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Washington, D.C. 20201

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Nationwide Review of Inpatient Rehabilitation Facilities' Compliance With Medicare's Transfer Regulation (A-04-04-00008)

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" in compliance with Medicare's transfer regulation during fiscal year 2003.

IRFs did not always code claims in compliance with Medicare's transfer regulation. Nationwide, we identified 2,473 IRF claims coded and paid as discharges to home that potentially should have been paid as transfers. We visited or contacted seven IRFs that were responsible for 112 of these claims and found that all 112 claims should have been coded as transfers rather than as discharges. We also repriced a sample of 100 of the 2,473 claims and estimated that overpayments to IRFs totaled \$11,967,555 in fiscal year 2003.

The seven 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, 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 \$11,967,555 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 Common Working File 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. Please refer to report number A-04-04-00008 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NATIONWIDE REVIEW OF
INPATIENT REHABILITATION
FACILITIES' COMPLIANCE WITH
MEDICARE'S TRANSFER
REGULATION**



Daniel R. Levinson
Inspector General

SEPTEMBER 2006
A-04-04-00008

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

An inpatient rehabilitation facility (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. 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" in compliance with Medicare's transfer regulation during fiscal year 2003.

SUMMARY OF FINDINGS

IRFs did not always code claims in compliance with Medicare's transfer regulation. Nationwide, we identified 2,473 IRF claims coded and paid as discharges to home that potentially should have been paid as transfers. We visited or contacted seven IRFs that were responsible for 112 of these claims and found that all 112 claims should have been coded as transfers rather than as discharges. We also repriced a sample of 100 of the 2,473 claims and estimated that overpayments to IRFs totaled \$11,967,555 in fiscal year 2003.

The seven 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, 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.

RECOMMENDATIONS

We recommend that CMS:

- instruct the fiscal intermediaries to review the claims in question and to recover, as appropriate, the estimated \$11,967,555 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 Common Working File 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.¹ 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.

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. CMS specifies that the following patient status codes are subject to the transfer payment regulation:²

¹See 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.

²See May 17, 2002, CMS Program Memorandum (Transmittal A-02-041, Change Request 2093).

- 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” in compliance with Medicare’s transfer regulation during fiscal year (FY) 2003.

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 the 2,473 claims that had shorter than average stays, that were coded as discharges to home, and that pertained to beneficiaries who were subsequently admitted to facilities listed in the transfer regulation. Payments for these claims totaled about \$40.1 million. These claims were filed by 615 IRFs in 45 States.

We did not review the overall internal control structure of the fiscal 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 review through substantive testing. We also did not review the medical records for the discharging IRFs to determine whether the 2,473 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 and five IRFs and contacted two additional IRFs to discuss the potential errors we identified. Six of the seven IRFs we visited or contacted had the largest number of identified potential errors in the Southeast. The seventh IRF was located in New York State. The seven IRFs were responsible for 112 of the 2,473 claims in the population.

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 fiscal intermediary 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.³
- We created a subset file of the refined nationwide file by extracting all claims with a status code of "01, discharged to home."
- We refined the nationwide file of "01" 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 124,041 claims that had shorter than average stays and were coded as discharged to home.
- We obtained from CMS the 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).
- We matched the subset file of 124,041 IRF claims against the files of transfer facility claims. This process identified 2,537 subsequent facility admissions that occurred on the same day as an IRF discharge and created a universe of potentially unreported transfers. We further reduced the number of claims to 2,473, totaling \$40.1 million, because we did not have the data to analyze 64 claims. Our population represented 2,473 IRF claims that were potentially miscoded as discharged to home instead of transferred to another provider.

³Maryland is exempt from the PPS.

- To determine whether Medicare overpaid any potentially miscoded IRF claims, we selected an unrestricted random sample of 100 claims from our population of 2,473 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 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 seven IRFs through site visits to five and telephone contacts with two.

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 2,473 IRF claims coded and paid as discharges to home that potentially should have been paid as transfers. We visited or contacted seven IRFs that were responsible for 112 of these claims and found that all 112 claims had been miscoded.

Additionally, we reviewed the claim histories for a sample of 100 of the 2,473 claims. Eight of the one hundred claims had been subsequently adjusted to reflect that transfers, not discharges, had occurred. We repriced the remaining 92 claims in our sample and calculated potential overpayments totaling \$591,048.

The seven 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, 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 2,473 claims, we estimate that Medicare overpaid IRFs \$11,967,555 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 TO HOME INSTEAD OF TRANSFERS

Nationwide, 2,473 IRF claims were potentially miscoded as discharges to home instead of transfers. The potential errors occurred at 615 IRFs in 45 States.

