



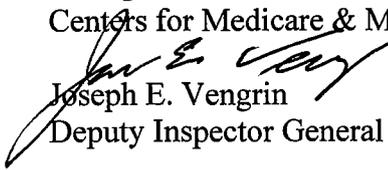
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV - 2 2006

**TO:** Leslie V. Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services

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

**SUBJECT:** Nationwide Review of Inpatient Rehabilitation Facility Claims Coded as  
"Discharged to Home With Home Health Agency Services"  
(A-04-04-00013)

The attached final report provides the results of our review of inpatient rehabilitation facilities' (IRF) compliance with Medicare's transfer regulation. Consistent with the regulation, Medicare pays the full prospective payment to an IRF that discharges a beneficiary to home. In contrast, Medicare pays a lesser amount for a transfer case. A transfer case is defined as one in which the beneficiary's IRF stay is shorter than average and the beneficiary is transferred to another IRF, a long term care hospital, an acute-care inpatient hospital, or a nursing home that accepts payment under the Medicare program or the Medicaid program.

Our objective was to determine whether IRFs coded claims as "discharged to home with home health agency services" in compliance with Medicare's transfer regulation during fiscal year 2003. We previously issued a similar report (A-04-04-00008) on IRF claims coded as "discharged to home."

IRFs did not always code claims in compliance with Medicare's transfer regulation. Nationwide, we identified 585 IRF claims coded and paid as discharges to home with home health agency services that potentially should have been paid as transfers. We visited or contacted four IRFs to verify the coding of 44 of these claims and found that all 44 claims should have been coded as transfers rather than as discharges. We also repriced a sample of 100 of the 585 claims and estimated that overpayments to IRFs totaled \$2,331,042 in fiscal year 2003.

The four IRFs that we contacted attributed miscoded claims at their facilities to clerical errors. In addition, a key Medicare claims-processing system, the Common Working File (CWF), did not contain the necessary edits to compare the date a beneficiary was discharged from an IRF with the date the beneficiary was admitted to another provider.

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

- instruct the fiscal intermediaries to review the claims in question and to recover, as appropriate, the estimated \$2,331,042 in overpayments;
- instruct the fiscal intermediaries to review claims paid after our audit period for possible coding errors like those found in this review; and
- implement edits in the CWF that match beneficiary discharge dates with admission dates to other providers to identify potentially miscoded claims.

In commenting on our draft report, CMS concurred with the recommendations and requested that we furnish the data necessary to initiate claim reviews and recovery of the estimated overpayments. We provided CMS with the requested data.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or 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-04-04-00013 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NATIONWIDE REVIEW OF  
INPATIENT REHABILITATION  
FACILITY CLAIMS CODED AS  
“DISCHARGED TO HOME WITH  
HOME HEALTH AGENCY SERVICES”**



Daniel R. Levinson  
Inspector General

November 2006  
A-04-04-00013

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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

An inpatient rehabilitation facility (IRF) is a hospital or a subunit of a hospital whose primary purpose is to provide intensive rehabilitation services to its inpatient population. Under the Medicare prospective payment system for IRFs, the Centers for Medicare & Medicaid Services (CMS) classifies beneficiaries into 1 of 100 case-mix groups depending on their clinical characteristics. CMS assigns each case-mix group a prospective payment rate and uses the rate to calculate the prospective payment.

Medicare pays the full prospective payment to an IRF that discharges a beneficiary to home. In contrast, under its transfer regulation, Medicare pays a lesser amount for a transfer case. A transfer case is defined as one in which the beneficiary's IRF stay is shorter than the average stay for the case-mix group and the beneficiary is transferred to another IRF, a long term care hospital, an acute-care inpatient hospital, or a nursing home that accepts payment under the Medicare program or the Medicaid program. Whether Medicare pays for a discharge to home or a transfer depends on the patient status code indicated on the IRF's claim.

