



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION IV  
61 FORSYTH STREET, SW, SUITE 3T41  
ATLANTA, GA 30303

April 24, 2012

Report Number: A-04-11-00078

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

Dear Mr. Rhoades:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Overpaid Some Fiscal Year 2008 and 2009 Jurisdiction 4 Inpatient Rehabilitation Facility Claims That Did Not Comply With Transfer Regulations*. 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 Eric Bowen, Audit Manager, at (404) 562-7789 or through email at [Eric.Bowen@oig.hhs.gov](mailto:Eric.Bowen@oig.hhs.gov). Please refer to report number A-04-11-00078 in all correspondence.

Sincerely,

/Lori S. Pilcher/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 East 12<sup>th</sup> Street, Room 355  
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE OVERPAID SOME FISCAL  
YEAR 2008 AND 2009 JURISDICTION 4  
INPATIENT REHABILITATION FACILITY  
CLAIMS THAT DID NOT COMPLY WITH  
TRANSFER REGULATIONS**



Daniel R. Levinson  
Inspector General

April 2012  
A-04-11-00078

# ***Office of Inspector General***

<http://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## ***Office of Audit Services***

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## ***Office of Evaluation and Inspections***

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## ***Office of Investigations***

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## ***Office of Counsel to the Inspector General***

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

## **THIS REPORT IS AVAILABLE TO THE PUBLIC**

at <http://oig.hhs.gov>

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.

## **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**

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. Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for IRFs. 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 generally pays a lesser amount for a transfer case, based on a per diem rate and the number of days that the beneficiary spent in the IRF.

Federal regulations define a transfer case as one in which (1) the beneficiary's IRF stay is shorter than the average stay for nontransfer cases in the case-mix group and (2) the beneficiary is transferred to another IRF; a short-term, acute-care prospective payment hospital; a long-term-care hospital; or a nursing home that qualifies for Medicare or Medicaid payments. Whether Medicare pays for a discharge or a transfer depends on the patient status code indicated on the IRF's claim.

Previous Office of Inspector General audits identified overpayments to transferring IRFs that did not comply with Medicare's transfer regulation. In response to our recommendations, Centers for Medicare & Medicaid Services (CMS) implemented an edit in the Common Working File (CWF) on April 1, 2007, to identify transfers improperly coded as discharges.

During fiscal years (FY) 2008 and 2009, CMS contracted with TrailBlazer Health Enterprises, LLC (TrailBlazer), to serve as the Medicare Administrative Contractor for Jurisdiction 4. This audit covered \$1,436,770 in Medicare Part A payments related to 73 claims, with dates of service ending in FY 2008 and 2009, submitted by 30 IRFs in Texas, Colorado, and Louisiana.

### **OBJECTIVE**

Our objective was to determine whether Medicare paid certain FY 2008 and 2009 Jurisdiction 4 IRF claims in accordance with Medicare's transfer regulations.

### **SUMMARY OF FINDINGS**

Medicare overpaid some FY 2008 and 2009 Jurisdiction 4 IRF claims that did not comply with transfer regulations. Because of system problems, TrailBlazer did not receive the CWF edit alerts notifying it that the miscoded claims required payment adjustment. Accordingly, Trailblazer could not respond appropriately to the CWF edit alerts, and it incorrectly paid 73 transfer claims as discharges. As a result, Medicare overpaid 30 IRFs by \$384,919 for FY 2008 and 2009.

## **RECOMMENDATIONS**

We recommend that TrailBlazer:

- recover \$384,919 in overpayments,
- ensure that it receives and properly addresses future CWF edit alerts in a timely manner, and
- educate Jurisdiction 4 IRFs on the importance of reporting the correct patient status code on transfer claims.

## **TRAILBLAZER HEALTH ENTERPRISES, LLC, COMMENTS**

In written comments on our draft report, TrailBlazer generally agreed with our recommendations and described corrective actions that it had taken or planned to take in response to our recommendations. TrailBlazer's comments are included in their entirety as the Appendix.

