



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

May 24, 2012

Report Number: A-04-11-00079

Scott Kimbell  
Director NGS Program Management Tier II  
13550 Triton Park Blvd.  
Louisville, KY 40223

Dear Mr. Kimbell:

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 13 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-04-11-00079 in all correspondence.

Sincerely,

/Lori S. Pilcher/  
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  
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Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE OVERPAID SOME FISCAL  
YEAR 2008 AND 2009 JURISDICTION 13  
INPATIENT REHABILITATION FACILITY  
CLAIMS THAT DID NOT COMPLY WITH  
TRANSFER REGULATIONS**



Daniel R. Levinson  
Inspector General

May 2012  
A-04-11-00079

# *Office of Inspector General*

<http://oig.hhs.gov>

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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 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 to home 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, the 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 National Government Services, Inc. (NGS) to serve as the Medicare Administrative Contractor for Jurisdiction 13. This audit covered \$1,511,722 in Medicare Part A payments related to 60 claims, with dates of service ending in FY 2009, submitted by 26 IRFs in Connecticut and New York.

### **OBJECTIVE**

Our objective was to determine whether Medicare paid certain FY 2008 and 2009 Jurisdiction 13 IRF claims in accordance with Medicare's transfer regulations.

### **SUMMARY OF FINDINGS**

Medicare overpaid some FY 2009 Jurisdiction 13 IRF claims that did not comply with transfer regulations. Because NGS management did not communicate the CMS change request to its staff, NGS did not review the CWF edit alert reports notifying it that the miscoded claims required payment adjustment. Accordingly, NGS did not respond appropriately to the CWF edit alerts, and it incorrectly paid 60 transfer claims as discharges. As a result, Medicare overpaid 26 IRFs by \$413,445 for FYs 2008 and 2009.

## **RECOMMENDATIONS**

We recommend that NGS:

- recover \$413,445 in overpayments,
- ensure that it receives and properly addresses future CWF edit alerts in a timely manner, and
- educate Jurisdiction 13 IRFs on the importance of reporting the correct patient status code on transfer claims.

## **NATIONAL GOVERNMENT SERVICES, INC., COMMENTS**

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

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## 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 patient 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;

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<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.

### **National Government Services, Inc.**

During fiscal years (FY) 2008 and 2009, CMS contracted with National Government Services, Inc. (NGS), to serve as the Medicare Administrative Contractor for Jurisdiction 13. This audit covered \$1,511,722 in Medicare Part A payments related to 60 claims, with dates of service ending in FY 2009, submitted by 26 IRFs in Connecticut and New York.<sup>3</sup>

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

### **Objective**

Our objective was to determine whether Medicare paid certain FY 2008 and 2009 Jurisdiction 13 IRF claims in accordance with Medicare's transfer regulations.

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<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 discharges to home or discharges to home with home health services (report number A-04-09-00059, issued June 29, 2010).

<sup>3</sup> Our review disclosed no NGS Medicare Part A payments for FY 2008 IRF transfer claims with patient status codes 01 or 06 that indicated discharge. All 60 NGS claims and payments identified were for FY 2009.

## Scope

Our review covered 60 NGS Medicare Part A payments totaling \$1,511,722 that related to 60 transfer claims. These 60 claims had dates of service ending in FY 2009 and were submitted by 26 IRFs in Connecticut and New York. After initial claims payment, the CWF edit identified these 60 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 NGS. Therefore, we limited our review to obtaining a general understanding of the IRF prospective payment system and NGS's policies and procedures for reviewing claims identified by the CWF.

We conducted our fieldwork at NGS offices in Indianapolis, Indiana in September 2011.

## Methodology

To accomplish our objective, we:

- reviewed Federal laws and regulations and CMS guidance concerning IRF transfers;
- extracted 321,986 IRF paid claims from CMS's National Claims History File for FYs 2008 and 2009;
- identified 218 IRF transfer claims nationwide with patient status codes 01 or 06 that indicated discharge by refining the nationwide file and 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>4</sup>
- identified 60 IRF transfer claims paid by NGS, out of 218 claims in the refined nationwide file;
- reviewed CMS's CWF claims history for the 60 claims to verify that the selected claims had not been canceled or superseded by corrected claims;
- sent the 60 claims to NGS officials to verify that the claims were miscoded and to determine the cause of the miscoding;
- interviewed NGS officials to understand how they processed IRF claims and to determine why NGS made payments for the miscoded claims;

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<sup>4</sup> Maryland is exempt from the prospective payment system.

- 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
- discussed the results of our review with NGS 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 2009 Jurisdiction 13 IRF claims that did not comply with transfer regulations. Because NGS management did not properly communicate the CMS change request to its staff, NGS did not review the CWF edit alert reports notifying it that the miscoded claims required payment adjustment. Accordingly, NGS did not respond appropriately to the CWF edit alerts, and it incorrectly paid 60 transfer claims as discharges. As a result, Medicare overpaid 26 IRFs by \$413,445 for FY 2008 and 2009.

### **PROGRAM REQUIREMENTS**

#### **Federal Regulations**

Section 1886(j)(1)(E) of the 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.

### **National Government Services, Inc., Policies and Procedures**

NGS policies and procedures require taking appropriate action to correctly process inpatient bills with improper patient discharge status codes. NGS is notified through an edit alert report that the CWF identified a miscoded claim. The claims processor at NGS cancels the claim, and the provider is required to resubmit a corrected claim.

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

Medicare overpaid 60 FY 2009 Jurisdiction 13 IRF claims that did not comply with transfer regulations because NGS did not review the CWF edit alerts notifying it that the miscoded claims required payment adjustment. As a result, Medicare overpaid 26 IRFs by \$413,445 for FY 2008 and 2009.

During our audit, NGS canceled the 60 miscoded claims and has been working with the IRFs to correct the claims. At the conclusion of our fieldwork 18 claims (\$183,704 in overpayments) were correctly adjusted, 26 claims (\$140,033 in overpayments) were still pending provider resubmissions, and 16 claims (\$89,708 in overpayments) were not resubmitted.

### **COMMUNICATION PROBLEMS**

The CMS edit alert report notified NGS staff that miscoded claims required payment adjustment. However, NGS management did not communicate to its staff the CMS change request that implemented the edit alert report and required contractors to adjust the identified claims.

According to NGS, it identified and corrected the communication problems that caused the miscoded claims to remain uncorrected. Additionally, NGS reviewed the subsequent CWF edit alert reports and verified that the edit is currently working and that NGS staff is responding appropriately.

### **RECOMMENDATIONS**

We recommend that NGS:

- recover \$413,445 in overpayments,
- ensure that it receives and properly addresses future CWF edit alerts in a timely manner, and

- educate Jurisdiction 13 IRFs on the importance of reporting the correct patient status code on transfer claims.

## **NATIONAL GOVERNMENT SERVICES, INC., COMMENTS**

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

# **APPENDIX**