### OBJECTIVE

Our objective was to determine whether IRFs coded claims as "discharged to home with home health agency services" in compliance with Medicare's transfer regulation during fiscal year (FY) 2003.<sup>1</sup>

### SUMMARY OF FINDINGS

IRFs did not always code claims in compliance with Medicare's transfer regulation. Nationwide, we identified 585 IRF claims coded and paid as discharges to home with home health agency services that potentially should have been paid as transfers. We visited or contacted four IRFs that were responsible for 44 of the 585 claims to verify the discharge status of the claims. The four IRFs acknowledged that all 44 claims should have been coded as transfers rather than as discharges. We also repriced a sample of 100 of the 585 claims and estimated that overpayments to IRFs totaled \$2,331,042 in FY 2003.

The four IRFs that we contacted attributed miscoded claims at their facilities to clerical errors. In addition, a key Medicare claims-processing system, the Common Working File (CWF), did not contain the necessary edits to compare the date a beneficiary was discharged from an IRF with the date the beneficiary was admitted to another provider.

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<sup>1</sup>We recently issued a related report on IRF claims coded as "discharged to home" (report number A-04-04-00008).

## **RECOMMENDATIONS**

We recommend that CMS:

- instruct the fiscal intermediaries to review the claims in question and to recover, as appropriate, the estimated \$2,331,042 in overpayments;
- instruct the fiscal intermediaries to review claims paid after our audit period for possible coding errors like those found in this review; and
- implement edits in the CWF that match beneficiary discharge dates with admission dates to other providers to identify potentially miscoded claims.

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

In its comments on our draft report, CMS concurred with the recommendations and requested that we furnish the data necessary to initiate claim reviews and recovery of the estimated overpayments. (See Appendix D for CMS's comments in their entirety.)

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

We provided CMS with the requested data.

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## INTRODUCTION

### BACKGROUND

#### **Inpatient Rehabilitation Facility Prospective Payment System**

An inpatient rehabilitation facility (IRF) is a hospital or a subunit of a hospital whose primary purpose is to provide intensive rehabilitation services to its inpatient population.

To control increasing costs, Congress provided for a Medicare prospective payment system (PPS) for IRFs.<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS) implemented the PPS for cost-reporting periods beginning on or after January 1, 2002. For cost-reporting periods beginning before October 1, 2002, Medicare paid a blend of the prospective payment and the payment under the prior cost-reimbursement system. For cost-reporting periods beginning on or after October 1, 2002, the payment consisted entirely of the prospective payment (section 1886(j) of the Social Security Act).

Under the PPS, CMS classifies beneficiaries into 1 of 100 case-mix groups depending on their clinical characteristics. CMS assigns each case-mix group a prospective payment rate and uses the rate to calculate the prospective payment.

#### **Transfer Payments**

Medicare regulations distinguish between discharges and transfers to certain types of facilities. Medicare pays the full prospective payment, based on the case-mix group, to an IRF that discharges a beneficiary to home. In contrast, Medicare pays a lesser amount, based on a per diem rate and the number of days that the beneficiary spent in the IRF, for a transfer case (42 CFR § 412.624(f)). A transfer case is defined as one in which:

- the beneficiary's IRF stay is shorter than the average stay for the nontransfer cases in the case-mix group (42 CFR § 412.624(f)) and
- the beneficiary is transferred to another IRF, a long term care hospital, an acute-care inpatient hospital, or a nursing home that accepts payment under the Medicare program or the Medicaid program (42 CFR § 412.602).

Whether Medicare pays for a discharge to home or a transfer depends on the patient status code indicated on the IRF's claim. IRFs use code 01 to indicate a discharge to home and 06 to indicate a discharge to home with home health agency (HHA) services.

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<sup>1</sup>See section 4421 of the Balanced Budget Act of 1997; section 125 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999; and section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

CMS specifies that the following patient status codes are subject to the transfer regulation:<sup>2</sup>

- 02—a short term (acute-care) inpatient hospital;
- 03—a skilled nursing facility;
- 61—a hospital-based, Medicare-approved swing bed within the IRF;
- 62—another IRF;
- 63—a long term care hospital; and
- 64—a Medicaid-only nursing facility.

### **Pricing Inpatient Rehabilitation Facility Claims**

To price IRF claims, CMS developed a computer program called the IRF PRICER. This program uses information specific to each IRF and information from each claim, including the patient status code, to calculate the price upon which to base the prospective payment.

