



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

May 21, 2010

Report Number: A-01-09-00525

Mr. Jim Elmore
Regional Vice President, Contract Administration
National Government Services
Mail Stop: INA 102-AF13
8115 Knue Road
Indianapolis, IN 46250

Dear Mr. Elmore:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Inpatient Rehabilitation Facility Claims Billed with Patient Status Code 05 Processed by National Government Services for Calendar Year 2007*. We will forward a copy of this report to the HHS action official noted on the following page 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 this 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kimberly Rapoza, Audit Manager, at (617) 565-2695 or through email at Kimberly.Rapoza@oig.hhs.gov. Please refer to report number A-01-09-00525 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare and Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
INPATIENT REHABILITATION
FACILITY CLAIMS BILLED WITH
PATIENT STATUS CODE 05
PROCESSED BY NATIONAL
GOVERNMENT SERVICES FOR
CALENDAR YEAR 2007**



Daniel R. Levinson
Inspector General

May 2010
A-01-09-00525

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for inpatient rehabilitation facilities (IRF). The system provides for a predetermined, per-discharge payment. The IRF uses information from a patient assessment instrument to classify patients into distinct case-mix groups based on clinical characteristics and expected resource use. Medicare makes a full case-mix-group payment to an IRF that discharges a beneficiary to home or to another institution that is not covered by Medicare's transfer regulations. However, pursuant to 42 CFR § 412.624(f), 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. Federal regulations define a transfer case as one in which:

- the beneficiary's IRF stay is shorter than the average stay for the nontransfer cases in 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.

IRFs use patient status codes that specify the type of institution, e.g., inpatient hospitals and skilled nursing facilities, to designate a transfer that is subject to the transfer regulation. Medicare makes per-diem transfer payments for claims submitted with these codes. IRFs use patient status code 05 to indicate that the beneficiary was "discharged/transferred to another type of institution not defined elsewhere." Medicare makes a full case-mix-group payment for claims submitted with this code.

During our audit period (calendar year (CY) 2007), CMS contracted with National Government Services (NGS) to serve as the Medicare Part A fiscal intermediary in 15 States including Connecticut, Indiana, Michigan, and New York. Our review covered 46 Medicare Part A claims totaling \$994,576 that were submitted by 26 IRFs in these 4 States and paid by NGS during CY 2007.

OBJECTIVE

Our objective was to determine whether IRFs correctly coded claims paid by NGS with patient status code 05.

SUMMARY OF FINDING

IRFs incorrectly coded 30 of the 46 claims that we reviewed with patient status code 05. These beneficiaries were actually transferred to facilities that were subject to the Medicare transfer regulations, e.g., inpatient hospitals, skilled nursing facilities, and Medicaid-only nursing homes. Because the IRFs did not use the appropriate transfer codes on these claims, NGS made \$300,304 in overpayments for miscoded transfers to 15 IRFs in CY 2007. As a result of our

audit work, IRFs have already refunded \$22,325 for 5 of the 30 claims, leaving \$277,979 in uncollected overpayments.

Overpayments occurred because of clerical errors and computer programming errors at the IRFs. In addition, CMS did not establish payment controls in its Common Working File to prevent and detect these overpayments until April 2007.

RECOMMENDATIONS

We recommend that NGS:

- recover the \$277,979 in outstanding overpayments for 25 claims and
- alert IRFs to the importance of reporting the correct patient status code on their claims.

NATIONAL GOVERNMENT SERVICES COMMENTS

In comments on our draft report, NGS stated that it would educate IRFs and recover the overpayments for the 10 Indiana and Michigan claims, which remain under its previous contract with CMS. For the remaining 15 New York and Connecticut claims, NGS stated that it had forwarded the draft report to the CMS project officer responsible for the Medicare contract jurisdiction to determine what actions should be taken with respect to our recommendations. NGS comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

The Prospective Payment System for Inpatient Rehabilitation Facilities

Inpatient rehabilitation facilities (IRF) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and an interdisciplinary, coordinated team approach to improve their ability to function. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for IRFs. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, implemented the prospective payment system for cost-reporting periods beginning on or after January 1, 2002. The system provides for a predetermined, per-discharge payment. The IRF uses information from a patient assessment instrument to classify patients into distinct case-mix groups based on clinical characteristics and expected resource use.

