



AUG 29 2005

Office of Audit Services  
Region I, Room 2425  
John F. Kennedy Federal Building  
Boston, MA 02203  
(617) 565-2684

Report Number: A-01-05-00508

Mr. Scott Bullock  
President and Chief Executive Officer  
MaineGeneral Health  
149 North St.  
Waterville, Maine 04901

Dear Mr. Bullock:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Review of Fiscal Year-End Billing For Inpatient Rehabilitation Facility Claims At MaineGeneral Medical Center for 2002, 2003 and 2004." A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. 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), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to report number A-01-05-00508 in all correspondence relating to this report.

Sincerely yours,

Michael J. Armstrong  
Regional Inspector General  
For Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**  
Charlotte S. Yeh, M.D.  
Regional Administrator  
Centers for Medicare & Medicaid Services – Region I  
Department of Health and Human Services  
Room 2325, J.F.K. Federal Building  
Boston, Massachusetts 02203

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF FISCAL YEAR-END  
BILLING FOR INPATIENT  
REHABILITATION FACILITY CLAIMS  
AT MAINEGENERAL MEDICAL  
CENTER FOR 2002, 2003 AND 2004**



**Daniel R. Levinson**  
Inspector General

**AUGUST 2005**  
**A-01-05-00508**

# ***Office of Inspector General***

<http://oig.hhs.gov>

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

The Centers for Medicare & Medicaid Services (CMS) implemented a prospective payment system for inpatient rehabilitation facilities (IRFs) for cost-reporting periods beginning on or after January 1, 2002. The prospective payment system provides for a predetermined payment per discharge. To receive this payment, the IRF must submit a single discharge bill for an entire inpatient stay. The payment encompasses all inpatient operating and capital costs with few exceptions.

CMS instructions state that when a beneficiary's stay overlaps the time in which the IRF becomes subject to prospective payment system rules, the payment will be based on the patient's date of discharge. An IRF should not split bills for these patients into separate fiscal years.

### **OBJECTIVE**

Our objective was to determine whether MaineGeneral Medical Center (the hospital) billed fiscal year-end inpatient rehabilitation claims in accordance with Medicare regulations.

### **SUMMARY OF FINDINGS**

The hospital did not bill 76 fiscal year-end claims for its IRF in accordance with Medicare regulations. Specifically, the hospital split claims for 38 IRF stays into two separate claims and received two separate Medicare payments for each IRF stay that spanned the fiscal year-end of June 30 in 2002, 2003, and 2004. Pursuant to Medicare regulations and CMS guidance, the entire IRF stay should have been billed as a single claim on the CMS Form 1450 (UB92). As a result of the incorrect billing, Medicare made net overpayments of \$254,915 for 2002, 2003, and 2004.

The payment errors occurred because the hospital did not have adequate controls to ensure that claims submitted at fiscal year-end were billed in accordance with Medicare regulations. Additionally, the hospital received inaccurate information from its fiscal intermediary that contributed to the ongoing problem of split billing in 2003 and 2004. We have addressed this issue with the fiscal intermediary.

### **RECOMMENDATIONS**

We recommend that the hospital:

- improve controls to ensure that current Medicare billing guidelines are followed; and
- continue to work with its fiscal intermediary to complete the voluntary repayment process involving the net overpayments of \$254,915 and determine the resulting effect on its Medicare cost reports for 2002, 2003, and 2004.

The hospital agreed with our findings and recommendations and detailed the steps they have taken to address the issues. Specifically, the hospital provided a full repayment of all Medicare overpayments and implemented improved processes and internal controls to ensure continued compliance.

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## **INTRODUCTION**

### **BACKGROUND**

The Social Security Amendments of 1983 established the prospective payment system (PPS) 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> As a result, IRFs continued to be paid pursuant to Section 1886(b) of the Social Security Act, as amended by Section 101 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. These rules based payments to IRFs on the Medicare reasonable costs per case, limited by a hospital-specific target amount per discharge.

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

The PPS provides for a predetermined payment per discharge. To receive this payment, the IRF must submit a single discharge bill for an entire inpatient stay. CMS instructions state that when a beneficiary's stay overlaps the time in which the IRF becomes subject to PPS rules, the payment will be based on the patient's date of discharge. An IRF should not split bills for these patients into separate fiscal years.