Claims must indicate the proper patient status codes because the IRF PRICER uses those codes in determining whether the claims will be priced as discharges or transfers. The IRF PRICER automatically calculates payments for claims with codes 02, 03, 61, 62, 63, or 64 at the per diem rate for transfers.

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

#### **Objective**

Our objective was to determine whether IRFs coded claims as “discharged to home with home health agency services” in compliance with Medicare’s transfer regulation during fiscal year (FY) 2003.<sup>3</sup>

#### **Scope**

Our audit included nationwide Medicare IRF PPS paid claims for patient discharges from October 1, 2002, through September 30, 2003 (FY 2003). We extracted the nationwide paid claims file from the CMS Data Extraction System. We focused on 585 claims that had shorter than average stays, that were coded as discharges to home with HHA services, and that pertained to beneficiaries who, on the same day of discharge, were subsequently admitted to a facility listed in the transfer regulation. Payments for these claims totaled about \$8.9 million. These claims were filed by 320 IRFs in 44 States.

We did not review the overall internal control structure of the intermediaries or CMS. We limited our internal control review to obtaining a general understanding of the IRF PPS pricing system as it pertained to payment of claims. We accomplished the objective of our

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<sup>2</sup>May 17, 2002, CMS Program Memorandum (Transmittal A-02-041, Change Request 2093).

<sup>3</sup>We recently issued a related report on IRF claims coded as “discharged to home” (report number A-04-04-00008).

review through substantive testing. We also did not review the medical records for the discharging IRFs to determine whether the 585 claims were properly coded as discharges.

Our review did not include instances in which a beneficiary was discharged from an IRF and subsequently admitted to a Medicaid-only nursing facility on the same day. Because our testing of Medicaid-only nursing home claims for one State noted a low error rate, we concluded that this area did not warrant further review.

We visited one fiscal intermediary (FI) and one IRF and contacted three additional IRFs to discuss the potential errors we identified. Three of the four IRFs we contacted were located in the Southeast. The fourth IRF was located in New York State. The four IRFs were responsible for 44 of the 585 claims in the universe.

## **Methodology**

To accomplish our objective, we performed the following procedures:

- We reviewed Federal law and regulations and CMS memorandums concerning IRF transfers.
- We interviewed CMS and FI officials to gain an understanding of how they processed IRF claims and to determine whether edits existed to review claims coded as discharges.
- We created a file of nationwide IRF paid claims data for FY 2003 by extracting the applicable claims from CMS's calendar years 2002 and 2003 files. The file we created represented \$6.2 billion in payments for 492,467 claims.
- We refined the nationwide file by excluding certain claims such as outlier claims, claims for expired patients, claims not primarily paid by Medicare, and claims paid to Maryland providers.<sup>4</sup>
- We created a subset file of the refined nationwide file by extracting all claims with a status code of "06, discharged to home with HHA services."
- We refined the nationwide file of "06" claims by removing claims for beneficiaries whose lengths of stay were equal to or greater than the average length of stay per case-mix group, leaving 137,797 claims that had shorter than average stays and were coded as discharged to home with HHA services.
- We obtained from CMS files of FY 2003 nationwide Medicare paid claims for the types of facilities listed in the transfer regulation (other IRFs, long term care hospitals, inpatient hospitals, and nursing homes that accept Medicare payment).

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<sup>4</sup>Maryland is exempt from the PPS.

- We matched the subset file of 137,797 IRF claims against the files of transfer facility claims. This process identified 585 subsequent facility admissions that occurred on the same day as an IRF discharge and created a universe of claims potentially miscoded by IRFs as discharged to home with HHA services instead of transferred to another provider.
- To determine whether Medicare overpaid any potentially miscoded IRF claims, we selected an unrestricted random sample of 100 claims from our population of 585 claims and performed the following steps:
  - We repriced each of the 100 claims by:
    - reviewing CMS’s IRF PRICER program to understand how the program priced transfer claims,
    - developing a modified version of the IRF PRICER and performing quality control tests (Appendix A) to verify that the modified PRICER accurately priced claims, and
    - recalculating each of the 100 claims using the modified PRICER.
  - We accessed the Common Working File (CWF) claim history for each of the 100 claims to determine whether the claim payment amount was subsequently adjusted for any reason. We refer to the amount paid for each claim, net of any adjustments, as the Medicare payment.
  - We compared our recalculated payment with the actual Medicare payment for each of the 100 claims to determine the potential overpayment or underpayment. Based on our sample results, we projected the dollar amount of potential overpayments to the population. (See Appendix B for details on our sampling methodology and Appendix C for the sampling projections.)
- We discussed the reasons for errors with officials of four IRFs by visiting one and telephoning three.