Transfer Payments

Under the IRF prospective payment system, Medicare makes a full case-mix-group payment to an IRF that discharges a beneficiary to home or to another institution that is not covered by Medicare's transfer regulations. However, pursuant to 42 CFR § 412.624(f), 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. Federal regulations define a transfer case as one in which:

- the beneficiary's IRF stay is shorter than the average stay for the nontransfer cases in 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 makes a full case-mix group payment or a transfer payment depends on the patient status code on the IRF's claim. IRFs use several different patient status codes to designate transfer to a specific institution that is subject to the transfer regulation: 02 – short-term inpatient hospital; 03 – skilled nursing facility; 61 – hospital-based, Medicare-approved swing bed within the IRF; 62 – another IRF; 63 – long-term-care hospital; and 64 – a Medicaid-only nursing facility. Medicare makes per-diem transfer payments for claims submitted with any of these codes.

IRFs use patient status code 05 to indicate that the beneficiary was “discharged/transferred to another type of institution not defined elsewhere.” Medicare makes a full case-mix-group payment for claims submitted with this code.

Prior Office of Inspector General Reviews

Two prior Office of Inspector General reviews of improperly coded IRF transfers¹ found that IRFs did not always code claims in compliance with Medicare's transfer regulation. Together, these two reviews identified \$14.3 million in potential overpayments for miscoded claims. Both reports recommended that CMS implement an edit to its Common Working File to prevent future overpayments for transfer cases. CMS agreed with the findings and recommendations.

In response to these reviews, CMS implemented an edit in its Common Working File in April 2007. The edit matches beneficiary discharge dates with admission dates to other providers to identify potentially miscoded claims. Claims identified as transfers are cancelled and returned to the IRF for correction.

National Government Services

During our audit period (calendar year (CY) 2007), CMS contracted with National Government Services (NGS) to serve as the Medicare Part A fiscal intermediary in 15 States. These States included Connecticut, Indiana, Michigan, and New York, which were the focus of our review. Under this contract, NGS processed and paid Medicare claims submitted by institutional providers.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether IRFs correctly coded claims paid by NGS with patient status code 05.

Scope

Our review initially identified 97 Medicare Part A claims totaling \$1,930,890 with patient status code of 05 that were submitted by 38 IRFs in Connecticut, Indiana, Michigan, and New York and paid by NGS during CY 2007. We limited our review to 46 claims submitted by 26 IRFs for shorter than average stays.

Our objective did not require an understanding or assessment of the complete internal control structure of IRFs or NGS. Therefore, we limited our review to (1) obtaining an understanding of IRFs' procedures for coding claims with patient status code 05, and (2) NGS's policies and procedures for reviewing claims identified by CMS's edit in the Common Working File.

Our fieldwork consisted of contacting NGS and the 26 IRFs that submitted the 46 claims. We conducted our fieldwork from July through September 2009.

¹ *Nationwide Review of Inpatient Rehabilitation Facilities' Compliance with Medicare's Transfer Regulation* (A-04-04-00008, September 11, 2006) and *Nationwide Review of Inpatient Rehabilitation Facility Claims Coded as "Discharged to Home with Home Health Agency Services"* (A-04-04-00013, November 2, 2006).

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and CMS manuals regarding IRF transfers;
- extracted IRF paid claims data from CMS's National Claims History file for CY 2007;
- created a subset of data of 97 claims paid by NGS in Connecticut, Indiana, Michigan, and New York and billed by IRFs with a patient status code of 05;
- refined the NGS file 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 46 claims that had shorter than average stays;
- reviewed CMS's Common Working File claims history for the 46 claims to determine whether the claims were correctly coded as "05" and to verify that the selected claims had not been canceled;
- contacted representatives of the 26 IRFs that submitted the selected claims to verify whether the claims were correctly coded and to determine the causes of miscoding;
- contacted five institutions that admitted the beneficiaries after the IRF transfer but did not submit Medicare claims for those stays to determine whether they accepted Medicare or Medicaid;
- used CMS's PRICER program to assist in determining the payment error amounts; and
- discussed the results of our review with officials of the IRFs and NGS.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

IRFs incorrectly coded 30 of the 46 claims that we reviewed with patient status code 05. These beneficiaries were actually transferred to facilities that were subject to the Medicare transfer regulations, e.g., inpatient hospitals, skilled nursing facilities, and Medicaid-only nursing homes. Because the IRFs did not use the appropriate transfer codes on these claims, NGS made \$300,304 in overpayments for miscoded transfers to 15 IRFs in CY 2007. As a result of our

audit work, IRFs have already refunded \$22,325 for 5 of the 30 claims, leaving \$277,979 in uncollected overpayments.

