



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

January 13, 2011

Report Number: A-01-10-00500

Ms. Melissa Halstead Rhodes
Area Director and Medicare CFO
Financial Management Operations Division
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, 11.2402
Dallas, TX 75234

Dear Ms. Rhoades:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of TrailBlazer Health Enterprises, LLC Payments For Inpatient Rehabilitation Facility Claims Billed With Patient Status Code 05 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-01-10-00500 in all correspondence.

Sincerely,

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

Enclosure

Page 2 – Ms. Melissa Halstead Rhoades

Direct Reply to HHS Action Official:

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

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF TRAILBLAZER HEALTH
ENTERPRISES, LLC PAYMENTS FOR
INPATIENT REHABILITATION FACILITY
CLAIMS BILLED WITH PATIENT STATUS
CODE 05 FOR CALENDAR YEAR 2007**



Daniel R. Levinson
Inspector General

January 2011
A-01-10-00500

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 non-transfer 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 to designate that a transfer is subject to the transfer regulation. Patient status codes also indicate the type of institution, e.g., inpatient hospitals and skilled nursing facility, to which a beneficiary is transferred. 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 TrailBlazer Health Enterprises, LLC (TrailBlazer) to serve as fiscal intermediary for the states covered by our review. Under this contract, TrailBlazer processed and paid Medicare claims submitted by institutional providers. In August 2007, CMS awarded TrailBlazer the Part A and B Medicare Administrative Contractor contract for Jurisdiction 4. Our review covered 41 Medicare Part A claims totaling \$790,093 that were submitted by 17 IRFs in Louisiana, New Mexico, Oklahoma, and Texas, and paid by TrailBlazer during CY 2007.

OBJECTIVE

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

SUMMARY OF FINDING

IRFs incorrectly coded 24 of the 41 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, and skilled nursing facilities, and Medicaid-only nursing

homes. Because the IRFs did not use the appropriate transfer codes on these claims, TrailBlazer made \$162,284 in overpayments for miscoded transfers to 10 IRFs in CY 2007. As a result of our audit work, one IRF has already refunded \$6,929 for one of the 24 claims, leaving \$155,355 in uncollected overpayments.

The overpayments occurred because IRFs did not have adequate controls to ensure the correct use of patient status code 05. In addition, Medicare payment controls in the Common Working File were not adequate to prevent and detect these overpayments until CMS established the necessary edit in April 2007.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the \$155,355 in outstanding overpayments for 23 claims and
- alert IRFs to the importance of reporting the correct patient status code on their claims.

TRAILBLAZER HEALTH ENTERPRISES COMMENTS

In comments on our draft report, Trailblazer concurred with our recommendations and described the corrective actions that it was taking or planned to take. Trailblazers also stated that it had recovered \$155,355 in overpayments based on the 23 claims we reported to be in error. Trailblazer's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We concur with Trailblazer's recalculation of the overpayments and have modified our report accordingly.

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 TRAILBLAZER HEALTH ENTERPRISES COMMENTS

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 non-transfer 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.

Contracts for Processing Medicare Part A Claims

During our audit period, calendar year (CY) 2007, CMS contracted with TrailBlazer Health Enterprises, LLC (TrailBlazer) to serve as the Medicare Part A fiscal intermediary (FI) for Colorado, New Mexico, Oklahoma, and Texas as well as for certain institutions in other states including Louisiana. Under this contract, TrailBlazer processed and paid Medicare claims submitted by institutional providers. In August 2007, CMS awarded TrailBlazer the Part A and B Medicare Administrative Contractor contract for Jurisdiction 4.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our review covered 41 Medicare Part A claims totaling \$790,093 during CY 2007 with patient status code of 05 that were submitted by 17 IRFs in four states including Louisiana, New Mexico, Oklahoma, and Texas. We limited our review to claims for shorter than average stays.

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

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).