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

## **FINDINGS AND RECOMMENDATIONS**

IRFs did not always code claims in compliance with Medicare’s transfer regulation. Nationwide, we identified 585 IRF claims coded and paid as discharges to home with HHA services that potentially should have been paid as transfers. We visited one IRF and contacted three additional IRFs that were responsible for 44 of these claims and found that all 44 claims represented miscoded claims.

Additionally, we reviewed the claim histories for a sample of 100 of the 585 claims. Seven of the one hundred claims had been subsequently adjusted to reflect that transfers had occurred, not discharges. We repriced the remaining 93 claims in our sample and calculated potential overpayments totaling \$463,427.

The four IRFs that we contacted attributed miscoded claims at their facilities to clerical errors. In addition, a key Medicare claims-processing system, the CWF, did not contain the necessary edits to compare the date a beneficiary was discharged from an IRF with the date the beneficiary was admitted to another provider.

Projecting our sample results to the population of 585 claims, we estimate that Medicare overpaid IRFs \$2,331,042 in FY 2003.

## **FEDERAL TRANSFER STATUTE AND REGULATIONS**

Section 1886(j)(1)(E) of the Social Security Act authorized the Secretary of the Department of Health and Human Services to adjust prospective payments to account for the early transfer of a beneficiary from an IRF to another site of care. Implementing regulations (42 CFR § 412.624(f)(1)) require an adjustment to an IRF's prospective payment if the beneficiary's stay in the IRF is shorter than the average stay for the given case-mix group and the beneficiary is transferred from an IRF to another facility as defined in 42 CFR § 412.602. These regulations apply if the transfer is to another IRF, a long term care hospital, an acute-care inpatient hospital, or a nursing home that accepts payment under either the Medicare program or the Medicaid program (or both) (42 CFR §§ 412.602 and 412.624(f)(1)).

Medicare pays for transfer cases on a per diem basis. CMS calculates the per diem payment rate by dividing the full case-mix-group payment rate by the average length of stay for the case-mix group. CMS then multiplies the per diem rate by the number of days that the beneficiary stayed in the IRF before being transferred. Medicare makes an additional half-day payment for the first day (42 CFR § 412.624(f)(2)).

## **CLAIMS POTENTIALLY MISCODED AS DISCHARGES INSTEAD OF TRANSFERS**

Nationwide, 585 IRF claims were potentially miscoded as discharges to home with HHA services instead of transfers. The potential errors occurred at 320 IRFs in 44 States.

We visited one IRF and contacted three IRFs that were responsible for 44 of the 585 claims in our review to verify the discharge status of the claims. The four IRFs acknowledged that all 44 claims should have been coded as transfers rather than as discharges.

We also reviewed the claim histories for 100 of the 585 claims. The IRF or the FI had subsequently adjusted 7 of the 100 claims to reflect that transfers had occurred, not discharges. The remaining 93 claims had not been subsequently adjusted and may have represented transfers. We repriced the 93 claims and calculated potential overpayments totaling \$463,427. Specifically:

- Sixty-six claims for discharges were followed by claims for admissions to Medicare skilled nursing facilities on the same days as the discharge dates. These claims resulted in potential overpayments of \$315,845 to the discharging IRFs.
- Twenty-seven claims for discharges were followed by claims for admissions to acute-care hospitals on the same days as the discharge dates. These claims resulted in potential overpayments of \$147,582 to the discharging IRFs.