# TABLE OF CONTENTS

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Prospective Payment System for Inpatient Rehabilitation Facilities .....	1
Transfer Payments for Inpatient Rehabilitation Facilities .....	1
Inpatient Rehabilitation Facility Pricer Program .....	2
Prior Office of Inspector General Reports and Centers for Medicare & Medicaid Services Corrective Actions.....	2
TrailBlazer Health Enterprises, LLC .....	2
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	2
Objective .....	2
Scope .....	3
Methodology .....	3
<b>FINDING AND RECOMMENDATIONS</b> .....	4
<b>PROGRAM REQUIREMENTS</b> .....	4
Federal Regulations .....	4
Centers for Medicare & Medicaid Services Guidance .....	4
TrailBlazer Policies and Procedures .....	5
<b>MEDICARE OVERPAYMENTS FOR MISCODED INPATIENT REHABILITATION FACILITY CLAIMS</b> .....	5
<b>SYSTEM PROBLEMS</b> .....	5
<b>RECOMMENDATIONS</b> .....	5
<b>TRAILBLAZER HEALTH ENTERPRISES, LLC, COMMENTS</b> .....	6
<b>APPENDIX</b>	
<b>TRAILBLAZER HEALTH ENTERPRISES, LLC, COMMENTS</b>	

## INTRODUCTION

### BACKGROUND

#### **Prospective Payment System for Inpatient Rehabilitation Facilities**

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. 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, began implementing 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 for Inpatient Rehabilitation Facilities**

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 generally pays a lesser amount for a transfer case, based on a per diem rate and the number of days that the beneficiary spent in the IRF. 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 short-term, acute-care prospective payment hospital; a long-term-care hospital; or a nursing home that qualifies for Medicare or Medicaid payments.

Whether Medicare pays for a discharge or a transfer depends on the patient status code indicated on the IRF's claim. Medicare pays the full discharge payment for two status codes: code 01 indicates a discharge to home and code 06 indicates a discharge to home with home health services. However, Medicare pays the transfer amount for the following patient status codes:

- 02 — a short-term, acute-care inpatient hospital;
- 03 — a skilled nursing facility;
- 61 — a hospital-based, Medicare-approved swing bed<sup>1</sup> within the IRF;
- 62 — another IRF;

---

<sup>1</sup> A swing bed is a hospital bed used to provide both long-term-care and acute care.

- 63 — a long-term-care hospital; and
- 64 — a Medicaid-only nursing facility.

### **Inpatient Rehabilitation Facility Pricer Program**

To price IRF claims, CMS developed the IRF Pricer program. This program uses information specific to each IRF and information from each claim, including the patient status code, to calculate the price on which to base the prospective payment. Provider claims must indicate the proper patient status codes because the IRF Pricer program uses those codes in determining whether the claims will be paid as discharges or transfers. The IRF Pricer program automatically calculates payments for claims with codes 02, 03, 61, 62, 63, or 64 at the per diem rate for transfers.

### **Prior Office of Inspector General Reports and Centers for Medicare & Medicaid Services Corrective Actions**

Previous Office of Inspector General audits identified Medicare overpayments that occurred because IRFs did not comply with Medicare's transfer regulation.<sup>2</sup> In those reports, we recommended that CMS implement edits in the Common Working File (CWF) that match beneficiary discharge dates with admission dates to other providers to identify claims potentially miscoded as discharges rather than transfers. In response to our recommendations, CMS implemented an edit on April 1, 2007. CMS's CWF edit identifies IRF claims with an improper patient discharge status code and produces an unsolicited informational response (edit alert) to the appropriate contractor.

### **TrailBlazer Health Enterprises, LLC**

During fiscal years (FY) 2008 and 2009, CMS contracted with TrailBlazer Health Enterprises, LLC (TrailBlazer), to serve as the Medicare Administrative Contractor for Jurisdiction 4.

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

### **Objective**

Our objective was to determine whether Medicare paid certain fiscal year (FY) 2008 and 2009 Jurisdiction 4 IRF claims in accordance with Medicare's transfer regulations.

---

<sup>2</sup> Our previous reports addressed IRF claims coded as discharges to home (report number A-04-04-00008, issued September 11, 2006), discharges to home with home health services (report number A-04-04-00013, issued November 2, 2006), and IRF claims coded as discharges to home or discharges to home with home health services (report number A-04-09-00059, issued June 29, 2010).

## Scope

Our review covered \$1,436,770 in Medicare Part A payments related to 73 transfer claims, with dates of service ending in FYs 2008 and 2009, submitted by 30 IRFs in Texas, Colorado, and Louisiana. After initial claims payment, the CWF edit identified these 73 claims as IRF transfers that were incorrectly coded and paid as discharges to home or discharges to home with home health services.

Our objective did not require an understanding or assessment of the complete internal control structure of TrailBlazer. Therefore, we limited our review to obtaining a general understanding of the IRF prospective payment system and TrailBlazer's policies and procedures for reviewing claims identified by the CWF.

We conducted our fieldwork from March through October 2011.