We visited or contacted seven IRFs that were responsible for 112 of the 2,473 claims in our review to verify the discharge status of the claims. The seven IRFs acknowledged that all 112 claims should have been coded as transfers rather than as discharges.

We also reviewed the claim histories for 100 of the 2,473 claims. The IRF or the fiscal intermediary had subsequently adjusted 8 of the 100 claims to reflect that transfers, not discharges, had occurred. The remaining 92 claims had not been subsequently adjusted and may have represented transfers. We repriced the 92 claims and calculated potential overpayments totaling \$591,048. Specifically:

- Fifty-two 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 \$246,005 to the discharging IRFs.

- Forty 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 \$345,043 to the discharging IRFs.

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

CLERICAL ERRORS AND LACK OF MEDICARE PAYMENT EDITS

The seven IRFs that we contacted attributed miscoded claims at their facilities to clerical errors. Moreover, a key Medicare claims-processing system, the Common Working File, 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 \$591,048 in potential overpayments for the claims in our sample. Based on the sample results, we estimate that Medicare overpaid IRFs \$11,967,555.

RECOMMENDATIONS

We recommend that CMS:

- instruct the fiscal intermediaries to review the claims in question and to recover, as appropriate, the estimated \$11,967,555 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 Common Working File 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 subject to verification and consistent with its policies and procedures. CMS requested that we furnish the data necessary to initiate additional claim reviews and recovery action. According to CMS, it also planned to (1) issue a special Medical Review Vulnerability Report to all fiscal intermediaries to alert them to the potential risk of miscoding IRF claims as discharges to home rather than transfers and (2) direct the intermediaries 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 Common Working File 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 program 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 payment amount that the fiscal intermediary 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” in compliance with Medicare’s transfer regulation during fiscal year (FY) 2003.

POPULATION

The population consisted of 2,473 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. We calculated the erroneous payments by using the payment methods described in section 1886(j)(1)(E) of the Social Security Act.

SAMPLE RESULTS AND PROJECTION

SAMPLE RESULTS

| Sample Size | Number of Errors | Value of Errors |
|------------------------|-----------------------------|----------------------------|
| 100 | 92 | \$591,048 |

VARIABLE PROJECTION

| | Projected Value of Overpayments for FY 2003 |
|---------------------------------|--|
| Point estimate | \$14,616,610 |
| 90-percent confidence interval: | |
| Lower limit | 11,967,555 |
| Upper limit | 17,265,664 |



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

DATE: JUL 10 2006

TO: Daniel R. Levinson
Inspector General

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

SUBJECT: Office of Inspector General (OIG) Draft Report: "Nationwide Review of Inpatient Rehabilitation Facilities' Compliance with Medicare's Transfer Regulation" (A-04-04-00008)

RECEIVED
305 JUL 11 2006
Administrator
Washington, DC 20201
OFFICE OF INSPECTOR
GENERAL

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.

An inpatient rehabilitation facility (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 the prospective payment system based on the case-mix rate. 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 is transferred from the IRF to an acute inpatient hospital, nursing home, or a long-term care facility. The OIG report indicates that the IRFs did not code claims in compliance with Medicare's transfer regulations. IRFs coded claims as discharged to home that potentially should have been paid as transfer cases, which resulted in an overpayment of approximately \$12,000,000.

The CMS requires its contractors to develop and utilize data analysis to identify those areas of the program that pose the greatest vulnerability, 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. Based on this analysis, the FIs identified inpatient rehabilitation as 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.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises. CMS looks forward to continued collaboration with the OIG. Our response to the audit recommendations follows.

Page 2 – Daniel R. Levinson

OIG Recommendation

The CMS should instruct the FIs to review the claims in question and to recover, as appropriate, the estimated \$11,967,555 in overpayments.

CMS Response

The CMS agrees that the overpayments (subject to verification) should be recovered. CMS plans to recover the overpayments identified, consistent with the Agency's policies and procedures.

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

OIG Recommendation

The CMS should instruct the fiscal intermediaries (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 and plan to: 1) issue a special Medical Review Vulnerability Report to all FIs in order to alert them to this potential program risk and 2) direct the FIs to conduct data analysis and based upon their findings, conduct provider education and medical review as necessary in order to ensure that these claims are paid appropriately.

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 OIG's recommendation for edits in the common working file that match beneficiary discharge dates with admission dates to other providers. This program instruction will be included in the April 2007 system release.