By coding the beneficiaries as discharged to home with HHA services, the IRFs claimed Medicare reimbursement at a higher rate than the rate paid for transfers.

### **CLERICAL ERRORS AND LACK OF MEDICARE PAYMENT EDITS**

The four IRFs attributed miscoded claims at their facilities to clerical errors. Moreover, a key Medicare claims-processing system, the CWF, did not contain the necessary edits to compare the date a beneficiary was discharged from an IRF with the date the beneficiary was admitted to another provider. Such edits could have detected potentially miscoded claims and flagged them for subsequent review.

### **ESTIMATED MEDICARE OVERPAYMENTS**

During FY 2003, IRFs received \$463,427 in potential overpayments for the claims in our sample. Based on the sample results, we estimate that Medicare overpaid IRFs \$2,331,042.

### **RECOMMENDATIONS**

We recommend that CMS:

- instruct the FIs to review the claims in question and to recover, as appropriate, the estimated \$2,331,042 in overpayments;
- instruct the FIs to review claims paid after our audit period for possible coding errors like those found in this review; and
- implement edits in the CWF that match beneficiary discharge dates with admission dates to other providers to identify potentially miscoded claims.

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

In its comments on our draft report, CMS concurred with the recommendations. CMS stated that it planned to recover the overpayments identified consistent with its policies and procedures and requested that we furnish the data necessary to initiate additional claim reviews and recovery action. According to CMS, it planned to (1) issue a vulnerability report to all FIs to alert them to the potential risk of miscoding IRF claims as discharges to home with HHA services rather than transfers and (2) direct the FIs to conduct data analysis and ensure that these claims are paid appropriately. CMS added that it would develop and

implement program instructions that adopt the recommendation for CWF edits. (See Appendix D for CMS's comments in their entirety.)

**OFFICE OF INSPECTOR GENERAL RESPONSE**

We provided CMS with the requested data on claims.

# **APPENDIXES**

**QUALITY CONTROL CHECK TO ENSURE THE ACCURACY OF  
REPRICED CLAIMS**

To confirm the accuracy of the modified PRICER that we used to reprice claims, we obtained the provider-specific files, the metropolitan statistical area files, and the claim files from the Centers for Medicare & Medicaid Services (CMS). This information is identical to the information the fiscal intermediaries use when pricing claims through CMS's inpatient rehabilitation facility (IRF) PRICER.

For selected claims in our universe, we compared the payment amount that the modified PRICER calculated for each claim as originally processed (i.e., without any corrections) with the amount originally paid for the claim. Essentially, we worked backward to determine whether the modified PRICER would calculate the same amount for a claim as the fiscal intermediaries calculated and paid. When the amount that the modified PRICER calculated matched the amount that the fiscal intermediary calculated, we concluded that the modified PRICER was accurate. When the amounts did not match, we identified the cause of the discrepancy and adjusted the modified PRICER accordingly.

**SAMPLING METHODOLOGY**

**OBJECTIVE**

Our objective was to determine whether IRFs coded claims as “discharged to home with home health agency services” in compliance with Medicare’s transfer payment regulation during fiscal year (FY) 2003.

**POPULATION**

The population consisted of 585 paid IRF claims for the period October 1, 2002, through September 30, 2003.

**SAMPLE UNIT**

The sample unit was a claim.

**SAMPLE DESIGN**

We used a simple random sample of claims.

**SAMPLE SIZE**

The sample size was 100 claims.

**ESTIMATION METHODOLOGY**

Using the Office of Inspector General, Office of Audit Services RAT-STATS variable appraisal program, we projected the excessive payments to IRFs resulting from erroneously coded claims.