## Methodology

To accomplish our objective, we:

- reviewed Federal laws, regulations, and CMS guidance concerning IRF transfers;
- extracted IRF paid claims from CMS's National Claims History File for FYs 2008 and 2009;
- refined the nationwide file by excluding certain claims, such as claims with lengths of stay equal to or greater than the average length of stay for the case-mix group, outlier claims, claims for deceased beneficiaries, claims not primarily paid by Medicare, and claims paid to Maryland providers;<sup>3</sup>
- identified 73 IRF claims paid by TrailBlazer with patient status codes 01 or 06 that indicated discharge;
- reviewed CMS's CWF claims history for the 73 claims to verify that the selected claims had not been canceled or superseded by corrected claims;
- sent the 73 claims to TrailBlazer officials to verify that the claims were miscoded and to determine the cause of the miscoding;
- interviewed TrailBlazer officials to understand how they processed IRF claims and to determine why TrailBlazer made payments for the miscoded claims;
- used CMS's Pricer program to reprice each improperly paid claim in our sample to determine the transfer payment amount, compare the repriced payment with the actual payment, and determine the value of the overpayment; and

---

<sup>3</sup> Maryland is exempt from the prospective payment system.

- discussed the results of our review with TrailBlazer officials.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATIONS**

Medicare overpaid some FY 2008 and 2009 Jurisdiction 4 IRF claims that did not comply with transfer regulations. Because of system problems, TrailBlazer did not receive the CWF edit alerts notifying it that the miscoded claims required payment adjustment. Accordingly, Trailblazer could not respond appropriately to the CWF edit alerts, and it incorrectly paid 73 transfer claims as discharges. As a result, Medicare overpaid 30 IRFs by \$384,919 for FYs 2008 and 2009.

## **PROGRAM REQUIREMENTS**

### **Federal 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 certain other facilities. Pursuant to implementing regulations, 42 CFR §§ 412.602 and 412.624(f)(1), IRFs receive an adjusted prospective payment if (1) the beneficiary's IRF stay is shorter than the average stay for nontransfer cases in the case-mix group and (2) the beneficiary is transferred to another IRF; a short-term, acute-care prospective payment hospital; a long-term-care hospital; or a nursing home that qualifies for Medicare or Medicaid payments.

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.

### **Centers for Medicare & Medicaid Services Guidance**

*The Medicare Claims Processing Manual*, chapter 3, section 140.3, 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.

Effective April 1, 2007, CMS implemented a CWF edit that identifies IRF transfer claims miscoded as discharges. When the CWF edit identifies transfer claims prior to payment, it cancels the claim. When it identifies a claim after payment, the CWF generates an edit alert that requires the Medicare Administrative Contractor to take action to correct the claim.

## **TrailBlazer Policies and Procedures**

TrailBlazer policy and procedures require taking appropriate action to correctly process inpatient bills with improper patient discharge status codes. TrailBlazer should be notified through an edit alert report that the CWF has identified a miscoded claim, and the claims processor at TrailBlazer researches each claim to verify the discharge and admission. Based on the admitting facility type, the claims processor corrects the patient discharge status code to adjust the Medicare payment to the correct amount.

## **MEDICARE OVERPAYMENTS FOR MISCODED INPATIENT REHABILITATION FACILITY CLAIMS**

Medicare overpaid some FY 2008 and 2009 Jurisdiction 4 IRF claims that did not comply with transfer regulations because TrailBlazer had not received the CWF edit alerts notifying it that the miscoded claims required payment adjustment. TrailBlazer had recognized that the CWF edit alerts were not being received and had notified the CWF maintainer. Additionally, TrailBlazer requested the available missing CWF edit alert reports and corrected those claims. Despite its efforts, not all CWF edit alert reports became available to TrailBlazer; therefore, Trailblazer could not respond appropriately to the CWF edit alerts, and it incorrectly paid 73 transfer claims as discharges.

## **SYSTEM PROBLEMS**

System problems interfered with TrailBlazer's ability to receive all edit alerts notifying it that miscoded claims required payment adjustment. As a result, Medicare overpaid 30 IRFs by \$384,919 for FY 2008 and 2009.

According to TrailBlazer, it identified and corrected the system problems that caused the miscoded claims to remain uncorrected. Furthermore, during our audit, TrailBlazer adjusted all 73 miscoded claims.

## **RECOMMENDATIONS**

We recommend that TrailBlazer:

- recover \$384,919 in overpayments,
- ensure that it receives and properly addresses future CWF edit alerts in a timely manner, and
- educate Jurisdiction 4 IRFs on the importance of reporting the correct patient status code on transfer claims.