Overpayments occurred because of clerical errors and computer programming errors at the IRFs. In addition, CMS did not establish payment controls in its Common Working File to prevent and detect these overpayments until April 2007.

PROGRAM REQUIREMENTS

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. Pursuant to implementing regulations (42 CFR §§ 412.602 and 412.624(f)(1)), IRFs receive an adjusted prospective payment if (1) the beneficiary's stay in the IRF is shorter than the average stay for the given case-mix group and (2) the beneficiary is transferred from an IRF to another IRF, a long term care hospital, an acute-care inpatient hospital, or a nursing home that accepts payment under either the Medicare or Medicaid programs.

Pursuant to 42 CFR § 412.624(f)(2), 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.

The Medicare Claims Processing Manual (the Manual), chapter 3, section 140.3, and chapter 25, section 75.2, lists the patient status codes that identify a transfer case, the code definitions, and examples of appropriate use. When an IRF uses these transfer codes, the claims processing system generates a per diem transfer payment to the IRF rather than a full case-mix-group payment.

PAYMENTS BASED ON INCORRECT PATIENT STATUS CODE

IRFs incorrectly coded 30 of the 46 claims that we reviewed with patient status code 05. These beneficiaries were actually transferred to facilities that were subject to the Medicare transfer regulations, e.g., inpatient hospitals, skilled nursing facilities, and Medicaid-only nursing homes. Because the IRFs did not use the appropriate transfer codes on these claims, NGS made \$300,304 in overpayments for miscoded transfers to 15 IRFs in CY 2007.

As a result of our audit, IRFs have already refunded \$22,325 for 5 of the 30 claims, leaving \$277,979 in uncollected overpayments.

CAUSES OF OVERPAYMENTS

Overpayments occurred because of clerical errors and computer programming errors at the IRFs. In addition, until April 2007, CMS's Common Working File did not contain the necessary edit to compare the date on which a beneficiary was discharged from an IRF with the date on which the beneficiary was admitted to another institution. The edit appears to be generally effective: only 3 of the 30 incorrectly coded claims that resulted in overpayments were submitted after CMS had implemented the edit. The edit did not identify 2 of these 3 claims as transfers because the institutions that admitted the beneficiaries after they were discharged from the IRF did not submit Medicare claims. We were unable to determine why the edit did not identify the remaining claim.

RECOMMENDATIONS

We recommend that NGS:

- recover the \$277,979 in outstanding overpayments for 25 claims and
- alert IRFs to the importance of reporting the correct patient status code on their claims.

NATIONAL GOVERNMENT SERVICES COMMENTS

In comments on our draft report, NGS stated that it would educate IRFs and recover the overpayments for the 10 Indiana and Michigan claims, which remain under its previous contract with CMS. For the remaining 15 New York and Connecticut claims, NGS stated that it had forwarded the draft report to the CMS project officer responsible for the Medicare contract jurisdiction to determine what actions should be taken with respect to our recommendations. NGS comments are included in their entirety as the Appendix.

APPENDIX



National Government Services, Inc.
8115 Knue Road
Indianapolis, Indiana 46250-1936
A CMS Contracted Agent

May 7, 2010

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

RE: Report Number A-01-09-00525

Dear Mr. Armstrong;

The following is National Government Service's (NGS) response to the Office of Inspector General (OIG) draft report entitled "Review of Inpatient Rehabilitation Facility Claims Billed with Patient Status Code 05 Processed by National Government Services for Calendar Year 2007. Please note, on November 14, 2008, the Centers for Medicare and Medicaid Services (CMS) contracted with NGS as a Medicare Administrative Contractor (MAC) to process the New York and Connecticut Medicare Part A claims that were previously the responsibility of NGS, but as a Legacy Title XVIII contractor.

For the ten (10) Indiana and Michigan claims, which remain under a Title XVIII contract, NGS will recoup the monies due and educate IRFs. However, for the fifteen (15) New York and Connecticut claims, we forwarded the draft report to [REDACTED] CMS [REDACTED]. Her team will determine our next steps related to the following:

- Recovering outstanding overpayments identified during the audit;
- Alerting IRFs to the importance of reporting the correct patient status code on their claims

When we receive her response, we will advise you of our next steps.

Sincerely,

A handwritten signature in black ink, appearing to read "David A. Marshall".

David A. Marshall
Chief Operating Officer
National Government Services

