS Instructions.
- Claims with TOB 111 are SuperOp Mass Adjusted claims, most due to Wage Index corrections. Of the 23 mass adjustments, three were adjusted against incorrectly processed interim bills originally submitted with TOB 113 or 114.
- Claims with TOB 112 are appropriate as the initial bill for interim billing. There were two claims, and these were correctly processed at the time of their billing. However, since these claims were processed, the provider has submitted TOB 113/114, which would require these two claims to be cancelled and then resubmitted with a TOB 117.
- Claims with TOB 113/114 are inappropriate for interim billing for IPF PPS Providers. All 134 claims with these TOBs were incorrectly billed. Change Request 3541 states that, for stays prior to and discharge after PPS implementation date, if the facility submitted multiple interim bills, the facility will need to submit cancels for all bills and then re-bill once the cancels have been accepted. There was no CMS requirement that instructed contractors to ensure the providers took this action. In addition, there was no requirement that outlined a Fiscal Intermediary Shared System (FISS) (i.e., the standard CMS Part A claims processing system) edit that would reject claims if other than cancels were received. As a result, claims have processed with TOBs 113 and 114. These claims will need to be cancelled. At the time of this review, some providers had begun to correct the claims.



**Medicare**  
Part A Intermediary

Type	Total	Incorrectly Processed
Admit thru Discharge	19	1
SuperOp Mass Adj	23	3
Interim Initial Bill	2	0
Adjustment 117	5	4
Interim TOB 113/114	134	134
Adjust. On split bill	1	1
<b>Total</b>	<b>184</b>	<b>143</b>

The overall issue identified during our review is that claims billed with TOB 113/114 for PPS IPF providers have paid incorrectly. This represented 94% of the claims processed incorrectly and 98.6% if adjustments against the incorrectly processed claim for the same TOBs are combined.

Four recommendations were made in the Office of Audit Services' draft report. Below is our response to each:

1. ***Make the appropriate adjustments to the sampled claims that resulted in overpayments of \$579,977.*** Due to the extended stays involved with IPF claims, it is difficult to determine an exact overpayment amount. As a resolution, we will send letters notifying each of these providers that their claims are being cancelled. We will attach a copy of Change Request 3541 to aide in re-billing the claims according to CMS guidelines.
2. ***Review our information on the additional 84 claims with potential overpayments estimated at \$487,180 and work with the IPFs that provided the service to recover any overpayments.*** During our review, we looked at all of the claims in the universe. Claims that were billed inappropriately will be cancelled and the money will be recovered. (See item 1.)
3. ***Analyze postpayment data from IPF claims submitted after our review to ensure that the claims were billed properly and paid correctly by Riverbend.*** We will: 1) Run reports that will identify any IPF claims paid after the provider's PPS effective date that have not been cancelled; and 2) Identify any adjustments that were processed as an interim bill. We will cancel all claims identified that were incorrectly processed and collect any money that was inappropriately claimed by the provider that may have been reimbursed.
4. ***Strengthen the process for educating personnel at IPFs and Riverbend on ways to prevent and detect incorrect Medicare billing.*** We have implemented a local workaround for a specific local system edit that should capture these types of situations



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## Medicare

Part A Intermediary

and may eliminate the majority of this issue until a FISS edit can be developed. It should be noted that if CMS elects to initiate a FISS edit which will reject IPF PPS claims that are billed with TOB 113 and 114, it appears that such a FISS prepayment edit could potentially eliminate 98.6% of these errors. Riverbend will also prepare and disseminate an educational article related to appropriate billing for IPFs based on CR3541.

We have improved our process for handling IPF PPS claims in-house to reduce vulnerability for the Program. To the extent that CMS elects to create a FISS edit to reject IPF PPS claims billed with TOB 113 and 114, it would seem that the Medicare Program's financial vulnerability could be further reduced if CMS determines that such a change would be cost-effective.

If you have any questions or need additional information, you may contact me at (423)535-7927 or via e-mail at [rodney.woods@riverbendgov.com](mailto:rodney.woods@riverbendgov.com).

Best Regards,

A handwritten signature in black ink that reads "Rodney Woods". The signature is written in a cursive style.

Rodney Woods  
President & CEO, Riverbend Government Benefits Administrator