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

#### **Objective**

Our objective was to determine whether MaineGeneral Medical Center (the hospital) billed fiscal year-end<sup>2</sup> inpatient rehabilitation claims in accordance with Medicare regulations.

#### **Scope**

The audit included a review of 76 Medicare claims made to the hospital for patient stays that spanned the hospital's fiscal year-end of June 30 in 2002, 2003, and 2004. The hospital was paid \$244,567, \$318,253, and \$424,037 for inpatient rehabilitation claims that spanned fiscal year-end 2002, 2003, and 2004, respectively.

Our review of internal controls was limited to obtaining an understanding of the hospital's internal control structure for developing and submitting claims that spanned the hospital's fiscal year-end.

We performed our fieldwork during March 2005 at the hospital in Augusta, Maine.

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

<sup>2</sup> "Fiscal year-end" refers to the end of the hospital's fiscal year of July 1 through June 30.

## **Methodology**

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- extracted paid claims data for 2002, 2003, and 2004 from CMS's National Claims History and the fiscal intermediary's claims processing system and identified a universe of 76 inpatient rehabilitation claims incorrectly billed by the hospital at its fiscal year-end;
- reviewed the applicable detailed records for the claims from CMS's Common Working File to verify that the claims represented a single inpatient rehabilitation stay;
- calculated the effect of incorrect billing by using CMS's Pricer Program; and
- discussed the results of our review with the hospital's fiscal intermediary, Associated Hospital Service, Inc.

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

## **FINDINGS AND RECOMMENDATIONS**

The hospital did not bill 76 fiscal year-end claims for its IRF in accordance with Medicare regulations. As a result, Medicare made net overpayments to the hospital of \$254,915 for fiscal years 2002, 2003, and 2004.

The payment errors occurred because the hospital did not have adequate controls to ensure that claims submitted at fiscal year-end were billed in accordance with Medicare regulations. Additionally, the hospital received inaccurate information from its fiscal intermediary that contributed to the ongoing problem of split billing in 2003 and 2004.

## **INTERIM BILLING REGULATIONS**

Pursuant to 42 CFR § 412.600, the IRF prospective payment system provides for a predetermined per-discharge payment. To receive this payment, an IRF must submit a single discharge bill for an entire inpatient stay. The payment encompasses all inpatient operating and capital costs with few exceptions. CMS guidance states that when a beneficiary's stay overlaps the time in which the IRF becomes subject to PPS rules, the payment will be based on the patient's date of discharge. Furthermore, provider instructions contained in the "Medicare Inpatient Rehabilitation Facility Prospective Payment System Training Manual" state that an IRF should not split bills that overlap the start of the fiscal year in which the IRF becomes subject to the PPS.

## **FISCAL YEAR-END CLAIMS SPLIT**

The hospital did not bill 76 fiscal year-end claims for its IRF in accordance with Medicare regulations. Specifically, the hospital split claims for 38 IRF stays into two separate claims. As a result, Medicare made two separate payments to the hospital for each IRF stay that spanned the fiscal year-end of June 30 in 2002, 2003, and 2004. Pursuant to Medicare regulations and CMS guidance, the entire IRF stay should have been billed as a single claim on CMS Form 1450 (UB92).

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

Medicare made net overpayments of \$254,915 to the hospital for claims submitted for fiscal year-ends 2002, 2003, and 2004. For several claims, the hospital received underpayments when the combining of two claims into a single claim caused certain thresholds to be exceeded. When these thresholds were exceeded, outlier payments were due or full payments were warranted instead of reduced-transfer or short-stay payments. The IRF PPS full payment is adjusted to account for situations such as transfers to other facilities and short stays of 3 days or less.

## **INADEQUATE BILLING CONTROLS**

The hospital did not have adequate controls to ensure that claims submitted at fiscal year-end were billed in accordance with Medicare regulations. Specifically, the hospital followed section 415.9 of the Medicare Hospital Manual, which is intended for hospitals that are not paid under a PPS. Section 415.9 states that “providers not on [the PPS] continue to submit split bills at the end of their fiscal year and allocate the days to the provider year in which they occurred.” As a result, the hospital continued to split bills at the end of its fiscal year to allocate Medicare days to the correct cost-reporting year. However, since IRFs transitioned to PPS, split billing is no longer allowed at fiscal year-end because payment is now based on the patient’s date of discharge.