Our fieldwork consisted of contacting TrailBlazer and the 17 IRFs that submitted the 41 claims. We conducted our fieldwork from May through October 2010.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and CMS manuals regarding IRF transfers;
- extracted IRF paid claims from CMS's National Claims History File for CY 2007;
- identified 41 IRF claims paid by TrailBlazer with a patient status code 05 by removing claims for beneficiaries whose lengths of stay were equal to or greater than the average length of stay per case-mix-group;
- reviewed CMS's Common Working File claims history for the 41 claims to determine whether they were correctly coded as "05" and to verify that the selected claims had not been canceled;
- contacted representatives of the 17 IRFs that submitted the selected claims to verify whether the claims were correctly coded and to determine the causes of miscoding;
- contacted 15 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 TrailBlazer.

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 24 of the 41 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, and skilled nursing facilities. Because the IRFs did not use the appropriate transfer codes on these claims, Medicare contractors made \$162,284 in overpayments for miscoded transfers to 10 IRFs in CY 2007.

Overpayments occurred because IRFs did not have adequate controls to ensure the correct use of patient status code 05. In addition, Medicare payment controls in the Common Working File were not adequate to prevent and detect these overpayments until CMS established the necessary edits in 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 24 of the 41 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. Because the IRFs did not use the appropriate transfer codes on these claims, TrailBlazer made \$162,284 in overpayments for miscoded transfers to 10 IRFs in CY 2007.

As a result of our audit, one IRF has already refunded \$6,929 for one of the 24 claims, leaving \$155,355 in uncollected overpayments.

CAUSES OF OVERPAYMENTS

Overpayments occurred because IRFs did not have adequate controls to ensure the correct use of patient status code 05. 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.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the \$155,355 in outstanding overpayments for 23 claims and
- alert IRFs to the importance of reporting the correct patient status code on their claims.

TRAILBLAZER HEALTH ENTERPRISES COMMENTS

In comments on our draft report, Trailblazer concurred with our recommendations and described the corrective actions that it was taking or planned to take. Trailblazers also stated that it had recovered \$155,355 in overpayments based on the 23 claims we reported to be in error. Trailblazer's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We concur with Trailblazer's recalculation of the overpayments and have modified our report accordingly.

APPENDIX

APPENDIX: TRAILBLAZER HEALTH ENTERPRISES, LLC - COMMENTS

January 3, 2011

Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region I
John F. Kennedy Federal Building, Room 2425
Boston, MA 02203

Report Number: A-01-10-00500

Dear Mr. Armstrong:

We received the December 7, 2010, draft report entitled "Review of Jurisdiction 4 Payments For Inpatient Rehabilitation Facility Claims Billed With Patient Status Code 05 For Calendar Year 2007." In the draft report, the OIG recommended that TrailBlazer:

- Recover the \$150,255 in outstanding overpayments for 23 claims; and
- Alert IRFs to the importance of reporting the correct patient status code on their claims.

Please consider the following responses to these recommendations for inclusion in the final report:

Recovery of Overpayments: Overpayments totaling \$155,355 were recovered by TrailBlazer. The difference between the OIG determined overpayment and the amount recovered by TrailBlazer is due to the FISS calculation of the claim payment with the corrected discharge status code. A detail listing of the recoveries is available upon request.

Provider Notification Activities:

TrailBlazer has produced several job aids and training materials to providers. These materials are available on our Website at the following locations:

"UB-04 Discharge Status Codes" job aid:

http://www.trailblazerhealth.com/Publications/Job%20Aid/ub-92a_discharge.pdf

Notice posted on June 3, 2009:

<http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13111>

Frequently Asked Question (FAQ):

<http://www.trailblazerhealth.com/Tools/FAQs.aspx?DomainID=1&ID=6074>

Top Telephone/Written Inquiries:

<http://www.trailblazerhealth.com/Publications/Job%20Aid/PartATopTelephone-WrittenInquiries.pdf>

Michael J. Armstrong

January 3, 2011

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If you have any questions regarding our response, please contact me.

Sincerely,

/s/ Melissa Halstead Rhoades

Melissa Halstead Rhoades
Area Director & Medicare CFO

cc: Terry Bird, Contracting Officer Technical Rep., CMS Southern MAC Pgm. Mgmt. Division
Gil R. Glover, President & Chief Operating Officer, TrailBlazer
Scott J. Manning, Vice President, Financial Management Operations, TrailBlazer
Kevin Bidwell, Vice President & Compliance Officer, TrailBlazer