## **TRAILBLAZER HEALTH ENTERPRISES, LLC, COMMENTS**

In written comments on our draft report, TrailBlazer generally agreed with our recommendations and described corrective actions that it had taken or planned to take in response to our recommendations. TrailBlazer's comments are included in their entirety as the Appendix.

# **APPENDIX**



March 22, 2012

Lori S. Pilcher  
Regional Inspector General for Audit Services  
Office of Inspector General  
Office of Audit Services, Region IV  
61 Forsyth Street SW, Suite 3T41  
Atlanta, GA 30303

Report Number: A-04-11-00078

Dear Ms. Pilcher:

We received the February 29, 2012, draft report entitled "Medicare Overpaid Some Fiscal Year 2008 and 2009 Jurisdiction 4 Inpatient Rehabilitation Facility Claims That Did Not Comply With Transfer Regulations." In the draft report, the OIG recommended that TrailBlazer:

- Recover \$384,919 in overpayments;
- Ensure that it receives and properly addresses future CWF edit alerts in a timely manner; and
- Educate Jurisdiction 4 IRFs on the importance of reporting the correct patient status code on transfer claims.

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

**Recovery of Overpayments:** TrailBlazer processed all 73 claims requiring adjustment and recovered the \$384,919 due the Medicare program.

**Receive and Process CWF Edit Alerts:** TrailBlazer processes all CWF edit alerts received in a timely manner. However, TrailBlazer is not the standard system maintainer and therefore, can not ensure timely receipt of CWF edit alerts. As noted in the draft report, these overpayments resulted from a problem with the FISS shared system which prevented TrailBlazer from receiving alerts/unsolicited responses. This problem impacted all contractors. It was reported to FISS immediately; however, it was not corrected for six months. In the future, if TrailBlazer identifies a problem preventing receipt of CWF edit alerts/unsolicited responses, we will report the problem to the responsible entity, i.e. FISS. Additionally, we will report the problem to the Medicare Administrative Contractor (MAC) Jurisdiction 4 Contracting Officer's Representative (COR), so that alternate arrangements can be made for communicating the CWF edit alerts/unsolicited responses to us in a timely manner.

**Provider Education Activities:** TrailBlazer provides a Part A Beginner's Guide to Medicare to assist providers with basic Part A information to help ensure Part A claims are submitted properly.

Lori S. Pilcher  
March 22, 2012  
Page 2 of 2

<http://www.trailblazerhealth.com/Publications/Training%20Manual/MedicareBasicsManual.pdf>

TrailBlazer also offers the TrailBlazer Inpatient Services manual, which includes IRF policies, billing information, requirements, revenue codes, form locators, discharge status information, initiatives and significant changes to the Medicare program.

<http://www.trailblazerhealth.com/Publications/Training%20Manual/InpatientServicesManual.pdf>

Part A Beginner's Guide to Medicare and Inpatient Services training are routinely offered through Web-based training events. The PowerPoint presentations are available for download and, upon completion of these events, the recorded training sessions are posted on the TrailBlazer Web site for reference.

<http://www.trailblazerhealth.com/Education/EncoreWBTs.aspx?DomainID=1>

Providers may also refer to TrailBlazer's Part A UB-04 Discharge Status Codes (Form Locator 17) job aid ([http://www.trailblazerhealth.com/Publications/Job%20Aid/ub-92a\\_discharge.pdf](http://www.trailblazerhealth.com/Publications/Job%20Aid/ub-92a_discharge.pdf)) for a list of patient discharge status codes and the IRF Web page (<http://www.trailblazerhealth.com/Facility%20Types/IRF/default.aspx?DomainID=1>) for information and links to educational resources. The IRF Web page contains a link to the notice posted on March 8, 2012, as a result of this OIG audit report. This notice was also sent in listserv and will be added to the TrailBlazer *eBulletin* for further exposure. In addition, these findings will be addressed in future online training sessions when appropriate.

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

Sincerely,

*/s/ Melissa Halstead Rhoades*

Melissa Halstead Rhoades  
Area Director & Medicare CFO

cc: Susan Oken, J4 MAC Contracting Officer's Representative, CMS  
Gil R. Glover, President & Chief Operating Officer, TrailBlazer  
Scott J. Manning, Vice President, Financial Management Operations, TrailBlazer  
Kevin Bidwell, Vice President & Compliance Officer, TrailBlazer