Additionally, the hospital received inaccurate information from its fiscal intermediary that contributed to the ongoing problem of split billing in 2003 and 2004. We have addressed this issue with the fiscal intermediary.

## **CORRECTIVE ACTIONS**

In December 2004, the hospital initiated corrective actions and submitted a check to its fiscal intermediary for \$101,542 in repayment of non-PPS claims submitted in error at its fiscal year-end of June 30, 2002. At the same time, the hospital began processing adjustments to several of these 2002 claims through the fiscal intermediary’s claims processing system. As a result, the hospital refunded the overpayment dollars for the 2002 non-PPS claims a second time. To receive correct PPS payments, the hospital must now complete the process of adjusting and resubmitting these stays as single claims and work with its fiscal intermediary to recoup any monies due when the adjustment process is complete.

During the course of our review, the hospital also refunded overpayments of \$204,397 for incorrect claims billed at the fiscal year-ends of 2003 and 2004 by submitting adjusted claims through the fiscal intermediary's claims process system.

## **RECOMMENDATIONS**

We recommend that the hospital:

- improve controls to ensure that current Medicare billing guidelines are followed; and
- continue to work with its fiscal intermediary to complete the voluntary repayment process involving the net overpayments of \$254,915 and determine the resulting effect on its Medicare cost reports for 2002, 2003, and 2004.

## **AUDITEE COMMENTS**

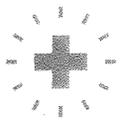
The hospital agreed with our findings and recommendations and detailed the steps they have taken to address the issues. Specifically, the hospital provided full repayment of all Medicare overpayments and improved its processes and internal controls, including:

- education of billing personnel;
- documentation of IRF billing procedures;
- communication with fiscal intermediary; and
- review of fiscal year-end 2005 claims to ensure continued compliance.

The hospital will also work with the fiscal intermediary to determine the impact on its Medicare cost reports for 2002, 2003, and 2004 as a result of the repayments made to CMS.

We have included the full text of the hospital's comments in an appendix to this report.

# **APPENDIX**



Your resource for life.

**MaineGeneral**  
Medical Center

6 East Chestnut Street  
Augusta, Maine 04330  
Phone: 207.626.1000

**APPENDIX**

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[www.maine-general.org](http://www.maine-general.org)

August 17, 2005

Mr. Michael Armstrong  
Regional Inspector General for Audit Services  
Office of Audit Services – Region I  
John F. Kennedy Federal Building  
Boston, MA 02203

**Re: Report# A-01-05-00508**

Dear Mr. Armstrong:

This letter is the response of MaineGeneral Medical Center to the draft report of the U.S. Department of Health and Human Services, Office of Inspector General, entitled “**Review of Fiscal Year-End Billing for Inpatient Rehabilitation Facility Claims at MaineGeneral Medical Center for 2002, 2003, and 2004**”, Report # A-01-05-00508. We concur with the findings and recommendations contained in this report, and appreciate the opportunity to offer the following comments.

As noted in the report, MaineGeneral Medical Center incorrectly billed 38 Intermediate Rehabilitation Facility (“IRF”) stays that spanned the fiscal year end. Pursuant to Medicare regulations and CMS guidance, the entire IRF stay should have been billed as a single claim. This error was due, in part, to incorrect advice from the Medicare Part A Fiscal Intermediary.

MaineGeneral Medical Center has taken the following steps as a result of this situation:

- Full repayment of all Medicare overpayments, in the total amount of \$254,915.
- Improved processes and internal controls, including:
  - Education of billing personnel;
  - Documentation of IRF billing procedures;
  - Communication with Medicare Part A Fiscal Intermediary; and
  - Concurrent review of selected IRF claims.
- Working with the fiscal intermediary to determine the impact on our Medicare cost reports for 2002, 2003, and 2004 as a result of the repayments made to CMS.
- Review of FYE 2005 claims to assure continued compliance.



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**MaineGeneral**  
Medical Center

**APPENDIX**

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We are confident that these steps will prevent a recurrence of this problem, and will contribute to the integrity of the Medicare program.

We appreciate the opportunity to work collaboratively with the Office of Inspector General to address this situation. Should you have questions, please do not hesitate to contact me.

Sincerely yours,

Kevin Brooks  
Vice President, Finance