## SAMPLE RESULTS AND PROJECTION

## SAMPLE RESULTS

<u>Sample Size</u>	<u>Number of Errors</u>	<u>Value of Errors</u>
100	93	\$463,427

## VARIABLE PROJECTION

	<u>Projected Value of Overpayments for FY 2003</u>
Point estimate	\$2,711,046
90-percent confidence interval	
Lower limit	\$2,331,042
Upper limit	\$3,091,049



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Centers for Medicare &amp; Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** AUG 23 2006

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

**FROM:** Mark B. McClellan, M.D., Ph.D.  
Administrator *Mark McClellan*

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Nationwide Review of Inpatient Rehabilitation Facility Claims Coded as "Discharged to Home with Home Health Agency Services" (A-04-04-00013)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on this audit report. We would like to thank the Office of Inspector General (OIG) for its recommendations on this issue. We are pleased to report that CMS has taken many proactive steps to ensure that we are making proper payments to inpatient rehabilitation facilities (IRFs). Even prior to the issuance of this report, CMS had identified IRFs as a potentially vulnerable area. Accordingly, CMS has taken proactive corrective actions to protect the trust funds from improper payments. These corrective actions have included performing medical review on IRF claims and educating providers on the correct way to bill for IRF services. Based on the recommendations included in this report, we will continue and refine, when appropriate, our actions to ensure the proper payment for IRF services.

An IRF is a hospital or a subunit of a hospital for which the primary purpose is to provide intensive rehabilitation services to its inpatient population. IRFs are paid under a prospective payment system (PPS) specifically tailored to IRFs, based on the case-mix rate, rather than being paid under the acute-care hospital inpatient PPS. A full payment rate is made to an IRF that discharges a beneficiary to his or her home. However, a lesser payment is made if the patient's stay is shorter than the average stay for the given case-mix group and the patient is transferred from the IRF to another IRF, an acute-care inpatient hospital, a long-term care facility, or a nursing home that qualifies to receive Medicare or Medicaid payments. The OIG report indicates that some IRFs did not always code claims in compliance with Medicare's transfer regulation. In some cases, IRFs coded claims as discharged to home with home health agency services that potentially should have been paid as transfer cases. As a result, according to the OIG draft report, IRFs received an estimated, extrapolated overpayment of \$2.3 million in fiscal year 2003.

The CMS requires its contractors to develop and utilize data analysis to identify those areas of the program that pose the greatest vulnerability and result in improper payments from either

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inadvertent errors or fraud; formulate interventions to address identified problems; and evaluate the impact and effectiveness of those interventions.

At the time of this report, the fiscal intermediaries (FIs) had conducted: 1) a prepay probe on high billing providers; 2) a prepay review of providers' error rates based on internal contractor specific parameters; and 3) a post-pay complex medical review. As mentioned above, based on this analysis, the FIs identified inpatient rehabilitation as a potential program vulnerability. To address this issue, the FIs have already conducted provider-specific education and developed news articles to clarify the intent of local and national policies and system edits.

The CMS appreciates the effort that went into this report and the opportunity to review and comment on the issues it raises. We always look forward to working collaboratively with our partners to protect the Medicare trust funds. Our response to the audit recommendations follows.

#### **OIG Recommendation**

The CMS should instruct FIs to review the claims in question and to recover, as appropriate, the estimated \$2,331,042 in overpayments.

#### **CMS Response**

The CMS agrees that the overpayments identified from a review of the claims in question should be recovered. CMS plans to recover the overpayments consistent with the Agency's policies and procedures.

The CMS requests that OIG furnish for each overpayment the data necessary (provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, we ask that Medicare contractor-specific data be written to separate CDs in order to better facilitate the transfer of information to the appropriate contractors.

#### **OIG Recommendation**

The CMS should instruct the FIs to review claims paid after the audit period for possible coding errors like those found in this review.

#### **CMS Response**

We concur with the recommendation. In addition to the actions already taken, CMS will: 1) issue a vulnerability report alerting the FIs of the OIG findings; 2) instruct FIs to intensify their post-pay data analysis based on the OIG findings and, if warranted, review claims and recover any overpayment; 3) instruct FIs to reassess providers' behavior identified for corrective action on a quarterly basis until they are in compliance with all billing and coding requirements; and 4) continue to work with the FIs to enhance the support and monitoring of IRF claims payment.

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**OIG Recommendation**

The CMS should implement edits in the common working file that match beneficiary discharge dates with admission dates to other providers to identify potentially miscoded claims.

**CMS Response**

We concur with the recommendation and will develop and implement program instructions that adopt this recommendation in the April 2007 system release. The correction will occur on or about April 2, 2007.